INDIVIDUAL EXPERIENCES OF BULLYING BEHAVIOURS – A PORTFOLIO OF RESEARCH AND THERAPEUTIC PRACTICE

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Section A: Preface

This portfolio seeks to provide comprehensive insights into the complex nature and experience of bullying behaviours. The portfolio has three components to it. Firstly, I present an empirical piece of research, which culminates in a theory as to the experience and nature of all aspects of bullying as portrayed by employees of A London Trust (ALT). Secondly, I present a psychodynamic case study of my clinical work with a client who showed remarkable resilience in later life having experienced extensive neglect and bullying behaviours during childhood. Finally, I present a paper which I hope to publish in British Medical Journal (BMJ) Open.

Before explaining the three components of this portfolio, I would like to provide some reflections on my journey into the world of counselling psychology and on this particular research. I left full-time education at the age of 16 and was fortunate to gain employment immediately in a factory. Whilst the work was for me too mundane, I recollect watching my fellow workers and being fascinated by how we are all so very different. I had no knowledge of psychology at this stage in my early career. I left this work after a relatively short period and, with jobs readily available at that time, accepted work in a sales office which offered funding for a two-year business study course. At this time, I had very little in the way of formal education, and this was an ideal choice. I recall having a conversation with the wife of a colleague, and she was a social worker. I was attracted to her profession and her ability to help people with a view to changing their lives for the better. Her comment to me, however, was that 'if you are expecting any thanks from people don't do it.' This comment dampened my interest somewhat, and I stayed with my sales office work. While I had a keen interest in psychological welfare, I was diverted away from the topic for some time as I embarked on a different work journey. My career away from psychology was varied and rewarding, but I still harboured a desire to move to work that was more meaningful to me and others, hence my transition in later life to train in the field of counselling psychology. I chose my placements carefully and wanted to be able not only to provide psychological therapies but also to contribute to the welfare of the workforce. My second-year placement at the Staff Psychological and Welfare Service (SPWS) at ALT enabled me to achieve these goals as I was providing psychological support to all grades/bands of employees with a variety of differing presentations.

The research component of this portfolio was considered prior to my starting at my placement within ALT. The latest NHS England staff survey results were released, and ALT appeared within the top five for the percentage of employees stating that they had experienced bullying. My interest in the subject of bullying behaviours in the workplace was therefore well-founded, and I had conversations with HR personnel on the subject.

Whilst extensive research had considered the impact of bullying behaviours on employees within healthcare environments, relatively little had been done which contemplated 'what constituted bullying to an individual', and it was here that my research journey started. The mixed-methods design of the research reflected the desire to answer the research question as fully as possible, and I felt comfortable with the volume of the work required and which I believed would add to the field of counselling psychology.

Each section of this portfolio is linked by a desire to improve the understanding and therefore the psychological welfare of individuals who have experienced bullying behaviours. The choice of method for the research element of the portfolio was driven by the needs of the research question. The choice of psychological therapy for the second section of my portfolio, my case study, was driven by the client presentation. The choice of journal for the final section of my portfolio, the publication of the results of this study, was determined by the relevant potential readership by healthcare staff.

Section B

The main body and the second section of this portfolio consist of the Doctoral Research entitled '*How do ALT Staff Perceive and Experience Bullying Behaviours? – A Mixed-Methods Study'*. The research aim was to consider the prevalence and types of bullying behaviours (negative acts) from a quantitative perspective and their relationships with the wellbeing of staff and, in particular, with stress, depression and anxiety. This quantitative data enabled an examination of the levels and types of bullying acts reported by staff as experienced. However, the main focus was to obtain, by way of qualitative data, the *experience* and *perception* of being bullied from the viewpoint of the 'target'. This qualitative data was analysed, and a theory proposed adopting constructivist grounded theory techniques (Charmaz, 2014). The results of both methods of enquiry were compared and contrasted at the analysis stage and similarities

and differences were highlighted. The findings are discussed in line with existing research and potential changes to working practice are suggested. The research section concludes with some implications for counselling psychology as a profession.

Section C

The third section of this portfolio is an example of a case study from my therapeutic practice. I have chosen this particular client as an example of someone who experienced bullying as a child, but this did not lead to his experiencing bullying in adult life. The client demonstrated a rich array of resilience and determination throughout his adult life. Brief psychodynamic therapy was adopted for this particular client, based on his presentation and the subsequent formulation. The case study is entitled '*Is Post-Traumatic Growth through Experiences of Childhood Bullying and Trauma Possible?*'

Section D

In this fourth and final section, I present a paper with the aim of submitting it for publication in the online journal BMJ Open. I have chosen this publication, as opposed to a pure counselling psychology journal, as papers within this publication reach a large healthcare audience target (Impact Factor 2.562) where I anticipate that interest in the subject matter will be wide ranging. BMJ Open is an online, open access journal, dedicated to publishing medical research from all disciplines and therapeutic areas. The journal publishes all research study types, from protocols through to and including small specialist studies. In addition, a recent mixed-methods study (Carter, Thompson, Crampton, Morrow, Burford, Gray, and Illing, 2013), which has been influential for reference purposes for this current study, was published in BMJ Open in 2013, and this was also a factor when considering which journal would be most appropriate and accepting of this current study. There is a lack of qualitative and especially mixed-methods studies in the domain of *bullying in the workplace,* and so this present research adds to the limited research in this area. The requirements for the journal are that the word count is circa 4,000 words, and the journal article presented in this fourth section of my portfolio follows this requirement with the main headings matching the format requested by BMJ Open and published by Carter et al. (2013).

Section B: Doctoral Research

How do ALT Staff Perceive and Experience Bullying Behaviours? – A Mixed-Methods Study.

Abstract

Tackling bullying within the healthcare profession is a major priority considering the costs and risks associated with it, and a full understanding of what behaviours constitute bullying is crucial (Allen, 2015). This mixed-methods study's QUAL/Quant aims were, firstly, to establish what ALT staff considered to be their experiences of bullying (QUAL) and, secondly, to consider the prevalence of negative acts and their potential relationships to levels of reported depression (Hypothesis 1), stress (Hypothesis 2) and anxiety (Hypothesis 3) (Quant). A pragmatic epistemological framework was utilised for this study with a qualitative focus. Employees from five divisions of ALT were invited to participate in this study, and 303 (response rate 27.5%) took part in the quantitative questionnaire-based study. Eight participants who had described experiences of being bullied were interviewed qualitatively. Prevalent negative behaviours, as reported were: being exposed to an unmanageable workload, having your opinions and views ignored, excessive monitoring of work, being ordered to do work below your level of competence, and being ignored or facing a hostile reaction when you approach. All three hypotheses were strongly supported, in that there was a significant positive relationship between reported experiences of negative acts and levels of depression, anxiety and stress. A constructivist grounded theory approach was adopted for the analysis of the qualitative data. The findings suggested that the experience of bullying was far more complex than the reporting of negative acts and included a stealth-like nature prior to individuals recognising a bullying event. The integration of both methods during the analysis enabled a more thorough exploration of the experience of bullying behaviours than either a qualitative or quantitative approach would have achieved in isolation.

Chapter 1 Introduction

1.1 Rationale and Aims

Workplace bullying can be considered a major social issue within the UK (Hoel, Cooper and Faragher, 2001). The Chartered Institute of Personnel Development (CIPD) suggests that bullying costs UK employers in excess of £2 billion a year. The estimate can be considerably higher when taking into account absenteeism, turnover and productivity (Allen, 2015). In the UK, nurses and midwives must uphold the professional standards that are set by the Nursing and Midwifery Council (NMC, 2015). These standards contain a section on working cooperatively and state that nurses should respect the expertise and contributions of colleagues and be supportive of colleagues who may be experiencing health or performance-related problems (Wilson, 2016). Guidance was issued to employers in 2006 that all NHS organisations should have bullying and harassment policies in place (Wilson, 2016). In considering the NHS in particular, the Francis Review into the Mid Staffordshire NHS Foundation Trust commented on the need for the NHS to become more open and fair in delivering safe, effective and responsive care (Singh, Chand, Shippen and Campbell, 2015). The General Medical Council stated in response to the report that these changes include creating an NHS where staff, including doctors and other health professionals, work in a culture in which they feel empowered and supported when they speak up (Singh, Chand, Shippen and Campbell, 2015).

For the healthcare profession, tackling bullying is a major priority given the costs and risks of dealing with the outcomes (Allen, 2015). It is, therefore, crucial to have a full understanding of what behaviours constitute bullying, rather than negative acts, in the workplace (Allen, 2015). Longo (2013) comments that without proper identification of bullying and also a willingness by management to acknowledge it, bullying may become a cultural norm. Targets of bullying are found to be at a higher risk of expulsion from the workplace and working life altogether (Glambek, Skogstad and Einarsen, 2014), making the elimination of bullying behaviours a high priority for employers.

The topic of the phenomenon of bullying continues to have considerable interest, particularly in the domains of organisational psychology and business and management (Lutgen-Sandvik, Tracy and Alberts, 2007). Whilst bullying is apparent in many

organisations, its occurrence within healthcare can be seen as more critical, as the outcome of healthcare is human wellbeing (Katrinli, Atabay, Gunay and Cangarli 2010). In the field of counselling psychology, this present research aims to add to the depth of understanding of the individuals' perceptions and experience of bullying behaviours. There are many therapies that are available and used to help victims of bullying behaviours, and a more detailed knowledge and understanding of what targets experience as bullying may help professionals develop insights into those therapies which may be appropriate for differing situations.

The aims of this present mixed-methods study within NHS England and, in particular ALT, are to consider the prevalence of bullying behaviour from a quantitative perspective and its relationships with staff wellbeing, and also to give regard to the experience and perception of being bullied from the viewpoint of the 'target' by way of qualitative data.

1.2 The 2015 NHS Staff Survey England

The results of the thirteenth national survey for NHS England staff were released in March 2016. Conducted in 2015, the national staff survey involved 297 NHS organisations in England; more than 741,000 NHS staff were invited to participate using a self-completion postal questionnaire or an online survey. Responses were received from 299,000 NHS staff, a response rate of 41% (42% in 2014).

Across all trust types, one in eight staff (13%) reported that they had experienced harassment or bullying from their manager one or more times. In addition, 18% of staff reported experiencing harassment or bullying by other colleagues on one or more occasions.

ALT is one of 43 foundation trusts (out of a total of 154 acute trusts in England) and is part of NHS England. This trust employs around [redacted] The response rate for ALT for the staff survey in 2015 was 36% (*N*=2,627).

The national survey for NHS England asks questions which are then classed as key findings, of which there are 32 in total. Two of these findings are:

- Key Finding 17: percentage of staff suffering work-related stress in the last 12 months

- Key Finding 26: percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

For both of these key findings, ALT appears as a 'negative finding', indicating that it appears in the worst 20% of acute trusts. From the 32 key findings, the report lists five key findings for which ALT compares least favourably with other acute trusts in England. Key Findings 17 and 26 listed in Table 1 appear in the bottom five ranking scores.

Table 1 - ALT key findings 17 and 26 year-on-year comparison

	2015	2014	2013
Key Finding 17	41 %	41 %	39 %
Key Finding 26	31 %	30 %	29 %

The national average scores for Key Findings 17 and 26 in 2015 were 36% and 26% respectively. It is suggested by NHS England that the bottom five Key Findings are areas which can be seen as a starting point for the employer to take local action to improve. The significance and motivation for this present study are to provide meaningful data to the management of ALT to aid understanding of the types of negative acts that are reported by staff and also staff perceptions of what bullying experiences they have encountered at ALT.

1.3 The History of Bullying Research

It has been suggested (Castronovo, Pullizzi and Evans, 2016) that nurse bullying, in particular, has been in existence for more than one hundred years; the authors comment that in 1909, the New York Times paid attention to 'the abominable outrages' and 'outright persecution' that head nurses who had abused their position of power had inflicted on nurses. The expression that 'nurses eat their young' is well known within the nursing profession, suggesting that young, new graduate nurses are bullied by their more senior counterparts (Castronovo et al., 2016). Workplace bullying research is considered to have started in the 1980s in Sweden and, at first, considered previous research on schoolyard bullying. A German-born physician and psychiatrist, Heinz Lemann, is considered to be a pioneer in this work (Lutgen-Sandvik et al., 2007).

Following his research into school bullying, he examined workplace bullying, which he classed as 'mobbing'. It was a few years later that Stale Einarsen in Norway, now a prominent researcher and figure in the area of workplace bullying, commenced his studies into mobbing and work harassment. It was only in 1990 in the UK that the freelance journalist Andrea Adams introduced the concept of 'bullying' to the UK by way of a series of broadcasts on the 'phenomenon'. Since then, significant research has emerged internationally. Prior to this time, in the USA in 1976, Carroll Brodsky produced a book after interviewing over 1,000 workers, called *The Harassed Worker.* The book received little interest at the time but is now considered to be a central piece of writing on the subject. Since the 1990s, US researchers have also considered workplace hostility behaviours. However, due to the many differing terms and definitions existing in the US, their work is considered less cohesive than international bullying research (Lutgen-Sandvik et al., 2007).

1.4 Definition of Bullying

In the UK, there is currently no legal definition of bullying. The Advisory, Conciliation and Arbitration Service (ACAS) defines bullying as offensive, intimidating, malicious or insulting behaviour, and as an abuse or misuse of power through means that undermine, humiliate, denigrate or injure the recipient. Bullying can be referred to by many different names, such as mobbing or harassment, as well as horizontal violence, vertical violence, nurse hostility, abuse and disruptive behaviour (Castronova et al., 2016). These names are sometimes used interchangeably and without their true meaning being apparent. This is the case for the ALT 'procedure for dealing with staff harassment and bullying', which deals with any type of harassment or bullying. Harassment, as opposed to bullying, can have different defining features, although sometimes it is intertwined with stories of bullying. Harassment tends to focus on specific elements of an individual, such as race, age, gender, sexual orientation, disability or nationality (Hollins Martin and Martin, 2010). Harassment has legislation associated with it, and only one incident is required for behaviour to be deemed as harassment. In contrast, there is no legal definition for bullying behaviours and a common feature is 'persistency of behaviour'. Harassment tends to be focused on an individual's dissimilarity to someone else, whereas bullying can be targeted at anyone (Allen, 2015).

Workplace mobbing is another term that can be used to describe employees who are picked on and 'ganged up' on by the leader, who can be a superior/s, co-worker or the organisation. The victim, who can be helpless in this situation, can be described as being *mobbed* and subject to *mob-like* behaviour. The term 'mobbing' tends to be used frequently within Europe but rarely in the UK. The difference in terms often relates to where the research was undertaken. In the UK and Ireland, the term bullying is used rather than mobbing; in the US, bullying has been referred to as emotional abuse. It has been found that in the US there is a lack of federal legislation addressing workplace bullying (Bartlett and Bartlett, 2011).

Adult bullying can be said to have four main features, namely intensity, repetition, duration and power disparity (Lutgen-Sandvik et al., 2007):

- **Intensity** is used to describe the number of negatives acts that the victim has been subjected to, and many targets report more than one act. In fact, Lutgen-Sandvik et al. (2007) suggest that only two or more incidents would be considered mobbing in the American workplace.
- **Repetition** of negative acts is implicit, and many authors (Einarsen and Hoel 2001) would not consider a one-off act as an instance of bullying.
- **Duration** reflects different aspects of time. Not only should two or more negative acts be experienced in a week, but a six-month minimum would also normally be applied to differentiate bullying from low-level negativity.
- **Power disparity** between the target and the perpetrator is considered 'central to the definition of bullying', suggesting that the victim has no control or is helpless to defend against abusive power (Lutgen-Sandvik et al., 2007). This disparity was a common issue found by Bartlett and Bartlett (2010) in their integrative literature review, where they stated that disparity created opportunities for the bully to exert power over the target.

The target is the term often referred to as the 'individual who is/has been subjected to bullying behaviours'. Bartlett and Bartlett (2010) described categories reported in the research as 'work-related bullying types' and as 'direct and indirect personal types of bullying behaviours', where direct bullying involves interactions between the bully and target and indirect bullying is between the bully and others who indirectly harm the individual. These types and behaviours are detailed in Table 2 and Table 3.

Table 2 - Work-Related Bullying Types

Workload	Work Process	Evaluation and Advancement
Work overload	Shifting opinions	Excessive monitoring
Removing responsibility	Overruling decisions	Judging work wrongly
Delegation of menial tasks	Flaunting status/power	Unfair criticism
Refusing leave	Professional status attack	Blocking promotion
Unrealistic Goals	Controlling resources	
Setting up to fail	Withholding information	

Table 3 - Indirect and Direct Personal Bullying Behaviours

Indirect	Direct
Isolation	Verbal attack/harassment
Ignoring	Belittling remarks
Excluding	Yelling
Not returning communications	Interrupting other
Gossip	Persistent criticism
Lies	Intentionally demeaning
False accusations	Humiliation
Undermining	Personal jokes
	Negative eye contact/staring
	Intimidation
	Manipulation
	Threats

Defending oneself against bullying suggests power; power is not just defined as top-down but can include educational power or power derived from a network of colleagues (Branch, Ramsey and Barker et al., 2013). Some bullying behaviour can be subtle, such as eye-rolling, tongue-clucking and emotional dismissal (Cox-Dzurec and Bromley, 2012). This behaviour can be confusing to workers who have come to the workplace just to work, and can be seen as absurd by others who have not lived through the experience themselves (Cox-Dzurec and Bromley, 2012). Victims can find it difficult to capture the emotional significance of what has happened to them; the process and the meaning can appear trivial when they try to explain the issue to others (Cox-Dzurec and Bromley, 2012). Bullying activities can be overt and intimidating or comparatively invisible (Cleary, Hunt and Horsfall, 2010).

One of the main authors over the last thirty years in the field of workplace bullying continues to be Stale Einarsen and his definition, adapted from research in Scandinavia, states that *'bullying is defined as a situation in which one or more persons systematically and over a long period of time perceive themselves to be on the receiving end of negative treatment on the part of one or more persons, in a situation in which the person(s) exposed to the treatment have difficulty in defending themselves against this treatment'* (Einarsen, 2000). This statement or definition of bullying behaviours encompasses the four features of intensity, repetition, duration and power disparity detailed above. The words 'perceive themselves' are the ones that are subjective, and varying definitions and different interpretations can be applied; this point is explored in this present study more fully.

There are also many frameworks that have been discussed and developed to try and understand the *phenomenon* of bullying, such as Karasek's Job Demand-Control Model (Karasek, 1979) which predicts that mental strain results from interactions of job demands and job decision latitude. The model suggests that low decision latitude and heavy job demands result in mental stain (Karasek, 1979). The Conflict Escalation Model of Glasl (1994) (cited in Zapf and Gross, 2001) was developed prior to research on workplace bullying being undertaken but suggests that levels of conflict escalate between three phases and nine stages commencing with a rational conflict and culminating in total destruction. The Affective Events Theory (Weiss and Cropanzano, 1996) is based on the assumption that each bullying event will produce an 'affective' reaction; for example, putting someone down will produce an emotion such as sadness

which will, in turn, affect subsequent behaviours, such as attitude to work and wellbeing (Brotheridge and Lee, 2010). This framework details the length and intensity of the bullying as a prime factor, rather than the individual events themselves. This present study considers the 'affective' reaction to bullying behaviours by way of both the quantitative part of the study (relationships between bullying behaviours and wellbeing) and also the qualitative part by exploring individual descriptions of bullying behavioural examples. The Cyclical Framework of Workplace Bullying (Branch et al., 2013) is a relatively new model which draws on the affective events theory and encompasses societal factors as a whole, the individual and organisational work environment, individual and organisational wellbeing and responses, the continuation of affective events and the cessation of affective events. Gaffney, DeMarco, Hofmeyer, Vessey and Budin (2012) theorised how nurses *make things right* when faced with bullying. The authors describe how they found that nurses place bullying in context, assess the situation, take action and then finally judge any outcomes.

This present study will build on the existing knowledge but also address some of the gaps in the theoretical literature. For example, Gaffney et al. (2012) included open-end questionnaires focusing on the experience of nurses; this present study will include the wider healthcare workforce with in-depth interviews. The Branch et al. (2013) review concludes that although there are advancements there is still much to be done, including the development of a guiding theory.

National culture can play a significant part in explaining how employers and employees may interpret and react to work behaviours, including bullying (Samnani and Singh, 2012). Bullying tactics can be interpreted and reacted to differently according to the culture and environment in which it takes place (Khan and Khan, 2012). Some cultures demand respect for the elderly and an acceptance of the authority that this entails; if we agree with our bosses whether they are right or wrong out of respect, we could leave ourselves open to more bullying. If we disagree, we could be seen as disrespectful; this could be a fine balance from the perspective of bosses and employees alike. In part due to the complexity of the bullying phenomenon, it is nearly impossible to develop an agreed definition of workplace bullying which reflects the range of cultural contexts while acknowledging the original academic work in the area (Branch et al., 2013).

1.5 Prevalence of Bullying

The prevalence of bullying can be difficult to ascertain due to the lack of a legal meaning of what constitutes bullying, and targets may also want to keep their situation secret. Victims can decline to be labelled as such, as the definition can imply weakness and passivity (Mikkelsen and Einarsen, 2001). The changeable definitions of bullying that have been described previously result in the prevalence of bullying reported varying between studies and indeed cultures. Lutgen-Sandvik et al. (2007) describe researchers using alternative methods to ascertain prevalence.

Consideration is given to the occurrence of negative acts over a period of time, and also the target would have to self-identify as a target to engage in an in-depth discussion regarding the bullying experienced. As noted, when targets are experiencing bullying, they may consider this to be a weakness and not wish to be self-identified as such, and this could result in the under-reporting of bullying. Bullying may further go unreported in the workplace due to staff being unfamiliar with the reporting procedure, the belief that nothing would change, fear of being labelled a complainer or trouble maker (as evidenced by Carter et al. (2013)), or fear of damaging future career prospects (Cleary et al., 2010). A lack of studies examining bullying from the victim's perspective could also limit conclusive estimates of prevalence (Beswick, Gore and Palferman 2006). This present study attempts to address both prevalence of bullying behaviours and bullying as perceived by the *target* within ALT.

Despite the lack of clarity, many studies have been undertaken over the last twenty years that considered the prevalence of bullying. Quine (2001) found that 44% of nurses reported having experienced bullying in the previous twelve months. Mikkelsen and Einarsen (2001) found that 4.1per cent of employees of a manufacturing company said they had been bullied (*N*=224), 3.3 per cent of a department store (*N*=215) and only 2 per cent of hospital staff (*N*=302). Hoel Cooper and Faragher (2001) found that 10.6 % of respondents from 70 organisations reported being bullied in the previous six months, rising to 24.7% over the previous five years. Demir, Rodwell and Flower (2013) found that 24% of Australian health professionals reported having experience of workplace bullying. Carter et al. (2013) found that 20% of healthcare workers in the North East of England had reported experiencing bullying behaviours.

A further consideration regarding prevalence rates is the methodological design used as mooted by Lutgen-Sandvik et al. (2007). Nielsen, Matthiesen and Einarsen (2010) undertook a meta-analysis (*N*=130,973) and found an average prevalence rate of 14.6% across all studies. When considering this average though, the authors comment that it can be influenced by the measurement method and sampling procedure used. For example, their results showed that:

- Studies using the self-labelling method with a definition provided the lowest estimate of bullying (present study will use this method).
- Methods using behavioural experience resulted in higher prevalence rates (present study will use this method also).
- Those studies using a self-labelled method but without a definition yielded even higher prevalence rates.

Based on their meta-analysis, the authors conclude that worldwide at least one in ten and maybe as many as one in five workers are exposed to bullying in the workplace (Nielsen, Matthiesen and Einarsen, 2010). Globally, therefore, millions of people are exposed to some level of workplace bullying (Notelaers and Einarsen, 2013).

1.6 Literature Review

1.6.1 Literature Search Strategy

The existing literature was rigorously searched using PsychINFO, MedLine and PubMed databases. The combination of these databases was deemed to provide an extensive range of studies on the vast topic of bullying. Key terms used for search criteria were 'workplace bullying', 'nurses', and 'NHS'; also, the author's name 'Einarsen' was used as an independent search criterion. For large-scale studies and prominent studies in the field, the search was not limited by year of publication but, for all other studies, the year of publication was limited to the last five years to capture the most recent publications. Reference lists from some of the texts found were also used to identify additional relevant literature. Internet searches via www.google.com and Google Scholar were performed to find other available literature. Studies excluded from the literature review were those that did not meet the standards of methodological rigour of others within the field. Methodological rigour included the strength of design and validity demonstrated by the authors in addition to the points made above. A diverse range of studies has been included within the review, taking into account

international culture and meta-analysis and the need to capture a wide range of studies applicable to this current research.

The literature review was completed ahead of the results and analysis stage, due to the time constraints of the doctoral programme, and also to take into account the mixed-methods nature of this study. The researcher recognises that if this were purely a qualitative study adhering to *true* constructivist grounded theory (Charmaz, 2014), then the literature review would have been completed after the analysis stage of the process.

In this literature review, an influential author of workplace bullying over the last thirty years, Stale Einarsen, and colleagues are introduced. Then, a most recent study carried out within NHS England (Carter et al., 2013) is introduced; the study is referenced throughout this report. The subject of 'bullying' can be wide-ranging and includes playground bullying, domestic bullying and violence, and workplace bullying. This current research considers workplace bullying and so focuses on this element of bullying during the literature review.

International workplace bullying is considered in general across differing settings and cultures, and workplace bullying research within the sector of healthcare is reviewed on an international basis. This review is refined by exploring the literature on bullying research within UK healthcare settings and the NHS. The literature review includes mixed-methods, quantitative and qualitative research.

1.6.2 Influential Authors

Stale Einarsen – Professor of Work and Organisational Psychology at the University of Bergen

One of the main authors and leading experts in the field of bullying over the last thirty years is Stale Einarsen, who is the Professor of Work and Organisational Psychology at the University of Bergen and Head of the Bergen Bullying Research Group (BBRG). He has published extensively on issues relating to workplace bullying. He was also one of the founding members of the International Association on Workplace Bullying and Harassment. The BBRG distributes and promotes the Negative Acts Questionnaire-Revised (NAQ-R) (Einarsen, Hoel and Notelaers, 2009), which is used in this present study.

The NAQ-R is a research inventory designed to measure perceived exposure to bullying and victimisation at work. It measures frequency, intensity and prevalence of workplace bullying and is perhaps the most frequently used inventory for measuring workplace bullying (www.uib.no/en/rg/bbrg). Many studies looking at the topic of bullying, both within the healthcare domain and elsewhere, have used the NAQ-R in its entirety or in parts combined with other measures (Linton and Power 2013; Lee and Brotheridge 2006; Lokke Vie, Glaso and Einarsen, 2010; Lutgen-Sandvik et al., 2007; Reknes et al., 2014; Carter et al., 2013). This questionnaire, and its predecessor the NAQ, are referenced regularly throughout this present study. In addition, Stale Einarsen and colleagues have authored many longitudinal studies and have attracted large participation numbers. Hence, these studies are included in the literature review irrespective of the year of publication.

In today's climate, with the technological age upon us and the emergence of so-called *cyber-bullying,* it may be that other categories of bullying behaviours are emerging that are not defined within the current 'negative acts' questionnaire. One of the aims of undertaking qualitative interviews within this present study is to ascertain, from the perspective of the employee, the nature of the bullying acts they are experiencing within the culture of the NHS and in particular ALT. This approach will determine whether all bullying or negative acts are included within the NAQ-R, or whether it could be adapted to incorporate contemporary issues such as cyber-bullying.

Carter et al. (2013) – Research Considering Workplace Bullying in NHS England

A recent comprehensive study (Carter et al., 2013) considered the prevalence and impact of bullying and barriers to reporting incidents in seven NHS trusts in the North East of England. In their study using questionnaires (*N*-2,950), 20% of respondents reported having been bullied in the previous six months (via completion of the NAQ-R), and 43% reported having witnessed bullying in the same period. The authors identified the five most common forms of bullying that were reported by staff responding to the NAQ-R, namely:

- Having your views and opinions ignored
- Being exposed to an unmanageable workload
- Someone withholding information which affects your performance
- Being ordered to do work below your level of competence

- Being given tasks with unreasonable or impossible targets or deadlines

In addition to utilising questionnaires, the authors undertook 43 telephone interviews to identify any barriers to reporting bullying. The main finding by inductive thematic analysis was that 'nothing would be done'. This was a similar finding to the descriptive study in Victoria, Australia (Farrell and Shafiei, 2012) where the least popular action to experiencing bullying was reporting through formal channels.

The Carter et al. (2013) study was published after the idea for this current research was created and has been a good source of reference. The Carter et al. (2013) research, however, focuses on 'barriers to reporting' bullying behaviours, whereas this current study focuses on the individual's 'perception' of bullying in terms of what happened to them and what constituted bullying to the individual. In addition, this present study undertakes in-depth face-to-face interviews with a diverse range of employees, rather than telephone interviews, as was the case with the Carter et al. (2013) study. This present study dovetails with the study by Carter et al. (2013) by considering what are the individual's perceptions of bullying. The issue of reporting is touched upon during the interviews in this present study but is not the major focus of investigation. This present study takes place within ALT, which has a huge diversity of employees from around the world, whereas the Carter et al. (2013) study was undertaken in the North East of England where the ethnicity of employees may not be as diverse. Carter et al. (2013) reported that 81.7% of respondents classed themselves as white British.

Illing, Carter, Thompson, Crampton, Morrow, Howse, Cooke and Burford (2013)

An extensive project was published for the National Institute for Health Research aimed at informing decision-making within the NHS in respect of the occurrence, causes, prevention and management of bullying and harassing behaviours. This report is extensive and comprises some 265 pages. Its summary confirms the variation in prevalence rates depending on the measurement methods used. The antecedents are described as complex with multiple causes at an individual, group and organisational level. The consequences are numerous and have negative implications for individuals, groups and organisations.

This research is explored further and in more detail under the literature review which follows and includes results on the detrimental effects on the psychological and physical health for the individual and on the group witnessing bullying behaviours,

which has been found to have higher levels of psychological distress. Results also cover the effects on the organisation as a whole, where consequences include lower job satisfaction, higher turnover of staff, higher absenteeism and a negative effect on patient care.

1.6.3 Workplace Bullying

A workplace study (*N*=2,215) reported that eight per cent of employees had experienced exposure to bullying at work (Matthiesen and Einarsen, 2007). The study gave a definition of bullying followed by a question as to whether the employee had been bullied over the previous six months; as previously stated, this method does result in a lower prevalence rate. Respondents were randomly selected from six Norwegian labour unions and the Norwegian Employers' Federation. These targets of bullying were reporting lower levels of self-esteem and social competency and higher levels of role stress, which included unclear demands and expectations around their daily activities and work schedules (Matthiesen and Einarsen, 2007). This particular study could have been enhanced by a measure of resilience amongst employees to ascertain if there were any relationships between resilience, self-esteem and bullying behaviours.

Lee and Brotheridge (2006) in their study of 180 adults in Canada from a variety of occupations identified three types of bullying: verbal abuse, undermining and belittlement. By using self-report questionnaires, including aspects of the NAQ-R, they found that belittlement led to feelings of self-doubt which could lead to a passive-and-ignoring coping mechanism which, in turn, led to ill-health and poor wellbeing as measured by the profile of mood scales (McNair, Lorr and Doppleman, 1971). Participants were not advised that the study was looking at bullying behaviour. In a further study using the same participants' data (Brotheridge and Lee, 2010), the authors considered the emotions experienced by victims of bullying. The findings suggested that for men bullying was associated with an active coping strategy, whereas for women it was associated with a passive coping strategy. Both studies were, however, a snapshot of an emotional response via questionnaires; a deeper understanding by way of some qualitative data was not provided and could only therefore be suggested.

Stale Einarsen and his colleagues (Lokke Vie, Glaso and Einarsen, 2010), using their developed NAQ-R and the Bergen Health checklist, found strong correlations between exposure to bullying and subjective psychosomatic and psychological health

complaints, including headaches, back-pain and nervousness (*N*=1,024) in a Norwegian transport company. This study concentrated on self-labelled targets of bullying but concluded that, irrespective of any self-labelling, persistent workplace bullying seemed to affect the health of the victims. It was noted that few studies focused on bullied target's perceptions of their own misfortunes and that there are benefits to participants of 'being heard' and 'being believed'. These findings were consistent with the findings of a study in Denmark (*N*=741) across three work sectors, where employees who were subject to bullying and bullying behaviours reported significantly more psychological health complaints than did others (Mikkelsen and Einarsen, 2001).

In considering another dimension of workplace bullying, a five-year prospective study considered the effects of bullying on employees leaving the workplace altogether or changing employer (Glambek, Skogstad and Einarsen, 2014). In total, 4,500 employees were randomly drawn from the Norwegian Central Employee register and invited to take part in the study considering bullying behaviours using the NAQ-R. The employees who took part (*N*=1,613) were contacted again at a two-year follow-up and a five-year follow-up. The results suggested that bullying was a pre-cursor to employees leaving working life and was also linked to the probability of being granted disability benefits. The authors of this study both considered self-labelled bullying and introduced an 'exposure to bullying scale' (new measurement scale) from the NAQ-R (Notelaers and Einarsen, 2013). They found that exposure to bullying behaviours was significantly associated with unemployment in five years and that a self-labelled definition of bullying was also associated with unemployment but at a lower level. This may in part be due to employees not recognising that they are themselves subject to bullying behaviours and thus not self-labelling as being bullied. This study had the strength of a large national representative sample and was conducted over a five-year period. However, the results could be viewed in the context of Norway, where there is high employment and so employees are perhaps more able to leave a job with which they are unhappy in a way that may not be possible in other countries.

Using the same database and participants (*N*=1,613), Einarsen and Nielsen (2014) found that exposure to workplace bullying was a significant predictor of mental health problems five years later. Similar to the study looking at employees leaving work as a consequence of bullying behaviours, the authors considered two ways of identifying bullying: self-reported and exposure to bullying using the 'exposure to bullying' scale.

As a measure of mental health, anxiety and depression, the Hopkins Symptoms Checklist-25 (Derogatis, Lipman, Rickels, Uhlenhuth and Covi, 1974) was used. Einarsen and Nielsen (2014) found that exposure to bullying behaviours at work was a predictor of higher levels of stress five years later. In addition, the authors found that the relationship between bullying and distress was valid for male but not female participants. The relationship between symptoms of distress and bullying was reciprocal for males, in that a baseline anxiety was related to experiencing bullying behaviours and bullying behaviours was a predictor of increased symptoms of distress. This was not shown to be the case for women. The measures used, however, were all self-reported and this could be a factor to consider when viewing the results. That said, the longitudinal basis of the study is something that is seldom evidenced in works of this type. Salin and Hoel (2013) also reported gender differences in reported prevalence rates and in the forms of bullying that were experienced. Whilst gender difference is not a main focus of this present study, demographics relating to gender will be gathered for comparative purposes.

Using the same longitudinal data (*N*=1,846), Nielsen, Nielsen, Notelaers and Einarsen (2015) reported that bullying behaviours experienced within the workplace were a risk factor for suicide ideation. They reported that the odds for suicide ideation at a later time were 2.05 higher for those reporting as being bullied than those not reporting bullying. Severely bullied workers were six times more likely than non-bullied workers to report suicide ideations. The question regarding suicide ideation, however, was based on the previous *week,* whereas the bullying statistics were based on the definition of bullying over the previous six months. Future research could include some qualitative interviews with individuals who have been bullied to obtain direct experiences.

Sickness presenteeism (SP) (working whilst ill) was considered in a longitudinal study by Conway, Clausen, Hansen and Hogh (2016) about the experience of bullying behaviour within ninety public and private workplaces. They reported that their study (*N*=1,664) provided indications of a relationship between frequent workplace bullying and SP, but that causal connections could not be established. It has been suggested that being a bystander to workplace bullying behaviours can also impact employees' psychological wellbeing. Emdad, Alipour, Hagberg and Jensen (2012) found that bystanding to workplace bullying was related to depressive symptoms 18 months later.

Post-traumatic stress disorder (PTSD) is an anxiety disorder which has three areas of symptoms: persistent re-experiencing of the event, avoidance of stimuli associated with the trauma and persistent arousal. All of these symptoms can result from a traumatic event, such as bullying. It has been suggested that a clinical diagnosis of PTSD can be a consequence of experiencing bullying behaviours. There is, however, a lack of longitudinal research providing absolute evidence regarding bullying as a precursor of PTSD. A review and meta- analysis of 29 studies found that an average of 57% of victims reported symptoms of PTSD above thresholds for caseness and a correlation of 0.42 was found between bullying and symptoms of PTSD (Nielsen, Tangen, Idsoe, Matthiesen and Mageroy 2015).

A review of 750 research articles (Nielsen, Magerey, Gjerstad and Einarsen, 2014) showed that there was a consistent finding of exposure to bullying relating positively to mental health problems and somatic symptoms over time. In addition, mental health problems were associated with subsequent exposure to bullying behaviours. Similarly, Verkuil, Atasayi and Molendijk (2015) in their systematic review and meta-analysis, found that there were positive associations between workplace bullying and symptoms of depression and stress-related psychological complaints (*N*=115,783). In this analysis, the observed effects were consistent for both white and blue-collar workers. In Denmark (Bonde, Gullander, Hansen, Grynderup, Persson, Hogh, Willert, Kaerlev, Rugulies, 2016), it was reported via interviews and major depression inventories (*N*=7,502 three-wave study across five years) that symptoms, including sick-leave and depressive symptoms, correlated with experiencing workplace bullying. In addition, irrespective of whether the bullying was discontinued or not, a diagnosis of depression tended to persist for several years afterwards (Bonde et al., 2016).

In a large-scale study of the prevalence of bullying within organisations in the UK, Hoel, Cooper and Faragher (2001) mailed a questionnaire to employees from seventy organisations within the private, public and voluntary sectors. 5,288 questionnaires were returned, which was a response rate of 42.8%. 10.6% of respondents reported having been bullied in the previous six months, and this rose to 24.7% for bullying within the previous five years. This prevalence level was found to be similar across each of the organisational status groups (which was the main focus of their study). The authors comment that their study confirmed that workplace bullying is a major social problem in the UK. This study attracted a large sample size and was entitled ‘The

Experience of Bullying'; however, the study could have been enhanced by perhaps including some qualitative data to obtain some *perceptions* of being bullied as this present study aims to do.

The experience of bullying and its consequences relating to staff health and wellbeing or staff retention could be considered within the bounds of the industry norms and what is deemed necessary and acceptable for the benefit of the industry – the *culture*. This view was evidenced by Alexander, MacLaren, O'Gorman and Taheri (2011) in their mixed-methods study of the catering industry. They found that verbal bullying, which was the most strongly reported form of bullying, had no effect on staff satisfaction or commitment at work. They commented that bullying behaviour was a cohesive part of kitchen culture and suggested that behavioural aspects rather than bullying characteristics should be a consideration for future studies. This view corresponds with the findings of Devonish (2013) who reported that job satisfaction could mediate the relationship between workplace bullying and task performance. This particular research was relevant to the catering industry, and it was considered that bullying was a cultural norm for the industry. It appears that the healthcare industry reports the same cultural norms, but it is not considered acceptable and has become a focus for change within the NHS.

1.6.4 International Bullying Research within Healthcare

Bullying has been recognised internationally, but in the US, there is still a culture of silence in many institutions (Gaffney et al 2012). Much of the literature concentrates on categories of bullying behaviours and number counts, with few studies considering the perception or experiences of bullying from the perspective of the staff. Gaffney et al. (2012) collected data from 99 nurses by way of an online survey with open-ended questions embedded within the questionnaire. Two additional concerns were cited by the nurses via the grounded theory analysis, and these were inadequate support from their colleagues within the hospitals and silence and inaction by nurse administrators. The authors commented that there is limited data on *nurses'* experiences of workplace bullying and that qualitative inquiry has the potential to provide researchers with a greater understanding of the intricacies of bullying in the workplace. This is a particular aim of this present study.

In respect of the management of bullying, Johnson, Boutain, Tsai, Beaton and Castro (2015) undertook an exploration of managers' discourses of workplace bullying. After 15 interviews with hospital nursing unit managers, they commented that there was a variety of different responses by managers to varying levels and descriptions of bullying behaviours within the workplace. They categorised bullying as an interpersonal issue between the perpetrator and the target, as resulting from the characteristics of the perpetrator, or as an *ambiguous situation.* For the category of *ambiguous situation,* managers described several actions that they take to combat workplace bullying, and one of the 'actions' was to do nothing. This study was from the perspective of the managers rather than the 'targets' and shows not only that targets have different perceptions as to what constitutes bullying, but also that managers have different perspectives as to how to combat the behaviours. The issue that 'nothing will be done' if bullying behaviours are reported was cited as a major barrier to reporting by Carter et al. (2013).

A significant number of newly registered nurses leave the profession within a few years of graduating, and bullying behaviours within the workplace may be a contributing factor (Vogelpohl, Rice, Edwards and Bork, 2013). The NAQ-R was used in a study of newly qualified nurses in the US to assess their experiences of workplace bullying. It was found that just over 20% of the nurses reported that they had been bullied in the workplace and that 29.5% had considered leaving because of it. Whilst this may seem alarming, the response rate within this study was seven per cent, with only 135 participants from a population of 2,079. Some qualitative data may have enhanced this study and provided a more in-depth analysis as to the nurses' experiences within their new careers. There may have been other factors that contributed to their wanting to leave the profession that were not considered in this study.

An Australian study using a different approach from the NAQ-R to assess bullying (Hoel and Cooper, 2000) employed a single-item measure of bullying. The study found that for hospital nurses, psychological distress was an outcome of bullying, and for aged-care nurses, depression was an impact (Rodwell and Demir, 2012). The aged-care nurses, by definition of their job, were looking after the older generation which can have its own impact on health. Full-time aged-care nurses, for example, had higher levels of psychological distress scores than their part-time equivalents. Demir, Rodwell and Flower (2013) found that the consequences of bullying were higher levels of

depression and psychological distress amongst health professionals working within a large Australian healthcare organisation (*N*=166), and this finding particularly related to mental health. A low-level of supervisor support was cited as an antecedent to the bullying reported. Also in Australia, a study found that nurses working in a culture of bullying experienced lower job satisfaction which can lead to increased rates of sick leave and nurse attrition which, in turn, can result in a decrease in workplace productivity, satisfaction and overall morale and wellbeing (Cleary, Hunt and Horsfall, 2010).

Again in Australia, Farrell and Shafiei (2012) reported that registered nurses and midwives (*N*=1,495) were more worried about bullying from colleagues than they were about bullying from patients, although bullying from patients was reported at 36% and bullying from other members of staff 32%. This study considered staff views on bullying within the previous four weeks, rather than a longer period which may have been more representative. The authors commented that the study could have been enhanced by some qualitative data, such as semi-structured interviews to explore nurses' perceptions of what constituted workplace aggression in all its different forms.

Another response to bullying behaviours among nurses is burnout, whereby nurses are too exhausted to function effectively. This issue was considered in Italy (*N*=658) where the authors reported that bullying did not affect health directly, but that workplace bullying partially mediated the relationship between organisational climate and burnout (Giorgi, Mancuso, Perez, D'Antonio, Mucci, Cupelli and Arcangeli, 2016). In Japan, the consequence of bullying behaviours on headaches, stiffness of the neck or shoulders, lumbago and pain of two or more joints was considered (*N*=1,642). It was reported that there was a significant relationship between workplace bullying and pain; however, the study mainly concerned professional caregivers and workers on night shifts, and it used a questionnaire regarding the frequency of pain (headache, stiffness of neck or shoulders, lumbago or two or more joints) over the previous month. If a response to experiencing pain was *sometimes*, *often* or *very often* it was considered that the symptom was present. Considering the nature of the work that health workers undertake, a stand-alone study of these symptoms without considering bullying behaviours may reveal a high level of pain in the parameters set.

A cross-sectional and descriptive study in Turkey considered whether there were differences between bullying behaviours experienced by physicians and nurses. The study found that 74% of physicians (*N*=201) reported experiencing bullying behaviours at least once over the 12 months and 82% of nurses (*N*=309) the same. The grade or status of the healthcare workers in this study was not significant when considering the bullying behaviours experienced; however, the authors reported that, for both work titles, younger and less experienced staff were more likely to report having experienced bullying behaviour (Ekici and Beder, 2014). Leong and Crossman (2016) undertook a qualitative study considering the reports of new nurses (*N*=26) and also preceptors (*N*=5) at five different hospitals in Singapore. The authors coin the term *tough love* to describe the procedure by which the teachers train and prepare the new nurses for the workplace. Whilst the intention of the supervisors may not be to 'bully' the nurses, the authors conclude by stating that this *tough love* may have good intentions but actually has an adverse effect, damaging the transition experience of new nurses and influencing their decision whether to remain in the healthcare profession (Leong and Crossman 2016).

A prospective study (*N*=1,582) in Norway considered the relationship of bullying behaviours and increased symptoms of three mental health complaints: depression, anxiety and fatigue. Symptoms were measured one year after the exposure to bullying behaviours was reported. This study, as do many in this field, utilised the NAQ for self-reported incidents of negative acts. Surprisingly perhaps, in this particular study, a relationship was found between bullying behaviours and fatigue and anxiety symptoms one year later but not for depressive symptoms. This finding may have been due to the time-lag only being one year, whereas developing anxiety symptoms may precede depressive symptoms, or it may have been due to the participants' generally being in good health. The authors did find that there may be a vicious circle between workplace bullying and mental health problems mutually affecting each other negatively (Reknes, Pallesen, Mageroy, Moen, Bjorvatn and Einarsen, 2014).

A study of the consequence of bullying within healthcare in Canada considered not only the outcome of symptoms of PTSD but also whether a protective role of psychological capital was evident. A counter-discussion to low self-esteem in individuals is resilience. There are varied definitions of resilience, but a common theme is strength. People who are described as resilient are also said to be able to persist in

overcoming challenging obstacles (Hart, Brannan and De Chesnay, 2014). The authors of this Canadian study (nurses *N*=1,205) utilised a psychological capital questionnaire which examined intrapersonal strength factors in combination with a measure of PTSD, and the NAQ. The results the authors found did not support their hypothesis that a high level of psychological capital would buffer the effects of bullying behaviours; they found that a higher reported level of experiencing bullying behaviours resulted in a higher level of PTSD symptomology, irrespective of the level of psychological capital. That said, the authors state that a higher level of psychological capital may protect some individuals from bullying (Laschinger and Noska 2015).

Ganz, Levy, Khalaila, Arad, Bennaroch, Kolpak, Drori, Benbinishty and Raanan (2015) considered the prevention of bullying by individuals and institutions rather than by psychological capital, although this could be part of the equation. They found in intensive care units (ICU) in Israel that the more a preventative plan is in place, either by an individual or the institution, the less likely bullying is to occur.

Within the ICU departments (*N*=156), no respondents reported daily bullying behaviours, but 29% reported that they were a victim of bullying via the NAQ-R. They also found that the work environment, rather than individual characteristics such as age or gender, had an impact on bullying and its prevention. As Alexander, MacLaren, O'Gorman and Taheri (2011) found within the catering industry, it was perceived as a 'cultural norm' in the stressful environment of the ICU.

1.6.5 Research into Bullying in the NHS

There have been over the years, studies in the healthcare environment in the UK considering the level of bullying and impacts on staff of this practice. Quine's study on bullying in healthcare environments (Quine, 2001) was commissioned in 1996 as part of a larger study into working life. This particular study concentrated on nurses and found that 44% reported experiencing bullying in the previous twelve months; this was nearly one in two nurses experiencing bullying of some form. Bullying behaviour was measured using a yes/no response to twenty questions asking whether any of these had been experienced in the last twelve months. If a nurse had answered yes to at least two occasions of forms of bullying experienced during the last 12 months, then the result would be included as experiencing bullying. It is important, therefore, that the prevalence method is considered in line with the results. The findings, however,

suggested that nurses who had reported being bullied were more likely to be reporting higher levels of anxiety and stress as measured by the Hospital Anxiety and Depression (HAD) Scale (Zigmond and Snaith, 1983). This aspect of the study was consistent with similar findings in Norway (Einarsen and Raknes, 1997). Illness symptoms ranged from sleep problems, feeling miserable and feeling unwanted or devalued; eight per cent of staff had taken time off work because of the bullying behaviours and the impact on their health (Quine, 2001).

In a mixed-methods study (*N*=99), staff from two NHS trusts (Burnes and Pope, 2007) reported that 63% from Trust A had either experienced or witnessed bullying behaviours and 52.8% from Trust B reported the same. The number of staff reporting bullying behaviours was slightly higher than those reported by Quine (2001), but the measuring scale used was not defined in the Burnes and Pope (2007) study, so a comparison is difficult. In this mixed-methods study, however, there was an additional focus on the impact of bullying behaviours. Staff reported by way of the qualitative part of the questionnaire, feelings of isolation, fear and worthlessness. Some of the comments described by *targets* were feeling 'stupid, lonely and vulnerable' and 'powerless, small and embarrassed'. Whilst this study attempted to assess peoples' feelings associated with experiencing and indeed witnessing bullying behaviours, if it were to be replicated, a more in-depth interview with staff could be undertaken to explore their experience of being bullied.

Carter et al. (2013) undertook the most recent study into workplace bullying within the NHS. The study design was a cross-sectional questionnaire (*N*=2,950) and semi-structured interviews (*N*=43) conducted over the telephone. The prevalence of bullying was assessed using the NAQ-R and the impact assessed using the General Health Questionnaire 12, intentions to leave work and job satisfaction. The focus of this particular study was barriers to reporting bullying behaviours. Male staff and staff with disabilities reported the higher levels of bullying.

Overall, 20% of staff reported experiencing bullying behaviours in the previous six months, and managers were the most common source of bullying. The qualitative data identified workload pressures and organisational culture as factors contributing to workplace bullying (Carter et al., 2013). The mixed-methods approach used in this study provided the trust with valuable data, but some semi-structured face-to-face

interviews may have elicited deeper meanings than the telephone interviews and may be a consideration for future studies of this type.

1.7 Aims of Present Study

This present study, by way of the quantitative data analysis, will replicate existing studies that have been undertaken over the last twenty years in terms of considering the prevalence and nature of bullying events and their subsequent relationships with health complaints such as depression, anxiety and stress. These three health complaints were chosen as the most reported relationships with bullying events according to the literature review detailed above. The gaps in the literature concern the availability of qualitative studies and studies considering individuals' perceptions of bullying behaviours. This present study will add to the existing research with the quantitative data analysis but will also provide new research by the inclusion of qualitative data via the mixed-methods design. The aim of the quantitative part of this study was to consider the relationships between reported levels of negative acts and levels of reported depression, anxiety and stress.

The aim of the qualitative part of the study was to consider what the ***meaning, experience and perception*** of being bullied were to the individual and to construct a theory on the experience of bullying behaviour from the perspective of the employee. The literature review revealed that many studies have only concentrated on the prevalence rates, which can vary depending on the measurement tool used, and that studies could have been enhanced by including a qualitative part also. This study, whilst including a quantitative element, will also include a qualitative section to add to the limited literature in this domain. Based on the aforementioned literature review, the hypotheses for the quantitative part of the study are:

H1 There will be a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and higher reported levels of depression as measured by the Patient Health Questionnaire (PHQ 9) (Kroenke, Spitzer and Williams, 2001).
H1º There will not be a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and higher reported levels of depression as measured by the PHQ 9.

H2 There will be a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and higher reported levels of stress as measured by the Perceived Stress Scale (PSS) (Cohen, Kamarck and Mermelstein, 1983).
H2º There will not be a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and higher levels of stress as measured by the PSS.

H3 There will be a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and higher reported levels of anxiety as measured by the Generalised Anxiety Disorder 7 (GAD 7) (Spitzer, Kroenke, Williams and Lowe, 2006).
H3º There will not be a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and higher reported levels of anxiety as measured by the GAD 7.

The overall research question incorporating the mixed methods design is 'How do ALT staff perceive and experience bullying behaviours?'

Chapter 2 Methodology and Methods

2.1 Overview of the Research Question

The research question is: How do ALT Staff Perceive and Experience Bullying Behaviours? – A Mixed-Methods Study.

As stated in the previous chapter, this research aimed to address the above question both quantitatively and qualitatively. The objective of the quantitative part of the study was to assess via questionnaires (*N*=303) the frequency and incidence of bullying behaviours experienced and any potential relationships with mental health issues such as levels of stress, anxiety or depression reported. The objective of the qualitative part of the study was to theorise what the experience and perception of bullying was to the individuals (*N*=8) via semi-structured interviews analysed using constructivist grounded theory techniques. The combination of both methods was to provide a more in-depth understanding of the subject matter.

The first part of the study was quantitative and via self-report questionnaires; there were 48 questions (excluding demographics) between four questionnaires (detailed under materials). The questionnaires were selected to meet the overall aim of the research question, and all four questionnaires have research validity and reliability.

Based on the comprehensive literature review detailed in the previous chapter, the following hypotheses for the quantitative part of the study were proposed:

H1 There will be a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and higher reported levels of depression as measured by the PHQ 9.
H1º There will not be a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and higher reported levels of depression as measured by the PHQ 9.

H2 There will be a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and higher reported levels of stress as measured by the PSS.
H2º There will not be a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and higher levels of stress as measured by the PSS.

H3 There will be a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and higher reported levels of anxiety as measured by the GAD 7.
H3º There will not be a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and higher reported levels of anxiety as measured by the GAD 7.

The second part of the study was qualitative and, as the term 'bullying' is broad, the purpose of this part of the study was to consider what the ***meaning, experience and perception*** of being bullied were to the individual. The qualitative part of this study was via semi-structured interviews and, as the perception of being bullied is subjective, it differed for each individual. Questions such as 'what actual events happened to you that you could describe in your own words?' and 'If I didn't know what bullying was, how would you describe it to me' were tentatively asked to engage participants in describing what bullying was to them and what it meant to them. As the interviews progressed, the questions were revised to build upon emerging categories and in line with grounded theory techniques.

Analysis of the data was via grounded theory techniques for the qualitative part of the study with a view to shaping a theory grounded in the data. The analysis of the quantitative part of the study was via analysis of variance and correlations. The two methods of analysis converged at the analysis stage.

2.2 Rationale for Adopting a Mixed-Methods Approach

The literature review revealed many studies that focused on quantitative research and considered the prevalence of bullying by varying methods and analysis, but many discussed their limitations in respect of the lack of qualitative data. The research question 'How do ALT Staff Perceive and Experience Bullying?' could encompass many avenues of exploration and, therefore, could have been undertaken by either a quantitative study or a qualitative study. However, the researcher felt that neither one of these methods by themselves comprehensively answered the research question being asked. The question of the experience of bullying as being unique to the individual's experience was best served, the researcher felt, by speaking with individuals who had themselves experienced in *their perception* bullying behaviours. By using semi-structured intensive interviewing, the researcher aimed to elicit as closely as possible

the participants' experience of being bullied to access their subjective experience; what it consisted of, more than how it felt, to be bullied. The collection and analysis of data was carried out using grounded theory principles. Whilst this method was aimed at addressing the part of the question, 'the perception of being bullied', it did not by itself fully answer the part of the research question that was 'as experienced' by NHS staff.

Foss and Ellefsen (2002) comment that quantitative and qualitative methods spring from different epistemological backgrounds but, when combined, add new perspectives to the phenomenon under investigation. It perhaps should not be seen that one method takes a higher classification than the other, but both methods are equally valid and necessary to allow the researcher to gain a richer and more comprehensive view of the subject under investigation (Foss and Ellefsen, 2002).

In counselling psychology, Smith (2012) commented that very few mixed-methods studies had been published in the *Journal of Counselling and Development* and that only five per cent of research articles published in the period 2003 to 2010 used mixed-methods designs. One of the obstacles was considered to be the time and resources available to complete a dual study. Using either one of the qualitative or quantitative methods in isolation could mean, however, that studies fell short of providing findings applicable to real life situations (Smith, 2012). This issue was one of the considerations for this present study, and it was felt that using both methods was the best way of answering the research question despite the timeframe and resources available under the constraints of completing research for a DPsych in counselling psychology.

Carter et al. (2013), cited earlier as influential authors, researched workplace bullying in the NHS using a mixed-methods design. They commented that this approach enabled triangulation across both quantitative and qualitative data and provided them with a deeper understanding of the topic. The Carter et al. (2013) study considered why NHS staff did not report bullying behaviours as well as frequency counts of negative acts, also using the NAQ-R. The authors commented that their data from qualitative interviews supported their findings from the quantitative data via questionnaires. This approach was a consideration for the present study, where the higher number of negative acts reported via the questionnaires may also support or not the categories from the qualitative part of the study.

The use of a quantitative or qualitative-only study did not fully meet the overall research question or aims of this research, and so a mixed-methods approach was deemed a more pragmatic, thorough and appropriate methodology. Pluye and Hong (2014) comment that by only using either qualitative or quantitative methods, researchers may miss important evidence. Brewer and Hunter's (1989) multi-method approach describes investigators being able to 'attack a research problem with an arsenal of methods that have non-overlapping weaknesses in additional to their complementary strengths.' This present study adopted the same mixed-methods design rationale as Carter et al. (2013) but differed in respect of the concurrent triangulation procedural strategy adopted.

2.3 Epistemological Position

Mixed-methods research is characterised as having philosophical and technical challenges (Bishop, 2014). Historically, it is recognised that the positivist paradigm (or latterly post-positivist paradigm) underlies the quantitative methods, and the constructivist or interpretive paradigms underlie the qualitative methods (Tashakkori and Teddlie, 1998). Tashakkori and Teddlie (1998) describe the emergence of peacekeepers between the two camps and the compatibility perhaps of the two in the description of pragmatists. Theorists who are deemed to be pragmatically-orientated refer to such studies adopting both qualitative and quantitative methods to meet the research questions aims as 'mixed-methods'. Paradigm purists may disagree with the mixed-methods concept due to the fundamental differences in the philosophies underlying them. The roots of pragmatism can be traced back to American scholars, such as Charles Sanders Peirce, William James, John Dewey and Herbert Mead (Cornish and Gillespie, 2009).

Qualitative study prioritises depth of understanding over the breadth of coverage (Cooper, Camic, Long, Panter, Rindskopf and Sher, 2012). The present study recognises that this element is important to answer the research question set; however, the researcher believes that both objective and subjective points of view are valid for this particular study and therefore a breadth of coverage is also required, which can only be added via a qualitative element. Cornish and Gillespie (2009) argue that pragmatism gives priority to people's everyday experience, and Brewer and Hunter

(1989) called for a more integrated methodological approach, focusing on the need for individual researchers to combine methods in their investigations.

The research cycle (cycle of scientific methodology) discussed in Tashakkori and Teddlie (1998) describes research travelling through a cycle of discovery and learning at least once before it ends. This present study, with two components comprising the method design, will have two starting points. The first concerns the hypothesising of expectations of the quantitative part of the study, and the second moves from grounded results through inductive logic to general inferences such as theory. Pragmatists accept that there will be a choice of inductive and deductive logic in the course of research, and this present research adopts these principles.

2.4 Epistemological Reflexivity

I realised early on in the planning of this research that the two lines of methodological enquiry crossed two very different paradigms which, at times, could be deemed incompatible due to the differing philosophies. However, in a similar vein to Carter et al. (2013), I felt that the two methods would provide a deeper level of understanding to the topic of perceived bullying from staff within ALT. Originally, I focused on the technical challenges of the mixed-methods research and, as Bishop (2014) stated, I fell into the same trap as many researchers, i.e. seeing the quantitative part of the study as a technique for collecting and analysing data and the qualitative part as a way of gaining insights into individual's perspectives and meaning of their situation and building a theory. I did not fully appreciate the philosophical challenges to any in-depth degree. I was interested in the *truth* as being useful, and this to me could be objective as well as subjective. In addition, the subjective was an insight that sat comfortably within the realms of my being a trainee counselling psychologist.

One of the questions that I continued to ask myself around the base of trust or knowledge was what would be or could be the external consequences of this research? Was the research intended to build knowledge from a realist perspective which the questionnaires and quantitative were deemed to provide, or to build a theory built from the evidence grounded in the data? I knew that I was just as interested in the potential external consequences of what my research could provide based on the results of the NHS staff survey within ALT. The answer was that I wanted a holistic view of the context of bullying behaviours within ALT, and so concluded that I had to include the

adoption of a pragmatic approach whilst accepting the epistemological differences between the two methods of enquiry. I felt comfortable adopting the two methods and chose to integrate the findings during the analysis stage to provide a more comprehensive answer to the research question to satisfy my curiosity and to answer the research question posed. Therefore, the epistemological position that I acquired for this project was one of pragmatism, and this matches my ontology of the truth being a combination of objectivity and subjectivity.

2.5 Personal Reflexivity

I was on placement at the SPWS based at the ALT and saw clients on a regular basis. I had been on placement for over 18 months, and all the clients worked for ALT and were offered up to eight sessions of therapy if required as part of their employment contract. Some are offered more sessions if needed. During this time, clients brought a variety of presentations, as would be expected from this type of service, including bereavement, relationship difficulties, stress, depression, anxiety, problematic drinking misuse, and trauma.

I had seen clients that presented with stress from an overworked diary with many demands, and also clients who reported stress/depression/anxiety as a result of what they described as bullying behaviours. As noted in the introduction, each year, the ALT staff survey results include the percentage of respondents who report being bullied by other members of staff. This figure is rising gradually each year. Staff members attend the SPWS with experiences of how the bullying makes them feel, including anxiety/depression and stress traits. However, what one person may perceive as bullying may not be the same as another, and this is where the subjectivity and interest in the research question first arose. The experience of being bullied comes from an understanding from the insiders' perspective, constructivism, which can only be accessed by talking with the individuals.

There is much research on the impact of bullying on staff whether within the NHS or in other organisations (see literature review). However, as also noted in the literature review, there is less research into what individuals perceive is bullying behaviour. I wanted to be able to complete some research into this area, not only for personal inquiry and to meet the requirements of the doctoral programme but also to be able to

provide some meaningful research back to the trust with insights into people's perceptions of their reality of bullying.

On this basis, I wanted to obtain individuals' perceptions of what bullying behaviours were to them and to analyse the data potentially to construct a theory from the data. In addition, I wanted to obtain a larger-scale enquiry as to what bullying behaviours were most frequently reported and their possible relationships with stress, depression and anxiety. The overall result of this methodological design would be to form an integrated analysis and meaningful report.

2.6 Research Design

Mixed-methods studies are ones that combine both the quantitative and qualitative methods into one single study, such as this present study. Pluye and Hong (2014) considered in their review of mixed-methods studies that true mixed-methods research was where three conditions were fulfilled:

- At least one qualitative and one quantitative method were combined
- Each method was used rigorously
- The data collections, analysis and/or results were integrated.

This present study meets these conditions.

Originally, the researcher started this study as a mixed-methods equivalent status design across both paradigms (the emergence of these was in the 1960s to 1980s) (Tashakkori and Teddlie, 1998). However, as the study's objectives progressed, it became apparent that the qualitative part of the study was the part that would potentially elicit more answers to the research question and would form new questions in line with grounded theory methodology. The quantitative part was a feature that would provide data detailing the types of negative acts reported by a large number of employees. The prominent part of the study, however, during the analysis would be the qualitative element where individual's actual experiences of *their* perceptions of bullying would be explored and theorised. Therefore, the research design was a parallel/simultaneous study QUAL/Quan which will best answer the research question (Tashakkori and Teddlie, 1998). An overview of the procedure is displayed diagrammatically in Figure 1.

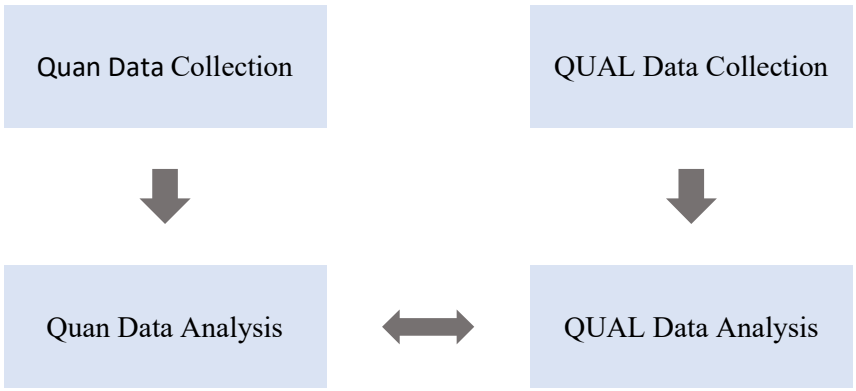


Figure 1 - QUAL plus Quant (Cresswell, 2003)

The qualitative and quantitative data were collected simultaneously as shown in the above figure by QUAL + Quan. The data was analysed simultaneously following the principles of correlations for the Quan and constructivist grounded theory analysis for the QUAL. During the analysis, the findings were compared and combined with any similarities highlighted and contrasted.

This concurrent triangulation strategy, which is described as the most familiar of the mixed-methods models, was chosen by the researcher mainly for timescale practicalities of the thesis requirements as data for both methods could be collected within a shorter timeframe than a sequential approach.

2.7 Participants

The London Trust comprises four boards, each one containing five or six divisions (excluding the administration board). The total number of staff is circa 8,100. Originally, the researcher assumed that, if NHS ethical approval was obtained, then this would result in the study being open to all employees of ALT. This view stemmed from researcher naivety, and the researcher soon established that individual divisional or departmental 'in principle' approval had to be verbally obtained prior to approaching NHS Research and Development (R and D) for NHS ethical passport approval to undertake the study.

For this study to gain approval from NHS R and D, the matron or ward sister from the relevant division was contacted to assess whether or not they would be prepared to

grant permission for this study to be undertaken in their unit. Once approval in principle had been verbalised by the applicable matron or ward sister, their unit could be included within the application to NHS R and D for the study to take place.

The inclusion of the five divisions from three of the boards was as a result of meetings with the relevant managers included within them. One of the divisions had conducted its own mini-survey (no reliability statistics or validity) (*N*=35) into stressors in the workplace and was surprised to find that over half of the staff who responded replied 'yes' to the question 'are they always, often or sometimes bullied?' As was found during the literature review, however, the way the question is formatted will have an impact on the prevalence of bullying reported. A yes/no question without a definition produced the highest prevalence rates reported by staff across research studies. This particular division, however, was keen to be included in this research with the prospect of gaining some insights into what employees term as bullying.

This requirement dovetailed with the research question that I was proposing. On subsequent meetings with other divisions, there was equal interest and a desire from management to understand more about the phenomenon. The result of these meetings determined the inclusion of the divisions, rather than that they had a better or worse bullying culture than other parts of ALT. The five divisions did provide a fair reflection of ALT as a whole. When reviewing the NHS staff survey results for 2015, ALT reported for Key Finding 17 and Key Finding 26, 41% and 31% respectively. Results for the five divisions represented from three boards are shown in Table 4 below.

Table 4 - Key Findings 17 and 26 Reports from Board-level

Board	Key Finding 17 - percentage of staff reporting suffering work-related stress in the previous 12 months	Key Finding 26 - percentage of staff experiencing harassment, bullying or abuse from staff in the previous 12 months
[redacted]	37 %	28 %
[redacted]	46 %	33 %
[redacted]	39 %	33 %

The five divisions included one from the [redacted], one from the [redacted] and three from the [redacted], as follows:

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

The number of staff to be invited to take part in this current research totalled 1,100 for the quantitative share of the research and, from this pool of employees, those who had experienced bullying were asked if they would like to participate in the qualitative part of the study. A management summary is available to all participants, on request; if this is required, participants are requested to contact the researcher directly on the telephone number or email address provided on the participant information sheet and de-brief form.

2.8 Ethics Approval

The study received ethical approval from the Department of Psychological Research Committee, City, University of London and the Research and Development Office in

ALT. The procedure for NHS ethical approval from ALT was extremely time-consuming and involved detailed breakdowns and explanations of exactly which divisions would be included and what support would be offered to staff, bearing in mind the very sensitive nature of the subject matter. In addition, the BPS Code of Human Research Ethics was adhered to (www.bps.org.uk)

2.9 Quantitative

2.9.1 Materials

The NAQ-R (Einarsen, Hoel and Notelaers, 2009) (Appendix A) is a 22-item measure of bullying and victimisation, which asks employees to assess the extent of negative experiences they have had in the work environment. Permission to use the questionnaire was granted from the author. The NAQ-R can be used to identify bullying workplace behaviours over certain periods, such as daily, in the last week, month and last six months.

The NAQ-R asks employees to report the number and type of any negative experiences in the work-place. It focuses on specific behaviours, such as 'have you been ordered to do work below your level of competence' or 'had excessive monitoring of your work', rather than on subjective perceptions of bullying. These 22 negative act behaviours are answered never (1) now and then (2) monthly (3) weekly (4) and daily (5). To assess the extent of bullying behaviours, the scores can be added up to result in an overall score ranging from 22 (no bullying behaviours experienced) to 110 (experienced all 22 bullying behaviours daily). It also includes an overall measure of perceived workplace bullying by providing a definition of workplace bullying and asking whether or not this has happened to the employee in the last six months with a response of yes/no.

The term 'negative acts' is used rather than bullying in an attempt to not bias the participant's responses as to what may have happened to them in the workplace. One of the objectives of this present study was to provide ALT with some quantitative data on the prevalence and types of bullying as perceived by the employees.

The NAQ-R has been used across the world in many different studies, and its structure and reliability met the objective of this present study.

The Cronbach Alpha for the 22 items in the NAQ-R was 0.81-0.92 (Lutgen-Sandvik et al., 2007) and 0.90 (Einarsen et al., 2009), indicating excellent reliability and validity.

The PHQ 9 (Kroenke, Spitzer and Williams, 2001) (Appendix B) measures the severity of depression across nine items. This particular questionnaire is half the length of other depression measures but has equivalent properties and has similar sensitivities. The overall score ranges from 0 to 27, with cut-off points at 0-4, 5-9, 10-14, 15-19 and 20-27 representing thresholds for none, mild, moderate, moderately severe and severe depression (Kroenke and Spitzer 2002). There are arguments for and against leaving in or out the ninth item on the questionnaire, which is 'thoughts that you would be better off dead or of hurting yourself in some way.' In clinical samples, it is an important question for discussions on suicide ideation; however, this question is sometimes omitted for research purposes where responses are anonymous. In this present study, the question has been left in, as it could be an important item to feed back to management in respect of staff and relationships with this data item against items from the NAQ-R.

In a study of 6,000 patients in eight primary care clinics and seven obstetrics-gynaecology clinics, the PHQ 9 was found to be a reliable and valid measure of depression severity (Kroenke et al., 2001). The internal reliability of the PHQ 9 was excellent, with a Cronbach's alpha of 0.89 in the primary care study and 0.86 in the obstetrics-gynaecology study. The PHQ 9 is free to use for research purposes.

The GAD 7 (Spitzer, Kroenke, Williams and Lowe, 2006) (Appendix C) is a self-report anxiety questionnaire that is similar to the PHQ 9 in depression and measures the severity of anxiety across seven items. The overall score ranges from 0-21, with cut off points at 0-4, 5-9, 10-14 and 15-21 representing thresholds for none, mild, moderate and severe anxiety. The questionnaire was validated for use within the general population in a study undertaken in Germany in 2008 (N=5,030) (Lowe, Decker, Muller, Brahler, Schellberg, Herzog and Herzberg, 2008). The study concluded that the evidence supported reliability and validity of the GAD 7 as a measure of anxiety in the general population. Internal consistency was 0.89. The GAD 7 is free to use for research purposes.

The PSS (Cohen, Kamarck and Mermelstein, 1983) (Appendix D) is a 10-item scale which evaluates a person's perception of their situation as to whether it is threatening or demanding and their ability to utilise their coping mechanisms. It is a measure of the degree that an individual appraises their life situations as stressful. The original scale

had 14 items; however, Cohen and Williamson (1988) re-evaluated the original scale against the new 10-item scale and concluded that this scale was superior to the original scale. Hence, the newer scale has been used in this present study. Both the 14-item and the 10-item scales were deemed to be valid and reliable. The 10-item scale is scored by reversing the scoring on four positive items such as 'in the past month how often have you felt that you were on top of things' and then summing across all ten items resulting in an overall score of 0-40. A score of around 13 would be considered average and a score of 20 or more would be considered high stress.

The PSS provided adequate reliability and correlated with life events and physical symptomatology. The internal consistency of the original 14 item scale was acceptable as the lowest coefficient was (0.78). Cohen and Williamson (1988) in a comparison with the 14-item scale (*N*=1,587) found that by dropping the four items, the internal reliability was (alpha coefficient = 0.78) making the 10-item scale at least as good as the original 14-item scale. The PSS is free to use for research purposes.

The demographic questions asked as part of the overall questionnaire were:

- Male/Female
- Age
- Division
- Staff Band
- Time in Job
- Ethnic Group

A copy of the full questionnaire, including the consent form, demographics and de-brief form is provided in Appendix E.

2.9.2 Inclusion/Exclusion criteria

All participants were to be over 18 years of age and employed by the trust for any period of time and included full time and part time staff. There were no exclusion criteria.

2.9.3 Recruitment

The number of variables from the four questionnaires determined the required number of participants for the results to be considered to have validity. The number of

participants that took part determined the number of relationships between variables that could be considered for analysis purposes (Kerlinger and Pedhazur, 1973).

As a general rule, 15 participants could be considered to be the minimum number of participants required per variable with a minimum number of 100 participants, a minimum size to be useful (Clark-Carter 2007). In this study, for example, there could potentially be 25 variables (22 items on the NAQ-R and one total score on each of the PHQ 9, GAD 7 and the PSS); 25 multiplied by 15 equals 375. This would be the number required if all 22 items were to be analysed individually with the other variables by way of regression analysis. In this study there were two variables per correlation, A power analysis using an effect size of 0.2 and a power of 0.8 (Field 2009; Clark-Clark 2007) demonstrated that a minimum number of participants would be 191

In this study (QUAL-Quant) the researcher has analysed, by way of correlations, the four total scores from the four questionnaires; therefore, there are four variables requiring a minimum of 100 participants, a minimum size to be useful (Clark-Carter 2007). The actual number of participants across the five divisions was 303 (a response rate of 27.5 %).

Cluster sampling was used insofar as employees from the named divisions within ALT were invited to take part in the study, either via an email providing a link to the survey or via attendance at their quarterly staff meeting or corporate governance meetings. At these meetings, the researcher provided a 10-minute presentation (Appendix F) on the research and invited employees either to complete a hard paper copy of the questionnaire or access the questionnaire online. However, it was convenience sampling within the individual divisions which may be a more realistic description of the sampling method.

It was found that at the staff meetings attended within the [redacted] 15-20 employees attended each meeting, and the majority completed the hard copy of the questionnaire during their break. The completed questionnaire was then handed back to the researcher to input the data onto Qualtrics and, for this reason, there is a high number of participants from this division included within the quantitative part of the study (45%). For the [redacted] Division, however, around 80-100 employees attended twice-weekly staff briefings, and staff

were invited to complete the questionnaire online; they did not do so within this particular division, and so the numbers from this division were very low.

Also, presentations were undertaken at the corporate governance meetings at both the [redacted] and the [redacted], where circa 200 people were in attendance. Promotions and presentations of this type to staff set out the aims of the study and helped to generate responses. The researcher provided regular updates to the matron/ward managers of each division via a group email detailing numbers of participants to date. The collection and promotion of the study were undertaken over a three-month period before the survey was closed for the analysis of the data to begin.

2.9.4 Data Collection

Qualtrics LLC is a private research software company established in 2002 and based in Provo, Utah. The company's Qualtrics Research Suite includes a solution for online surveys, and the software collects and analyses online survey data on behalf of its customers. Academic institutions are included within the customer base and City, University of London has a licence that enables its academic students to utilise the software for the purpose of research. It is this software that was used to collect all data for this part of the study. The researcher input the demographic questions and the three questionnaire(s) combined with the participant information sheet and de-brief form to create a single point for participants to access the survey online.

Matrons/ward sisters were asked if they would like their division to take part in this study. The confirmed five divisions took part, and it was explained by the researcher that participants' responses were confidential and that no employee could be identified individually if they chose to take part in the study. For all divisions, the link to the study's questionnaires was emailed individually to the member of staffs by the ward sister/matron. The link was to the Qualtrics account set up purely for this study. The participant firstly read the participant information form and consent form online and, if acceptable, they ticked a box giving consent to take part in the study. The participant then answered the 48 questions plus the basic demographic information listed above.

The researcher attended many staff meetings and also corporate governance meetings to promote the aims and purpose of the study. During these meetings, participation and consent forms were available to read and take away. In addition, if any member of staff

wanted to complete a hard paper copy of the questionnaire, they were able to do so. Many staff took advantage of this, as they found it difficult to access computers during the working day, and this approach was deemed more favourable by the ward sister than an email link. Once completed, the researcher input the responses directly onto Qualtrics. This method of data collection was designed for ease of completion by the participant (taking into consideration their hectic job roles within the NHS). The maximum amount of time for the participant to read and complete the survey was circa 30 minutes. The researcher was guided to a large extent by the individual ward sister as to what delivery and promotional methods were utilised.

2.9.5 Ethical Considerations

All participants in this study were current staff of ALT and were capable of making informed consent to take part. All staff from the included divisions were invited to take part in the study whether by email providing a link to the questionnaires or by attending group staff meetings where the researcher explained the purpose of the study. Those wishing to take part in the study either ticked a box on the Qualtrics software programme or provided consent on a hard copy of the questionnaires consent form, indicating that they had read, understood and accepted what the research involved and that their participation was entirely voluntary. Following completion of the survey, participants were provided with information regarding support services they could access if it were felt necessary by the participant.

2.9.6 Data Analysis

All data collected via Qualtrics and was exported into IBM SPSS Statistics for data analysis. IBM SPSS Statistics is a software package used for statistical analysis. The previous company name was SPSS Inc., and it was acquired by IBM in 2009. The current version (2015) is officially named IBM SPSS Statistics and is the one used for this research.

The researcher ensured that any individual response was not able to be traced to an individual employee. If there were relatively few individuals making a particular sub-group, then the researcher would not have reported data individually under results. For example, if there were only a few employees in the category staff Band 4, the findings would have reported Band 5 and lower and 6 and above. The researcher followed this logic for all the demographic questions to ensure complete confidentiality of all

participants. For the purpose of this study and the reporting, confidentiality was ensured as the results reported were not sub-categorised into individual divisions but reported for the total number of participants that took part.

Descriptive statistics were produced to provide details of the demographics of the participants, and the data was provided for analysis any clusters/higher instances of negative act scores reported by particular participant sectors such as age, gender or band. Analysis of variance was also performed. Pearson's Correlation techniques were adopted via IBM SPSS to ascertain if any relationships existed between the variables on the four questionnaires. In the first instance, they were carried out to test the hypotheses:

H1 There will be a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and higher reported levels of depression as measured by the PHQ 9.
H1º There will not be a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and higher reported levels of depression as measured by the PHQ 9.

H2 There will be a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and higher reported levels of stress as measured by the PSS.
H2º There will not be a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and higher levels of stress as measured by the PSS.

H3 There will be a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and higher reported levels of anxiety as measured by the GAD 7.
H3º There will not be a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and higher reported levels of anxiety as measured by the GAD 7.

Where data collection was via presentations at staff meetings, the majority of questionnaires were completed fully, and only a few were missing elements that were replaced by the researcher by means of the scale. Where the questionnaires were completed online and participants left the survey prior to the end, all data completed up

to the point of exit was included in the analysis providing the individual questionnaire scales had been fully completed; in total there were 273 fully completed questionnaires including all scales. There were 273 fully completed scales including the NAQ-R and only the fully completed NAQ-R scales were included in the analysis.

2.10 Qualitative

2.10.1 Rationale for adopting grounded theory analysis

Qualitative inquiry has the potential to guide researchers to a greater understanding of the complexities of bullying in the workplace (Gaffney, DeMarco, Hofmeyer, Vessey and Budin, 2012). Gaffney et al. (2012) comment that research, including in healthcare environments, has concentrated on the prevalence rates of bullying and suggest that qualitative approaches may provide a fuller understanding of the phenomenon. This perspective was evidenced further throughout the literature review. Whilst this present study will obtain prevalence frequencies of bullying behaviours as discussed previously, the researcher felt that a greater depth of research material would be obtained by incorporating a qualitative element also. In considering the method of analysis, the researcher considered an 'interpretive' method. However, while much research has been undertaken that details the experience of bullying, as reflected in the literature review, little has been done about analysing data and constructing a theory as to what individuals perceive bullying to be – what does it look like to them?

It was necessary to establish what individuals thought *bullying was* and what formed the basis of their reality to construct a theory. Glaser and Strauss (1967, 1968) first mooted the suggestion of developing theory/s that were *grounded* in the data rather than testing hypotheses from existing theory. The authors in the 1960s were considering death and dying and, from collected data and subsequent analysis, produced a theoretical analysis of the social organisation and temporal order of dying (Charmaz, 2014). To elicit meaningful data, the questions were designed to be thought-provoking and to enable the participant to speak openly. The construction of this schedule follows.

2.10.2 Construction of the Interview Schedule

Intensive interviewing was adopted as the preferred method for this current research. The characteristics of this method are:

- Selection of research participants who have first-hand experience that fits the research topic
- In-depth exploration of participants' experience and situations
- Reliance on open-ended questions
- Objective of obtaining detailed responses
- Emphasis on understanding the research participant's perspective, meanings, and experience
- Practice of following up on unanticipated areas of inquiry, hints, and implicit views and accounts of actions (Charmaz,2014)

The interviews and the interview schedule (Appendix G) were designed to elicit the participant's actual experiences and details of what happened to them. The interview schedule was therefore designed to encompass a flexibility of questions and to enable the researcher to build on the schedule of questions as more data was collected and analysed. The interviewer used encouraging and non-judgemental summaries and reflective statements throughout the interviews. At the outset of the interview, participants were shown a copy of the NAQ-R highlighting some negative acts and they were prompted as to whether any of these applied to them or whether there were others that did not appear on the questionnaire. This led participants into the interview regarding their own experiences.

The interviewing approach stayed the same as the interviews were conducted and the study developed in line with grounded theory analysis. The aspect that did evolve was the inclusion of developed questions and subject matter as the interviews progressed.

2.10.3 Inclusion/Exclusion Criteria

All participants were to have sufficient command of the English language to engage in spoken English to engage in an interview and also have the ability to give informed consent. All participants were over 18 years old. Participants were required to have experience of being bullied during the preceding twelve months but were excluded if they were in the process of any legal or disciplinary actions in the workplace. Employees currently employed in the five divisions detailed above were invited to take part in the study.

2.10.4 Recruitment

Where invited by the ward sister/matron, the researcher attended staff meetings and explained the aims of this research by way of a PowerPoint presentation (Appendix F). If any member of staff was interested in taking part in the qualitative part of the study, they were asked to contact the researcher after the meeting by phone or email in confidence. The request for participants was also displayed on staff notice boards in the participating divisions by way of a leaflet (Appendix H).

Following a telephone conversation or email correspondence initiated by the participant, the researcher explained what was required from the interview and discussed the inclusion/exclusion criteria; if the participant accepted, they were invited to attend the SPWS at a mutually agreed time. Three of the participants who took part had access to a confidential space at their place of work, and so the interviews were conducted there. At the beginning of the interview, the participant was given time to read the information sheet and the accompanying consent form. The participant was advised that should they decide at any time that they would like to stop the interview then this was possible and all data would be deleted. Once the participant signed the consent form, the interview commenced. All interviews were audio-recorded using a digital recorder. The interview was scheduled to last 60 minutes plus 10 minutes debrief, and this was advised to the participant. The average time taken for the interviews (N=8) was 50 minutes. Following the conclusion of the interview, participants were provided with a de-brief form (Appendix I).

The principles of grounded theory are that the data is analysed as the research progresses, enabling the researcher to re-visit categories with future interviews and thus construct a theory. This approach continues until 'theoretical saturation' is deemed to have been reached and the researcher is satisfied that additional data is not necessary for the arising categories (Glaser and Strauss, 1967). Construction of a theory is then possible. Guest, Bunce and Johnson (2006) researched the question of how many interviews would be enough. After conducting interviews and analysis for each set of six interviews ten times (N=60), their finding was that 80 (73%) of the total number of codes developed were from the first six interviews, and an additional 20 codes were identified within the next 6 interviews (cumulative 92%) (Guest et al., 2006).

Whilst the authors conclude that their findings cannot necessarily be generalised to all other studies, as a guide for this present research, participant numbers of 6 to 12 would be considered appropriate. However, this target was monitored in line with the quality of data collected and once the interviews had commenced. In line with theoretical sampling methods and grounded theory principles based on the categories emerging from the data, further interviews with subsequent participants were conducted exploring these newly identified categories (Charmaz, 2014).

2.10.5 Data Collection

Five interviews took place at the SPWS, which is a confidential space that is away from the main workplace buildings of ALT. It is housed in a separate, self-contained building, and so other staff or managers did not see the participants attend. The premises also contain the welfare and counselling service and occupational health division. At the participants' request, three of the interviews took place in private offices, and we were not disturbed.

Participants were made aware that the interviews were to be audio-recorded and that the material would be stored in a secure environment. Interview transcripts had any identifiable content removed or changed to protect anonymity. Participant information is held under ethical and legal obligations of confidentiality, and only basic demographic information was obtained. Where participants had provided their email and mobile numbers, these were destroyed following completion of the interview. Participants (N=8) included representation from a wide range of staff bands (Consultant to Band 3), and male and female. All five divisions had at least one participant.

2.10.6 Ethical Considerations

Participants were asked to contact the researcher in the first instance if they would like to take part in this study. It was their own decision to apply to be included, without researcher influence. This decision was not dependent on whether or not they had taken part in the quantitative part of the study. The researcher would not necessarily know anyway whether or not participants had completed the quantitative survey. The participant was asked to sign a consent form which confirmed that they have read, understood and accepted what the research involved and that their participation was entirely voluntary. If a previous client of the researcher approached the researcher and qualified for participation, confidentiality regarding the course of psychological therapy

would be respected and left up to the discretion of the participant as to whether they felt any issues previously disclosed had any relevance to this study.

There was the possibility that the participant may become distressed during the interview. This risk was managed by ensuring that they were constantly made aware that they did not need to disclose any material they felt uncomfortable about disclosing and ensuring that they knew they could pause or stop the interview at any time.

The very private nature of the material to be collected was known by the researcher. Thus, maintaining the balance between meeting the needs of this research for the benefit of both employees and management and safeguarding the needs of the participants was of prime importance, especially as some participants have been or still are under a great deal of stress.

The interview structure was regularly monitored, and the researcher remembered that the interview was research and not therapy. The researcher further explained that participation was entirely voluntary and that participants could withdraw up to one week after the interview if on reflection they decided that they did not want their data to be included as part of this research. Participants were provided with information regarding support services that they could access should they feel it necessary following the interview. Participants for whom the research raised concerns personally were advised that they could contact the SPWS, where they would be offered confidential support by someone other than the researcher.

It was considered unlikely that any issue requiring consideration of limiting confidentiality would arise; however, the researcher adhered to the principles of the British Psychological Society (BPS) and legal and professional obligations generally. In the unlikely event that disclosure occurred which required a breach in confidentiality or further action, e.g. safeguarding, the researcher would have sought the support and supervision of the lead clinician of the SPWS, which is a service that is used to handling such sensitive matters.

2.11 Data Analysis

The grounded theory approach to qualitative data analysis can be traced back to Glaser and Strauss in 1967 in their studying of death and dying (Charmaz, 2014). In their early writings and methods, their approach was based on positivism and had the

epistemological assumptions of logic and a systematic approach. During the 1990s, the grounded theory approach moved away from the positivism in both Glazer's and Strauss's earlier writings into a more flexible approach incorporating the perspective that the researcher constructs rather than discovers. Charmaz (2014) used the term constructivist which acknowledged the researcher's involvement in the construction and interpretation of the data. Charmaz (2014) emphasises flexible guidelines rather than the methodological rules first described by Glazer and Strauss and it is this position of Charmaz' constructivist grounded theory that has been adopted for this study which has moved away from the more positivist epistemological position advocated by the original works of Glaser and Strauss. Charmaz describes her position as building on the pragmatist underpinnings in grounded theory which matches my own epistemological position for this research of pragmatism (Charmaz, 2014).

Willig (2013) comments that there are three main versions of grounded theory that dominate the field, and these are the classical (Glaserian) version as preferred by Glazer's early writings, Strauss and Corbin's more structured approach and latterly Charmaz (2006) constructivist approach. Glazer and Strauss (1967) described grounded theory as involving the discovery of theory from the data which plays down the role of the researcher in the process whereas Charmaz (2014) argues that theories are constructed by the researcher through an interaction with the data.

Grounded theory was developed to enable the study of social processes and for researchers to theorise social processes within a particular setting. In order that these processes could be identified and processes explained and therefore theorised, researchers engaged in full cyclical enquiry referred to as the full version of grounded theory; however, some researchers have recently used grounded theory as a method of analysis only and this is referred to as an abbreviated version (Willig, 2013). In this abbreviated version, researchers subject the interview transcripts to grounded theory inspired coding. This current research has adopted the Charmaz (2014) full version constructivist grounded theory approach.

Data collection and analysis were conducted simultaneously in an interactive process. All interviews were transcribed verbatim by the researcher, with all extra and non-linguistic features noted. Any references to a division or names of staff/managers were removed, and participants were assigned a different name for confidentiality purposes.

Initial coding of the transcript involved studying the fragments of data within the text with the researcher defining what the data was about. This was the first stage of the analysis and any ideas or thoughts that occurred to the researcher at the time were written down in full in the form of a memo. Any non-verbal cues were noted during the transcribing stage as part of the recording and also during this first stage of coding. Thus, if a participant was showing signs of frustration or anger, the researcher noted these aspects as part of the coding procedure and they were included within memos written by the researcher and also incorporated into the emerging categories. Coding is described as the pivotal link between collecting data and the development of an emergent theory (Charmaz, 2014).

Once this process was completed for the first interview, any subsequent interview questions were adapted to include emerging categories. Charmaz (2014) comments that the iterative process of grounded theory often brings the researcher back to research participants that have already been interviewed or, alternatively, new lines of inquiry are included in future interviews reflecting developing analyses. Whilst research participants who had been interviewed already were not re-interviewed, new lines of inquiry that emanated from the data were included in future interviews. This was evidenced by asking participants in some future interviews what it was that made them stay at the organisation despite the bullying they had experienced. This questioning was a result of a new line of inquiry following new thoughts that occurred during the analysis.

Constant comparative methods of visiting the data were used and unexpected ideas emerged as the process continued. The researcher kept a memo-bank of ideas and thoughts as they occurred throughout the whole analytical and data collection period. This information was re-visited and reviewed constantly (Example Appendix K). This initial coding process was followed by a more focused, selective phase of coding whereby the researcher collated frequent or significant initial codes with the purpose of staying close to the data but also considering any emergent categories (Collective categories are demonstrated in Appendix J). This formed part of the ongoing theory construction process.

This approach was combined with the process of theoretical sampling described earlier and, in theory, should have been a seamless link between analyses and sampling

methods. However, as Charmaz (2014) described and the researcher was aware, the journey was not necessarily by a pre-defined linear route but included many stops and starts and U-turns.

Theoretical sampling was adopted throughout the collection and analysis of data with tentative categories explored and adapted with future participants. Whilst eight interviews were undertaken and this, in some respects could be considered a low number, it was felt that the data was comprehensive and that any further interviews conducted would be repetitive and few new categories emerging. This was in line with the findings from Guest et al (2006) who found that 73% of the total number of codes developed were from their first six interviews. It was felt that from the eight interviews and the analysis that a theory of the bullying experience could be constructed and that further interviews would not necessarily enhance or identify new findings in constructing a theory. Whilst others such as Cresswell (2007) suggest around 20-30 interviews, the researcher in this present scenario was also under the time constraints of a doctoral programme and had this as a consideration as well, which limited the number of participants that could be fully incorporated.

Charmaz' (2014) constructivist grounded theory emphasises the involvement of the researcher and that the researcher is not an impartial observer but that they must examine what their preconceptions may be that will shape the analysis. Prior to undertaking this study, my thoughts concerned firstly what the differences were between harassment and bullying and was there a distinction. I found out about this distinction early on in my readings and this then shaped my research question into what employees considered bullying was to them. My reading had also led me to consider why health services were so different to other businesses and ones that I had worked in previously. My assumptions were that a particular type of person or personality would come forward to be interviewed; this was not borne out as participants were from all bands and, on face value, personality types. This realisation led me to be more inquisitive as to what their own experience of bullying was. I believe that this step helped in my own questioning techniques and curiosity and enabled me subsequently to construct a theory from the data.

Chapter 3 Analysis

3.1 Analysis Overview

The analysis chapter is divided into three sections. The first part is a summary of the quantitative findings organised as follows:

- The quantitative part of the research which reports the demographics of participants
- The occurrences of experienced bullying behaviours as reported by participants
- The frequencies of each of the listed 22 negative acts

Pearson's Correlation techniques were adopted via IBM SPSS to ascertain whether any significant relationships existed between the variables on the four questionnaires. These were undertaken to test the three hypotheses:

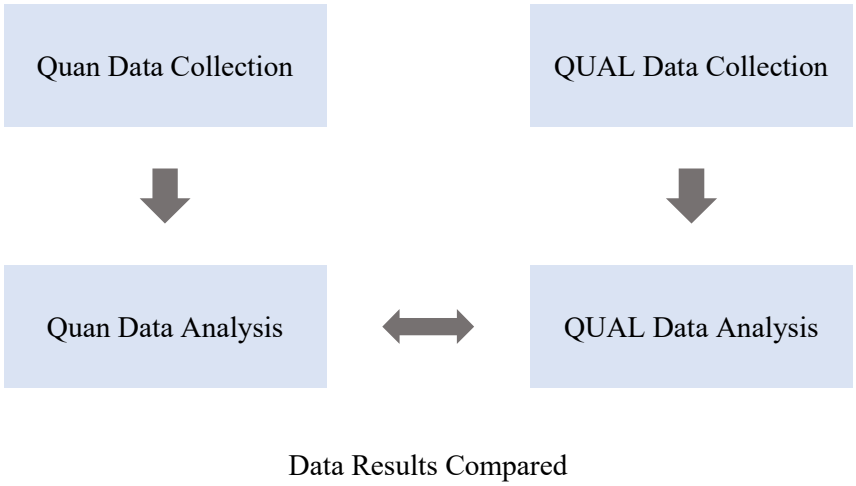
H1 There will be a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and higher reported levels of depression as measured by the PHQ 9.
H1º There will not be a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and higher reported levels of depression as measured by the PHQ 9.

H2 There will be a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and higher reported levels of stress as measured by the PSS.
H2º There will not be a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and higher levels of stress as measured by the PSS.

H3 There will be a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and higher reported levels of anxiety as measured by the GAD 7.
H3º There will not be a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and higher reported levels of anxiety as measured by the GAD 7.

The second part of this chapter focuses on the qualitative grounded theory analysis, where the aim of the study was to consider what the ***meaning, experience and perception*** of being bullied was to the individual.

Finally, in the third section, the results are compared and contrasted with any similarities and differences highlighted. The mixed-methods strategy that has been followed (Cresswell, 2003) is outlined in Chapter 2 and is illustrated in Figure 1, which is reproduced below for ease of reference:



3.2 Introduction to Quantitative Findings

The four questionnaires completed were:

- NAQ-R (Einarsen, Hoel and Notelaers, 2009)
- GAD 7 (Spitzer, Kroenke, Williams and Lowe, 2006)
- PSS (Cohen, Kamarck and Mermelstein, 1983)
- PHQ 9 (Kroenke, Spitzer and Williams, 2001)

Where the questionnaires were completed online, and participants left the survey before the end, data completed up to the point of exit was included in the analysis.

3.3 Summary of Quantitative Findings

All four questionnaires reported good reliability as detailed in the previous chapter. To ensure that this current study also had good reliability, Cronbach's Alpha was calculated on the data. As the PSS includes some reversed scoring, Cronbach's Alpha

was calculated on the reversed scored items also and is shown as PSS (R). The results are shown in Table 5 and confirm good reliability for all four questionnaires:

Table 5 - Reliability Cronbach's Alpha for Questionnaires

Questionnaire	Alpha
NAQ-R	0.93
GAD 7	0.93
PSS (R)	0.72
PSS	0.89
PHQ 9	0.90

3.3.1 Descriptive Statistics

The participants included 235 females and 57 males, with ages ranging from 22 to 68, with a median of 39. The largest group described themselves as white-British (111 – 36 per cent), but more than half were represented by a further 15 ethnic categories:

- Any other white background: 67 – 22 %
- Any other Asian background: 36 – 2 per cent
- African: 18 – 6 per cent
- White Irish: 14 – 5 per cent
- Any other ethnic group not listed: 14 – 5 per cent
- Indian: 8 – 3 per cent
- Caribbean: 8 – 3 per cent
- Black/African Caribbean: 8 – 3 per cent

A range of staff bands was represented, with the largest group coming from Band 6, as shown in Table 6. **Error! Reference source not found.** details the length of time of employment of respondents.

Table 6 - Occupational Groups Represented by Questionnaire Participants

Occupational Staff Bands	Frequency	Percentage of respondents (per cent)
Band 3	22	8
Band 4	16	5
Band 5	72	24
Band 6	93	32
Band 7	26	9
Band 8 +	37	13
Would rather not say	28	9

Note: *N*=294

Table 7 - Number of Years Employed by ALT

Employment	N	%
Less than one year	39	13
2 to 5 years	111	38
Six years plus	144	49

Note: *N*=294

A summary of all participant characteristics is detailed below in Table 8.

Table 8 - All Participant Characteristics

	Frequency	%
Gender		
Male	57	19
Female	237	80
Other	2	1
Age		
20-29	68	22

30-39	92	30
40-49	85	28
50-59	52	17
60-69	7	3
Ethnicity		
White-English/Welsh/Scottish/Northern Irish/British	111	37
White-Irish	14	5
Any other white background	67	22
Mixed multiple ethnic group-white and black Caribbean	1	0.5
Mixed multiple ethnic group-white and black African	1	0.5
Indian	8	3
Pakistani	1	0.5
Bangladeshi	2	1
Any other Asian Background	36	12
African	18	6
Caribbean	8	3
Any other Black/African/Caribbean background	8	3
Arab	1	0.5
Any other ethnic group not listed	14	5
Length of employment		
Less than one year	39	13
2-5 years	111	38
6 years plus	144	49
Staff band		
3	22	8
4	16	5
5	72	24
6	93	32
7	26	9
8+	37	13
Would rather not say	28	9

3.3.2 Bullying Behaviours

Table 9 shows the frequencies and percentages of respondents answering the direct question:

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

Table 9 - Frequencies and Percentages of Experiences of Workplace Bullying Total

Experience of Bullying	n	Per cent
No	144	53
Yes – but only rarely	72	26
Yes – now and then	40	15
Yes – several times per week	12	4
Yes – almost daily	5	2

Note*: N*=273

It can be seen from Table 9 that 53% of participants reported no experience of bullying behaviours; however, 47% of respondents reported experiencing some form of workplace bullying ranging from yes - but only rarely to yes - almost daily.

Table 10 details the responses to the question:

The following behaviours are often seen as examples of negative behaviour in the workplace. Over the last six months, how often have you been subjected to the following negative acts at work? The responses were 'never', 'now and then', 'monthly', 'weekly' or 'daily'.

Table 10 - Prevalence of 22 Negative Behaviours among all Participants

Negative Act	*M*	*SD*	Variance
1. Someone withholding information which affects your performance	1.58	0.88	0.77
2. Being humiliated or ridiculed in connection with your work	1.55	0.80	0.64
3. Being ordered to do work below your level of competence	1.69	1.01	1.03
4. Having key areas of responsibility removed or replaced with more trivial or unpleasant tasks	1.58	0.97	0.93
5. Spreading of gossip and rumours about you	1.59	0.92	0.84
6. Being ignored, excluded or being 'sent to Coventry' (silent treatment)	1.64	1.02	1.04
7. Having insulting or offensive remarks made about your person (i.e. habits and background), your attitudes or private life	1.38	0.76	0.58
8. Being shouted at or being the target of spontaneous anger (or rage)	1.60	0.87	0.75
9. Intimidating behaviour such as finger-pointing, invasion of personal space, shoving, blocking/barring the way	1.30	0.64	0.41
10. Hints or signals from others that you should quit your job	1.25	0.63	0.40
11. Repeated reminders of your errors or mistakes	1.55	0.82	0.67
12. Being ignored or facing a hostile reaction when you approach	1.68	0.99	0.99
13. Persistent criticism of your work and effort	1.50	0.85	0.72
14.Having your opinions and views ignored	1.86	0.97	0.95
15. Practical jokes carried out by people you	1.26	0.58	0.34

don't get on with			
16.Being given tasks with unreasonable or impossible targets or deadlines	1.65	1.00	1.00
17. Having allegations made against you	1.37	0.72	0.52
18. Excessive monitoring of your work	1.81	1.08	1.17
19. Pressure not to claim something which by right you are entitles to (e.g. sick leave, holiday entitlement, travel expenses)	1.42	0.84	0.70
20. Being the subject of excessive teasing and sarcasm	1.23	0.59	0.35
21. Being exposed to an unmanageable workload	2.02	1.24	1.53
22. Threats of violence or physical abuse or actual abuse	1.12	0.51	0.26

Note: *N*=273

The top five prevalent negative behaviours reported by participants and classified by the highest mean score out of five and as shown in Table 10 were:

1. Being exposed to an unmanageable workload
2. Having your opinions and views ignored
3. Excessive monitoring of your work
4. Being ordered to do work below your level of competence
5. Being ignored or facing a hostile reaction when you approach

3.3.3 Defining simple cut-off scores for the NAQ-R

The direct question asking respondents whether they have experienced bullying was detailed in Table 8. However, Notelaers and Einarsen, 2013 introduced an alternative method for reporting prevalence rates, which is based on the 22 negative acts and cut-off scores. The scores range from 22 to 110, and the authors consider this method to be superior to the direct question. This method has also been used to calculate prevalence rates, and the pie chart in Figure 2 demonstrates these combined cut-off values (Notelaers and Einarsen, 2013) for the scores of the 22 negative acts. This new method of reporting bullying behaviours was introduced recently by the authors as an 'exposure to bullying scale', where participants may not class themselves as being bullied, though

have been subjected to bullying behaviours as detailed within the NAQ-R responses. The total scores from this method are shown in Figure 2, based on the following bands (*N*-273):

- Total score between 22 and 33 = not bullied
- Total score between 34 and 44 = occasionally bullied (Moderate)
- Total score of 45 or more = Victim of severe workplace bullying (Victim)

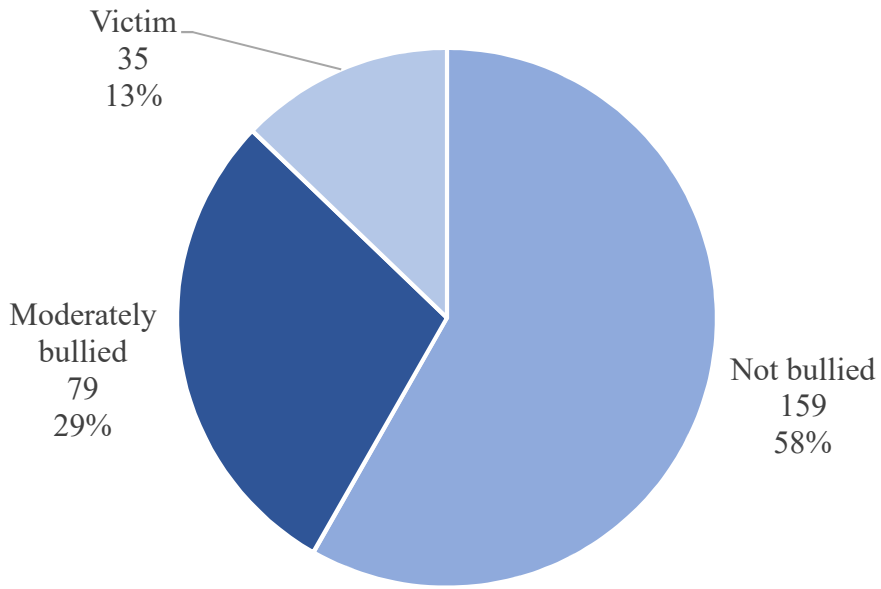


Figure 2 - NAQ-R Exposure to Bullying Scale Combining Simple Cut-off Scores

When considering these negative acts and any relationships that may exist between these and levels of reported stress, depression and anxiety, the three hypotheses were tested by using Pearson Correlations. Two tailed tests were used to assess the possibilities of any relationships in either direction (Field 2009). The results of these are detailed in Table 11.

Table 11 - Pearson Correlations between the Variables of the NAQ-R, GAD 7, PSS and PHQ 9

	1	2	3	4
NAQ-R	-			
GAD 7	0.54	-		
PSS	0.40	0.67	-	
PHQ 9	0.42	0.67	0.66	-

Note: (p <0.001) (two-tailed)

3.3.4 Inferential Statistics

The three hypotheses were tested, and all three were found to be strongly supported.

Results for Hypothesis 1

Hypothesis 1 was found to be strongly supported; there was a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and the reported levels of depression as measured by the PHQ 9 $r = 0.42$, $p < 0.001$.

Results for Hypothesis 2

Hypothesis 2 was found to be strongly supported; there was a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and higher levels of stress as measured by the PSS $r = 0.40$, $p < 0.001$.

Results for Hypothesis 3

Hypothesis 3 was found to be strongly supported; there was a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and higher reported levels of anxiety as measured by the GAD 7 $r = 0.54$, $p < 0.001$.

3.3.5 Further Relationships between GAD 7, PHQ 9 and PSS

In addition to the testing of the hypotheses, the Pearson Correlations also found significant relationships between:

- GAD 7 and PHQ 9 ($r = 0.69$, $p < 0.001$)
- GAD 7 and PSS ($r = 0.67$, $p < 0.001$)
- PSS and PHQ 9 ($r= 0.66$, $p < 0.001$)

3.3.6 Influence of Gender Groups on Reported Levels of Negative Acts

In order to test the influence of gender on the reported levels of negative acts, analysis of variance was undertaken. The results found that there were no significant differences between gender groups and the reported level of negative acts; $F(2,270) = 0.58$, $p = 0.59$. Male SD 10.49 M 32.16; Female SD 12.54 M 34.04.

3.3.7 Influence of Staff Bands on Reported Levels of Negative Acts

In order to test the influence of staff bands on the reported level of negative acts, analysis of variance was undertaken. The results found that there were no significant differences between staff bands and the reported levels of negative acts; $F(6,266) = 1.75$, $p = 0.11$.

Table 12 - Staff Band and Reported Levels of Negative Acts

	SD	**M**
Band 3	10.20	35.63
Band 4	8.35	31.00
Band 5	14.30	38.86
Band 6	9.95	30.46
Band 7	14.02	34.47
Band 8+	15.66	35.79

3.3.8 Influence of Ethnic Groups on Reported Levels of Negative Acts

In order to test the influence of ethnic groups on reported levels of negative acts, analysis of variance was undertaken. It was found that there was a significant effect of ethnic group category classification and levels of reported negative acts; $F(10,257) = 3.87$, $p = 0.01$

Table 13 - Ethnic Group and Reported Levels of Negative Acts

	SD	M
White-English/Welsh/Scottish/Northern Irish/British	11.00	33.07
White-Irish	9.53	33.92
Any other white background	10.99	31.90
Any other mixed/Multiple ethnic background	4.24	40.00
Indian	5.63	32.50
Bangladeshi	10.66	32.50
Any other Asian Background	8.01	29.14
African	16.37	40.59
Caribbean	18.63	43.86
Any other Black/African/Caribbean background	24.69	51.62
Any other ethnic group not listed	7.70	32.08

Bonferroni post-hoc tests revealed that the category of any other Black/African/Caribbean background had significantly higher reported levels of negative acts than the following categories:

- White-English/Welsh/Scottish/Northern Irish/British $p = 0.01$:
- White-Irish $p = 0.05$
- Any other white background $p = 0.01$
- Any other Asian background $p = 0.01$
- Any other ethnic group not listed $p = 0.01$

There were no significant differences found between any of the other ethnicity groups (all p's = 1.00).

3.3.9 Influence of Time in Job on Reported Levels of Negative Acts

Finally, in order to test the influence of the time employees had been in employment and the reported levels of negative acts, analysis of variance was again undertaken. It was found that there was also a significant effect of the number of years reported as working at ALT and the levels of reported negative acts; $F(2,270) = 5.01$, $p = 0.01$.

Table 14 - Time in Job and Reported Levels of Negative Acts

	SD	M
Less than one year	6.35	27.95
2-5 years	13.07	34.50
6 years plus	12.27	34.63

Bonferroni post-hoc tests revealed that participants who had been working at ALT for 2 to 5 years reported higher levels of negative acts than those working at ALT for less than one year; $p = 0.01$, there were also higher levels of reported negative acts from participants working at ALT for more than 6 years as opposed to less than 1-year $p = 0.01$.

There were no significant differences between the groups 2 to 5 years and 6 years plus ($p = 1.00$).

These findings could be further analysed between the respective five divisions that were included within this study; however, for confidentiality reasons, those breakdowns are not reported in the context of this report.

The findings for the qualitative aspect of this study now follow before the qualitative and quantitative results are compared and contrasted in the final section of this chapter.

3.4 Qualitative Findings

3.4.1 Introduction to Qualitative Findings

Detailed below are the participant demographics, which are then followed by a brief initial observation and personal reflexivity on the terminology of 'perception or reality' of bullying behaviours. This material is followed by the detailed analysis of the emerging categories and theory that transpired. Many extracts from participants were included within the initial categories; however, for ease of reading, only a selection for each heading is given below. An overview diagram is shown before detail is provided on the content of each category.

The transcripts of the data sets were completed by the researcher to keep the researcher familiar with the data and to enable a far more thorough understanding of the content (Braun and Clarke 2006). Once the initial coding and more focused coding was

completed, a constructivist theory of the experience of bullying behaviours in line with grounded theory principles began to emerge. During this stage, the findings progressed from the raw dataset into four emerging categories. The first category is 'bullying behaviours', as this was the category that the initial research question aimed to address and, to that extent, was somewhat self-imposed. The remaining three categories emerged throughout the data analysis stage. These category names changed frequently, as did the category sub-titles, and the researcher felt that some 'quotes' or 'extracts' could have been placed into maybe two or three other headings, as the boundaries between them were not always black and white. However, after much deliberation, final categories were decided upon based on what was deemed the most appropriate. The form of analysis was closely linked to an inductive approach, with the categories strongly linked to the data. In addition, the analysis aimed to go beyond the semantic content of the data and delve into a latent level as described by Braun and Clarke (2006). Braun and Clarke (2006), whilst arguing that thematic analysis is very much a method in its own right, concede that it is compatible with constructionist paradigms and is a tool that can be incorporated in other major analytical traditions such as grounded theory (Braun and Clarke 2006).

3.4.2 Participant Demographics

The number of participants who had described experiencing bullying in the workplace and were willing to come forward to take part in this study was eight. The eight participants comprised five females and three males with different ethnicity groups, and they encompassed a wide range of staff bands including consultant, doctor, nurse and porter. At least one participant from each of the five divisions was included in this study. The age range was 23 to 61. Whilst representation dynamics were not an overriding consideration for the qualitative part of this study, it is felt important to highlight to the reader that various representations of different divisions, ethnicity, ages and bands were present. There were no gaps that were not covered through age, gender or seniority of positions within ALT. For confidentiality reasons, all identifiers have been changed/removed from the names of the participants and the content of the extracts.

3.4.3 Validity

Braun and Clarke (2006) describe a checklist for the qualitative analysis which includes considering all data items being giving equal attention and ensuring that categories have not been generated from a few vivid examples but that the coding has been thorough, inclusive and comprehensive. The researcher ensured that this guidance was adhered to by not rushing the analysis, and sufficient time was given to each phase of the analysis. The data was analysed and interpreted rather than just described or paraphrased. This approach was assisted vastly by the quality of the data corpus and data sets (interviews) which offered rich, varied and detailed accounts of the topic of bullying experiences. Yardley (2000, 2017) states that the quality of qualitative research can be grouped into four dimensions:

- Sensitivity to context
- Commitment and rigour
- Transparency and coherence
- Impact and importance

Whilst there are no rigid rules regarding the quality of qualitative study and it is open to interpretation, this study considered the four dimensions described by Yardley (2000, 2017). In respect of the sensitivity to context, the researcher ensured that all NHS ethics requirements were adhered to and always considered that the employees prepared to be interviewed for the purpose of this study had done so in the context of the work setting which was itself of a sensitive nature. The researcher was not operating as a therapist and ensured that the interview, whilst empathic in nature, followed a pre-defined structure of questions. Yardley (2000, 2017) describes the sensitivities of the selection of some participants over others and the power of the researcher. In this present study, all participants who approached the researcher and were willing to be part of the study were selected for the qualitative interviews.

Commitment and rigour were shown throughout the research process by the long engagement of the researcher with the topic matter and by the lengthy immersion in the datasets, allowing for comprehensive analysis culminating in a theory that was grounded within the data. The commitment to the study was evidenced by the researcher working within the confines of the thesis timeframes but not by rushing from one stage of analysis to another without careful consideration of the categories

emerging from the data. The analysis continued over several months after all the interviews had been undertaken.

Transparency of the procedure adopted for the qualitative part of the study is detailed within the methodology chapter and highlights the relevant aspects of the research process. The transparency includes a full description of each stage of the collection of data from the initial presentations that were delivered to staff through to the descriptions of each stage of the coding process and the culmination of a theory. The transparency also includes the researchers' preconceived ideas and assumptions which are detailed in reflexivity.

Yardley (2000, 2017) describes the decisive criteria for judging the quality of qualitative research as impact and utility, which can be assessed by the objectives of the research – have they been met? The original objective of the qualitative part of the study was to consider the experience of bullying from the perspective of the victim and consider what that looked like to them individually. This was achieved with a theory of the bullying experience from the perspective of the participants emerging. The impact of this current research and the contribution to the understanding of bullying within the field of healthcare is still ongoing. The researcher is currently presenting the findings to the trust and participants within the locations of the study. Yardley (2000, 2017) refers to research providing a novel and challenging perspective, this current research demonstrates throughout the following chapters that this has been met.

3.4.4 Perception or Reality?

One of the first observations as the interviews progressed was the term that was used in the title of the research and also when undertaking the interviews. This was the term 'perception' of bullying; one of the participants early on in the research made the point that this term was used as if bullying was not real, it was just the 'perception' from the employee. A change in the terminology used with future participants was therefore made by including the term 'experience'. It was felt there could be an underlying issue for some participants if they did not feel believed or validated. The following two quotes from Mike highlighted even more than originally thought by the researcher the sensitivity of the subject matter:

Mike ‘I have told her I think you are a bully and she said I am sorry that’s your perception and I say no it’s my experience it’s my experience and you know we have had this months of ignoring me, ignoring me, ignoring me.’ (2303-2307)

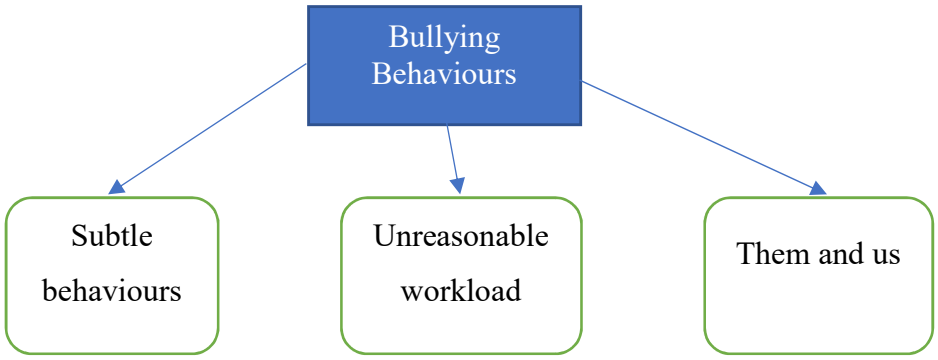
Mike ‘and she said, well I am sorry you feel that way, because that is your perception of the situation and I said I find it more of an experience than a perception because it’s not really in my head, it’s things that have happened.’ (2516-2520)

The interviews were undertaken with sensitivity and, whilst guided by the questions, the participants were given the space to tell their *experience*. The core categories that originated from the data analysis are discussed in detail but, before this, an overview of the core categories and sub-categories is provided below.

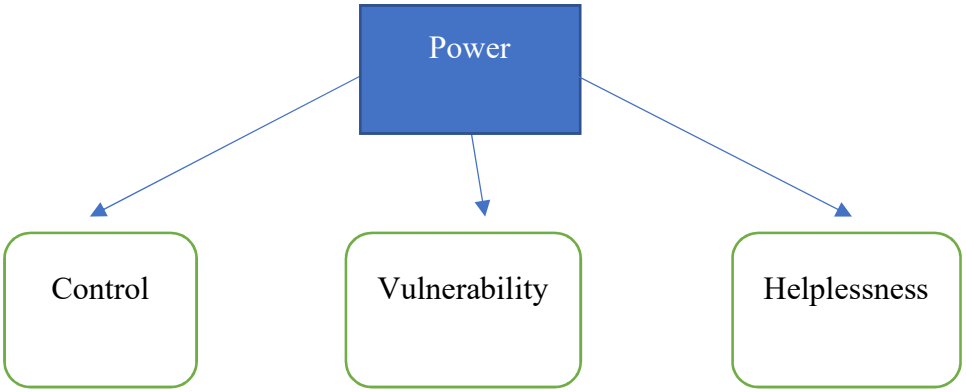
3.4.5 Qualitative Findings

Overview of Core Categories and sub-categories.

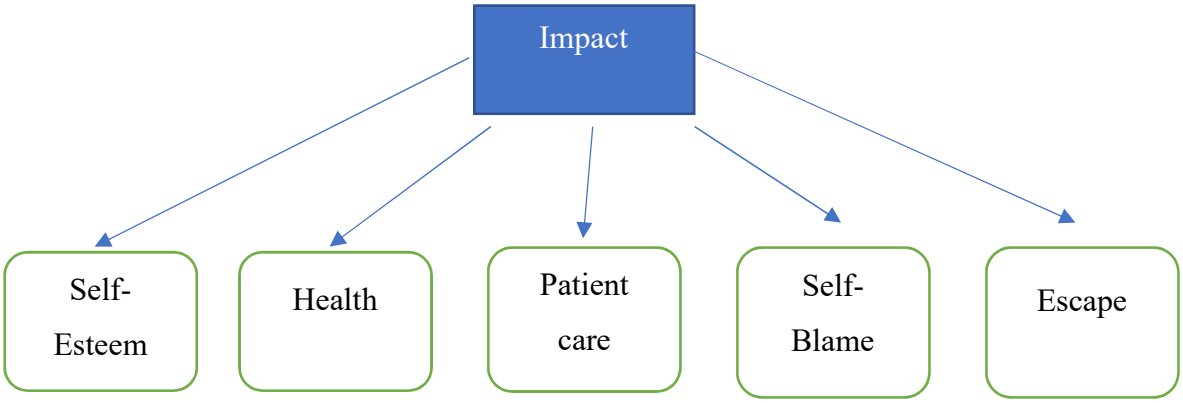
Core Category 1 – Bullying Behaviours



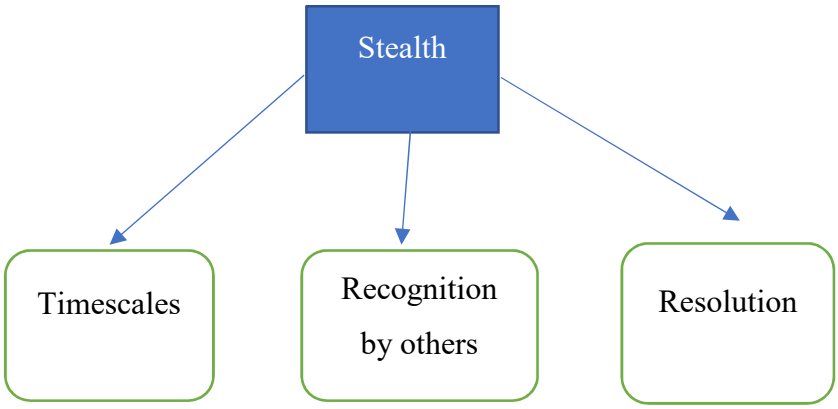
Core Category 2 – Power



Core Category 3 - Impact

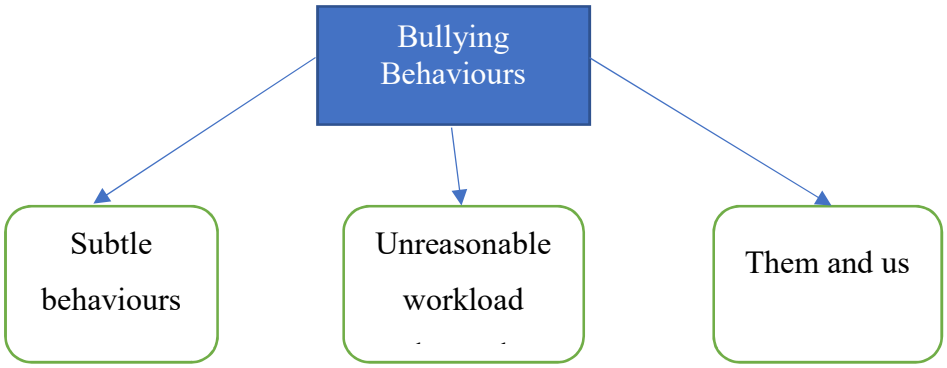


Core Category 4 - Stealth



3.4.6 Presentation of Qualitative Findings by Category

Category 1 – Bullying Behaviours



The Core Category 1 of bullying behaviours shown above was a somewhat self-imposed one, as the aims of the research and the research question set out to ascertain from employees what were their perceptions and experiences of bullying. On this basis, whilst interview questions evolved over the course of the eight interviews and were revised in line with grounded theory principles, the researcher attempted to remain inquisitive as to the nature of the bullying events from the perspective of the target. For this reason, during the initial coding and subsequent focused coding, many bullying behaviours were uncovered, and theory began to emerge from the data.

Subtle Behaviours

The findings suggested that some of these behaviours were under the radar and difficult to prove with hard evidence that would be required for any investigation into bullying. During the coding/s stages, subtle behaviours were noted as described in some form by every participant.

As there appeared to be numerous subtle behaviours identified, these were further sub-divided as follows:

Subtle Behaviours
i. Tone of communication
ii. Human interactions
iii. Hassling behaviour
iv. Withholding information

Some of the comments could be included in two or more of the sub-divisions as there was much crossover between them. For clarity and succinctness, a quotation is only used to highlight the dominant theme.

i) Tone of communication

One of the questions that was asked to all interviewees was 'What actual events happened to you that you could describe in your own words?' Many participants described events where the tone of communication used was aggressive or threatening in some way, over and above what could be deemed appropriate for the work setting and the overall demands of the job. The type of tone and communication would be

described as including a directive tone of voice. Terry when describing what actual events happened to him that he could describe stated that:

Terry 'the tone of voice the tone of engagement of the other person' (395-396)

Dea 'would that be verbal tone or by email?' (397)

Terry 'It could be verbal or via email and the constant request for more detailed information……another step, another step, another step and going into detail that would be that I would consider to be inappropriate to a request erm than part with a tone and some degree a threat that goes with it' (398-405)

Another participant, Mike, described letters that he had received and how he was 'shocked' by their 'tone'. Other communications included a description of the inconsistencies of the treatment of staff which included a note of perceived underlying unfairness. This was covered comprehensively also in a reply from Gill when describing bullying behaviours:

Gill 'not allowing you to have annual leave and the argument is that we have got to run a service which I totally understand but we are the service and if we don't have leave then we aren't going to be mentally well enough so I think there is a lot of using lots of pressure to not have sick leave to come in when you are sick but it's very subtle so its transfused but things like subtly undermining people in meetings, in a very subtle clever way, manipulation, it feels like there is manipulation, ignoring people, excluding people from decisions, excluding people from email trails, things like that I think, a really unspoken rule that you will stay late after work, you will do all your continuing professional development after work you will do in fact all your non-clinical work after work' (911-924).

ii) Human interactions

The tone and content of communication led the researcher onto a further sub-division headed 'human interactions' in an attempt to capture the essence of subtle behaviours of humans against other colleagues which were deemed to be bullying behaviours by participants. Within the category of bullying behaviours again these described behaviours would be under the defined 'bullying behaviours' radar and difficult for employees to provide any categorical evidence to substantiate.

To give participants the space to think about their bullying experiences, the question of what a non-bullying day would look like was posed; this provided varying responses, a couple of which are highlighted below:

Dea ‘So what would a non-bullying day look like to you?’ (1239)

Gill ‘you would come into work and every member of the team would greet each other with eye contact, and there wouldn’t be things slammed on the desk and there wouldn’t be any storming around and there wouldn’t be any subtle criticisms it would be a day where everyone speaks to each other and supports each other, and when we talk about patients we do it in a compassionate way, we don’t call people difficult, we call them challenging……..we would finish on time or nearly on time, within 15-20 minutes of the time and that would be encouraged and not penalised….everyone’s opinion would be valued and everyone is listened to and no one is talked over and no one feels frightened to speak up I suppose.’ (1240-1278)

The same question was asked to Alexis and her response was:

Alexis ‘it would be lovely, light, fun, rewarding and I wouldn’t be looking over my shoulder, happy.’ (1862-1863).

Further subtleties were described as management not saying goodbye if you leave on time or not greeting each other in the morning:

Gill ‘I suppose things like some of those little behaviours like ignoring people when they come into the room, you know when people leave on time, people won’t say goodbye to you if you leave on time so that you know they are not saying to you, you should be staying late but they are telling you by their behaviour that you should be staying late.’ (561-563)

iii) Hassling behaviour

Some participants found it difficult to recall certain particular ‘behaviours’ as such, but described behaviour as ‘hassling’ or ‘undermining’. This was summed up by Jasmine as being constantly ‘got at’ and as soon as one task was finished there was another and another.

Jasmine ‘she didn’t appear to be a nasty person but she kept chipping away at my confidence at what I was doing but undermining what I was doing as if what we had been doing all these years had no value at all and then just hassling you about other stuff as well, she was constantly going on about here is this risk assessment and yeah they are all done but just niggling away at you but yes, it is hard to think of actual things she has actually said.’ (276-282)

iv) Withholding information

Many of the participants explained that not only the tone and content of communication was inappropriate for the cohesion of a unit, but the lack of communication or what was regarded as withholding information was considered subtle bullying. Gill in answer to the question as to what one bullying behaviour would she change, answered that she would like more openness and transparency. I further questioned what she meant by this and she clarified, this was reiterated by other participants also.

Dea ‘verbal communication?’ (1014)

Gill ‘All kinds of communication, I think, people are so thirsty for any information and sometimes the information they get is just hearsay or it’s not correct, people are really desperate for information about what the future holds and where is the service going and there is not that filtering down……..well I guess that is bullying in a way isn’t it cos it’s withholding information, it’s intentionally withholding information so that people feel frightened and uncertain.’ (1015-1022)

As difficult as it was for the participants to eloquently describe the ‘subtle’ behaviours experienced, it was equally challenging to categorise them into defined boxes as there were many similarities and cross overs.

Unreasonable Workload Demands

Other bullying behaviours, such as the one of unreasonable workload demands were somewhat less challenging to categorise. These were sub-divided into three further re-occurring terminologies emanating from the data coding applied.

The sub-category of ‘unreasonable workload demands’ appearing in the bullying behaviours experienced category was subdivided into constant pressure, micro-management and ‘machine not human’:

Unreasonable Workload Demands
i. Constant pressure
ii. Micro-management
iii. Machine not human

i) Constant pressure

There was an understanding from participants that all roles within the hospital environment would carry a high level of commitment, and that they were working in a highly pressurised industry. However, many described that this went beyond what was acceptable in many cases and was therefore deemed as bullying in their experiences. The researcher explored what this entailed in an attempt to understand what was happening. A selection of responses is detailed below:

Alexis 'being given tasks with unreasonable or impossible targets or deadlines, yes every day, they make your life an absolute misery, they do not give you enough time to do your work properly and I am exhausted from it, it's just horrendous, that for me is one of the biggest bullying things, your contract is not doable'. (1359-1366).

Gill 'you have got to be seen to be working constantly throughout the day, and if you are seen at the computer too much and not seeing patients that is brought up with you, so you have to be, and even if you have a valid reason for being on the computer, it still doesn't matter you still need to be seen, if they don't feel you are working flat out end to end all day then not good enough, you can't have any time to reflect, any time to improve your practice, think of a better way of doing things, any kind of questioning is just squashed.' (931-939)

Terry 'within this institution it would be the high pressure and the high expectation of staff to go beyond their contractual work.' (384-385)

In order to further clarify and gain some insight as to where a boundary line was from being 'pressured' to do your work and 'bullying', a further question was put to participants:

Dea ‘so where would the boundary be between being asked to do your job or your work to go over to what you would consider to be bullying behaviour, where would that line be?’ (362-365)

Terry ‘I hadn’t thought about that before so for me if you are continuously pressurised to do more than is in your job description or should be expected of you then that to me is part of bullying……the line would be where it’s not taken erm where it is not expected that work finishes at a certain point in time and that some might be able to go beyond but some might not.’ (365-380)

ii) Micro-management

In addition to the constant pressure, participants described situations where they believed they were micro-managed to such an extent that it was deemed bullying behaviour.

When participants were describing examples of the constant pressure and demands, many described situations whereby it was like ‘big brother’ looking down on them watching every move. Two examples of this have been included for comparison. Terry described situations whereby he felt he was requested to continually provide more and more written information, whereas Kim described situations of observational micro-management. Examples of both of these situations are shown below:

Terry ‘the constant request for more detailed information without outlining in the first instance to have this……as soon as you have provided it there would be another step another step another step and going into detail that would be .. that would be considered to be inappropriate to a request.’ (398-404)

Kim ‘I was being, how can you say it, you know when people look over their shoulder, you can see that people are watching everything that you are doing.’ (3129-3132)

Dea ‘so micro-managed?’ (3133)

Kim ‘yes looking at all the detail, I remember people saying things that were very unkind, you could see people talking, bitching about you, it was very unpleasant.’ (3134-3136)

Dea ‘what type of things?’ (3137)

Kim 3138 – 3139 ‘they said oh she is very slow, she is stupid, how come she doesn’t know that, things like that.’ (3138-3139)

Kim was describing to me her experience of when she was a new member of staff to the particular division.

iii) Machine not human

There were many references throughout the interviews to not being felt valued as a person and feeling dehumanised. As there were many examples of this throughout the coding stage, it was felt that it warranted a sub-division by itself. This is the final sub-division of unreasonable work demands.

A selection of extracts is provided below:

Gill ‘if we have an upsetting situation with a patient then tough you still go and see your next patient straight away, you can’t be a human being and walk away because you are upset, you have to just keep going, keep going.’ (926-929)

Alexis ‘it felt as if everybody was on a machine, but it’s more than that, it’s more subtle than that.’ (1565)

Alexis ‘the whole of ALT feels like a factory……and there is an impersonal element to it, it’s a productivity issue the whole time, it’s not a nurturing environment.’ (1921-1931)

Khalid ‘she pushing me to work like a donkey.’ (2908)

In order to find some clarification from participants as to when behaviours become bullying behaviour rather than just ‘behaviours’ in the workplace, the researcher further questioned participants as to their experience of this:

Dea ‘So when does it cross over into bullying rather than too much work, what would be the cross-over point for you?’ (2372-2374).

Mike ‘It’s a really difficult thing to identify because I think if you have more than say six patients in the ward erm it’s a lot of physical work beyond that it’s over-burdened of work.’ (2375-2377)

Them and us

The final sub-category appearing under the category of bullying behaviours is classed as 'Them and Us' which encompasses participants' experiences of bullying behaviours that are from individuals in a higher position than they are in.

Some of these behaviours could have appeared in the next category of 'Power' however the 'Power' category focuses on *bullying as control* rather than a specific bullying behaviour. The defined 'Them and us' sub-category includes examples of detailed bullying behaviours from participants which was the rationale for including them here. The 'Them and us' sub-category is further divided into three sub-divisions which are labelled as 'opinions being ignored', 'belittling behaviours' and 'singled out'.

Them and Us
i. Opinions being ignored
ii. Belittling behaviours
iii. Singled out

i) Opinions being ignored

Many participants when questioned about their experiences of bullying behaviours described examples of not being listened to, whether that was from change management teams or the hierarchy. One participant mentioned that it was not a case of just not being listened to, it was a case of not being given a voice to be ignored:

Jasmine 'she didn't actually come up and observe or work with us at all, you know when someone is new it's always nice to do that.' (298-299)

Jasmine 'yeah she just, it was as if she wasn't interested not that she wasn't believing what I was saying.' (219-220)

Alexis 'there were huge difficulties as they hadn't listened to us and what we needed.' (1397-1398)

Mike 'I just overheard the plans and I said to the builders can I have a look at those plans and they said yes……. …… but they still weren't listening to staff, they weren't listening to us at all….' (2205-2207)

ii) Belittling behaviours

This next sub-division includes a variety of examples of bullying behaviours entitled 'belittling behaviours'; these again relate to individuals in a higher grade than the participants, hence under the category of 'them and us'. These behaviours were experienced by the participants as making them feel small and somewhat insignificant. Some of the examples of this type of bullying were described by the participants and are shown next after the question as to what bullying was to them was questioned. Dea 'So if I didn't know what bullying was how would you describe it to me?' (148)

Jasmine 'She somehow sort of verbally I suppose and through the things she was doing and saying made me feel small and useless and that I wasn't able to do my job.' (149-151)

Jasmine 'she was sort of demeaning the things I was saying as if they were not important and this and you start to doubt what you have held all along as you know what we are doing is good and we have had tremendous feedback over the years but that seems to count for nothing when somebody seems to be gunning for you.' (163-167)

This next example was recounted by a participant as an example of an event that took place while she was a relatively new member of staff. The probing question of when behaviours crossed the line to bullying was utilised:

Dea 'So when did you think it crossed the line in your own mind to this is bullying?' (690-691)

Gill 'so she was making all these really inappropriate comments about other members of this team that she wasn't necessarily managing … so she was making all these really inappropriate comments about other people to me and then she started saying inappropriate things to me about me like your voice is too loud, you know I have lots of comments about your face.' (716-720)

Dea 'If someone were to ask you within ALT what type of bullying would be experienced generally how would you reply?' (1722-1723)

Alexis 'It's belittling in different ways, it's making you feel incompetent' (1724-1725).

Dea ‘so quite humiliating to be shouted at like that?’ (3353)

Kim ‘yes that is how I felt, humiliated, and people would just stare and not say anything, because I remember when she was shouting there were a lot of people who saw it there.’ (3354-3357)

Dea ‘was this shouting about the relatives or were there other examples?’ (3358-3359)

Kim ‘yes yes and I remember she shouted at me another day during the handover, she was shouting at me, how long have you been here, how come you don’t know this, you know everybody is fed up with you, you better stand up.’ (3360-3364)

iii) Singled out

Finally, under the overall category of bullying behaviours and the sub-category of them and us is the sub-division ‘singled out’. Many of the participants described experiencing being ‘picked on’ or ‘singled out’ from the rest of their colleagues to be the target of bullying behaviours. Some of these examples are provided below:

Dea ‘was she speaking to other people in this way?’ (3367)

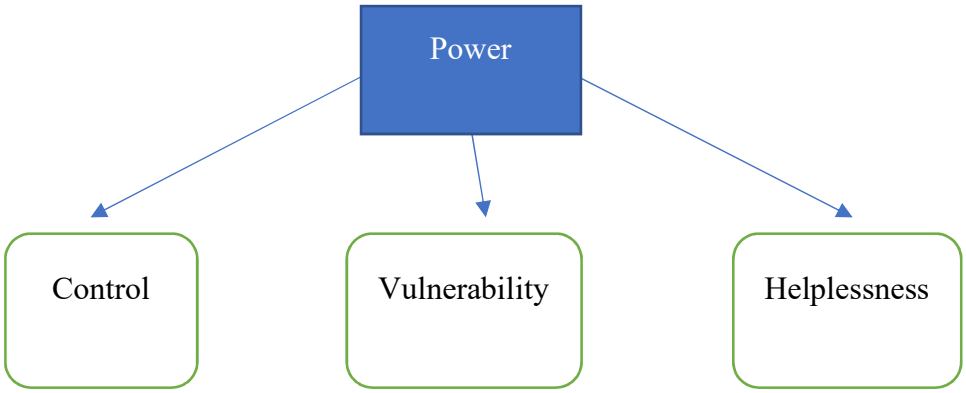
Kim ‘nooo, I was the main target at the time, nobody else.’ (3368)

Jasmine 85-86 ‘she seemed to pick a couple of people and leave some of the others alone.’ (85-86)

Alexis ‘I felt that I was being picked on, I felt bullied when she had to do my appraisal and I couldn’t face her.’ (1766-1767)

Sarah ‘……..no-one wanted to take my patients, if I wanted to take my mandatory coffee breaks, and lunch breaks that was how I was treated, I could feel I was being singled out.’ (3559-3561).

Category 2 – Power



The second main category is one of 'power' which, in this context, is defined as the ability to control people or events. This particular word and its implied meaning were found to be grounded in the data for every participant and, therefore, takes its place as an overriding category. This category comprises the sub-categories control, vulnerability and helplessness.

Control

The following quotations have been provided to highlight the experiences shared by the participants about the control that was enforced upon them in relation to the power of others. Participants were asked to describe an event that happened to them that they could recall.

Dea 'so what actual event is happening to you or has happened to you that you are able to describe in your own words?' (2680-2682)

Khalid 'when the person knows they have the power, that person knows they have the control for everything and this person uses this power for their own personal benefit.' (2683-2686)

Jasmine 'we need managers because they have the power to change things, but they also should be working with us not against us and that was very much against us.' (306-308)

Jasmine ‘it was very difficult when someone is more senior than you and they have been given this power to, I suppose you always think that they have more power than they probably have.’ (155-157)

Gill ‘using sort of small power games that you see over a sustained period of time just sort of re-enforced power roles….’ (559-561)

Gill ‘I went to my manager and it was actually her who was the biggest bully…she was in the most power and she would say the most terrible things.’ (692-699)

Alexis ‘I had no power, it was being done to me.’ (1892)

Vulnerability

The power category also encompassed the participants describing situations whereby they felt that they were experiencing bullying as a result of their vulnerability. During one interview, the target recalled a situation whereby she was a new member of staff and keen to learn; this extract highlights the vulnerability and resulting self-blame that arose as an outcome of feedback interactions.

Gill ‘I remember this situation where I was brought to one side and was told that I needed to have some feedback. The feedback was not like any I had received before, I was told to be careful not to bite off the hand that feeds you……it wasn’t constructive feedback…… I was mortified to have that feedback and at the time I didn’t realise or know much about a bullying culture, I just assumed I had done something wrong and that I was at fault and that everyone felt and thought these things about me and then you feel very frightened and small as you would in that situation.’ (669-689)

Gill ‘I can’t create a direct relation it’s not like I am stressed I am going off, but I mean I do wonder if you are vulnerable, I was trying very hard to please everyone, vast workload, you are doing it very quickly, you cut corners, you injure yourself.’ (951-955)

Alexis ‘I feel that if I say something wrong I will be pounced on, and I will be disciplined again for saying the wrong thing, it’s unpleasant.’ (1718-1721)

This final extract displays the combination of the vulnerability that Mike described and the control and subsequent power that he felt others had over him, which resulted in his expressing that he had experienced bullying behaviours.

Dea ‘and if someone had not been bullied before how would you describe to them how it made you feel?’ (2571-2572)

Mike ‘.....makes you feel a bit singled out, makes you doubt yourself especially if you know that you do a good job, I suppose it makes you feel a bit vulnerable as well, because somebody in authority who is bullying you, you do think that they have an element of control over me, and then they could say that well if you don’t do this then I am going to give you a warning so it puts you in this position of feeling vulnerable, and I think if you start getting backed into a corner you do start feeling frustrated and angry as well.’ (2573-2583)

Helplessness

The final sub-category under the overall category of power is the helplessness that participants described experiencing combined with the control and vulnerability. The helplessness was the experience of feeling that change could not be enforced by them to put a stop to the bullying behaviours.

After participants had described situations of the power and consequent control over them, more probing questions were asked in relation to this and some of the responses are provided below:

Dea ‘Did you feel you had any power to change that within the workplace when it was happening?’ (3302-3303)

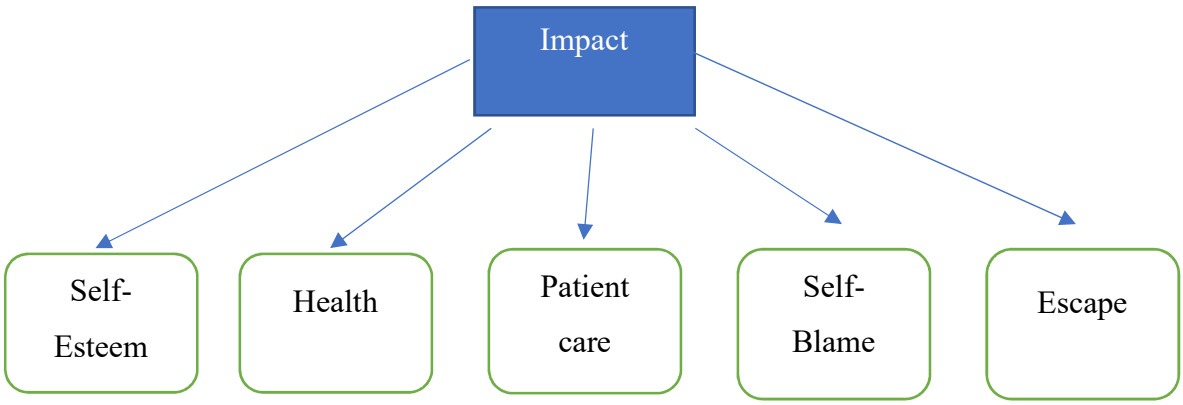
Kim ‘when it was happening no, but now I think I have the power, because I am saying my eyes are open to protect the young staff that they don’t go through the same thing.’ (3304-3306)

Jasmine ‘It was a real feeling of incompetence against the power of someone who could come in and unsettle everyone like that.’ (105-107)

Gill ‘I can try and do something but you have to be very careful, it’s very difficult but people are very scared to talk and very aware of the consequences, so you know they have been kept in a powerless state for such a long time, there is that learned helplessness as well.’ (609-613)

The power category contained experiences of control, vulnerability and helplessness.

Category 3 – Impact



The third major category is the impact that the bullying behaviours and the power over individuals had on participants. Whilst concentrating on the overriding research question of what individuals experience as bullying behaviours, it was difficult to complete this in isolation from the impact it had on them and subsequently on patient care. In addition, as the interviews progressed, questions arose as to why people would remain in that situation, and how would individuals extricate themselves from the bullying? This category, therefore, details the impact of bullying behaviours as described by the participants. The first sub-categories consider the impact on the individual and on patient care, and the last one details individual accounts of how the bullying ceased, and this is labelled 'escape'.

Self-Esteem

Participants described in their own words the way bullying impacted on their wellbeing and confidence; many used the word self-esteem and some of their answers are provided below:

Dea 'and if you could say to your bully at that time, how would you explain how that made you feel at the time?' (3312-3313)

Kim 'horrible…..made me feel…….unwanted, unwanted in that department, that people did not want me there, they made me feel….. I can't find the word… I felt very sad. It made me feel very low.' (3314-3317)

Terry 'I doubted myself, if I was wrong in what I had actually done and how I responded erm if I have exploited the system or my work in any way that may have

been inappropriate, it took away my fun from going getting up with a smile to go to work to a glad when I'm home again attitude erm and stopping to do anything extra that I have done for the trust before.' (446-452)

Gill 'when it is at its worst, losing sleep, being very anxious and distressed, it takes away your self-confidence, your self-esteem, makes you constantly second guess yourself and think am I going mad, am I this, am I that, is it just me?' (1046-1050)

Alexis 'the work was overwhelming, I felt incompetent, I was being made to feel incompetent, not able to do what was put in front of me.' (1545)

Health

The impact was not limited to self-esteem and appeared to go much deeper into health complaints as expanded upon next where participants gave their own examples of the impact on their health:

Jasmine 'You know when you wake up to go to the loo at 3 o'clock in the morning and you can't get back to sleep because you just, there is so much going on in your head, and that's not like me, I just, so months of not sleeping properly because I'm worrying about what's going to happen.' (102-105)

Gill 'It makes you feel very isolated, very lonely you feel you question yourself a lot, can make you feel very tearful, very pre-occupied, with just going over and over just ruminating, certain events over and over, you can be out with your friends and it's all you want to talk about cos it's all you think about it just takes over, it destroys peoples' lives for certain periods of time there is no denying that really, it's how it affects you and it makes you under confident and makes you really question what you are doing and why you are doing it.' (1075-1083)

Alexis 'I was upset, I was ill, my blood pressure went up.' (1470)

Mike 'It made me feel angry actually and frustrated, it almost made me feel like a child in a way, being in a playground and you don't know how to react, I felt most angry and frustrated and a bit surprised and resentful and just really made me feel less happy coming into work.' (2505 – 2510)

Dea '……so you feel quite isolated?' (2940)

Khalid ‘yes…..to be honest I tried to kill myself too, many times, yes, yes, because you do not have support, no one will help you, the same person who has to give me support is the same person bullying me, there is no point.’ (2941-2944)

Kim ‘I thought I shouldn’t be treated like this, at this time I was just very worried, very anxious, I wasn’t seeing it as being bullied, I just thought should I stay or leave this place, but it had a very knock on effect on my health because of the stress and anxiety that it gave me.’ (3182-3186)

Patient care

Some of the impact described was not only on the individuals own general health, as demonstrated above, but included that of the impact on patient care

Detailed below are four quotations that highlighted this concern from participants:

Jasmine ‘and when she said that I was resistant for change this is what I was asking for not a resistance to change but what is right for patients.’ (240-242)

Alexis ‘I said this is putting a huge amount of pressure on me and I can’t do this and I am not giving proper care because I am rushing from one patient to another.’ (1423-1424)

Alexis ‘I was very stressed with this and I wasn’t doing my job properly, there was a risk to patients’ safety and I kept telling people but no one wanted to do anything about it.’ (1460-1463)

Kim ‘I’m new and struggling with a patient, the patient is unwell, I need help, they are all just watching, I am struggling, the monitor is alarming, I am struggling, I was turning my back away and then I saw them (mimics gossiping/laughing) I just saw them that was a shock, you have a new starter struggling with a sick patient and they are just there staring, talking not coming to help and I shouted can someone come and help me and they all ran away like little ants…….’ (3375-3384)

Self-blame

In conjunction with the ‘singled out’ experiences described by participants, there were elements of self-blame that came through the narratives during the coding procedures. These were considered to be different to the ‘singled out’ descriptors and deemed appropriate to warrant their own sub-division under the impact category.

Terry ‘So that’s where I thought actually am I the only one who experiences that or others in a similar way and is this just an attitude of high achieving and expecting to work beyond what you are contracted to do.’ (341-344)

Sarah ‘you know I was paranoid at one point, maybe they want me out of here, this department, they want me out of here, which is why they treated me like that, maybe management didn’t want me here which is why, cos it seemed to me to be seen as vindictive.’ (3830-3834)

Gill provided an analogy which at the time made the researcher feel quite uncomfortable with the content and subject matter, but it is included here as a final quotation for this sub-division and is a powerful descriptor of the ‘self-blame’ that victims of bullying can experience.

Gill ‘it’s a bit like rape victims people don’t believe rape victims they say they make it up or its their own fault or they blame them for wearing a short skirt or drinking too much that’s what it feels like to be bullied it’s your own fault you shouldn’t have been out late with a man, it feels like you went to the department and you worked in it so expect to be bullied.’ (1320-1327)

Escape

As the interviews progressed and a theory was being considered, it occurred to the researcher to consider why individuals would remain in a situation of being subjected to bullying behaviours and the subsequent described health complaints that ensued. Some consideration was therefore given to how individuals would either accept the bullying behaviour as the norm or would fall back on alternative coping mechanisms. Detailed below are the findings of the initial and focused coding in relation to this area, categorised under the headings of ‘escape’ to depict escaping the bullying behaviours. They are further sub-divided into ‘becoming the bully’, ‘not just me’ and ‘resigning/leaving’.

Escape

i. Becoming the bully

ii. Not just me

iii. Resigning/leaving

i) Becoming the bully

During the interview with Gill, she described a situation where she was displaying signs of becoming the bully. In addition, Alexis detailed an account where she was reported for the sharpness of her emails when in a position herself of high stress-levels due to exhibited bullying behaviours against her. In contrast, Kim describes how her experienced bullying behaviours resulted in her becoming a protector for other new members of staff to try and ensure that they were not subjected to the same level of victimisation that she was. Extracts of these three accounts are detailed below:

Dea 'Do you find yourself showing these bullying behaviours?' (1213)

Gill 'I'm sure I have and that devastates me.' (1214)

Gill 'staff turnover is quite high, they disappear just as much as the scapegoats, I don't think it's nice to be in either, you need the favourites to make the people feel scapegoated but I don't think the favourites necessarily like being, at first it's probably quite nice but just because you are the one that is being sent on the courses, and then of course that creates bullying.' (1125-1131)

Gill 'what saddens me is that good staff become bullies because either you are a bully or you get bullied, so they exhibit those kind of behaviours, because it is just the normal.' (1201-1203)

Alexis 'I was then reported for disciplinary action because I had been sharp in emails ……my emails were short and sharp and I looked at them and they were……business-like.' (1452-1457)

Kim 'if I see any new staff in the ward, I start to befriend them, and just make myself available and talk them through, don't worry about anything, if people say this just do that, if people say this just ignore it, you are going to be fine, I am watching the staff, I don't want what I experienced happening to anybody else.' (3237-3742)

ii) Not just me

There were accounts of feelings of being very isolated during the experience of being bullied, isolated from being able to talk to others about it for fear of being judged or ousted. However, for some, there was an escape or release when there was a realisation that the bullying was not so personal as they had led themselves to believe. Mike, Kim and Jasmine's comments are provided below to illustrate this point:

Dea 'so it is not so isolating now?' (2594)

Mike 'No they have recognised it, that it is happening to them and they can see that it's happening to me too, so that's you know, kind of like makes me feel supported which is good but when it does start happening you do feel quite alone because you think why…' (2596-2600)

Jasmine 'it did feel a bit better when I realised that it wasn't just me.' (108)

Dea 'is it normally when people start?' (3226)

Kim 'It's normally when people start, as soon as you are the new person' (3227-3228).

iii) Resigning/Leaving

One form of escape from the bullying behaviours that occurred to the researcher is to leave the organisation. When probed as to why individuals would stay in a situation that causes such undue distress the responses were as follows:

Jasmine 'But yeah it just feels like a lucky escape somehow but had she stayed and got that job I would have handed my notice in.' (293-295)

Terry 'erm I was about to resign from the job and looking elsewhere.' (445)

Gill 'around the time of the informal complaint it escalated, it reached a real peak and then I moved areas and then that informal complaint was put aside.' (1087-1089)

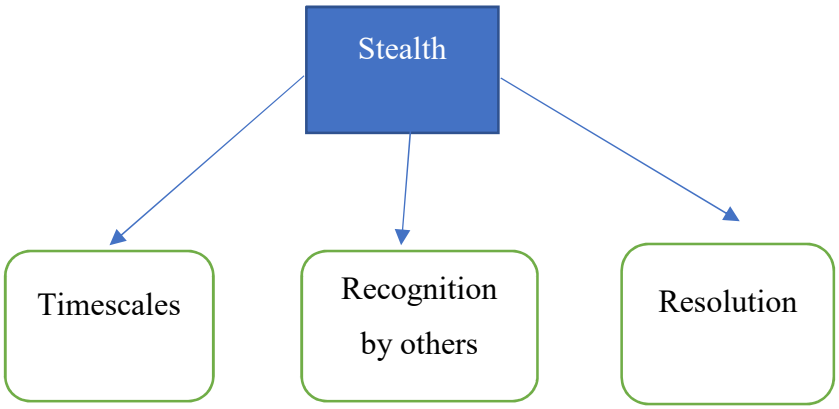
Alexis 'well I left the department because I was fed up with it.' (1393-1394)

Mike 'I was just on the throes of putting in my resignation letter but I thought no I am going to stick to my guns.' (2450-2452)

The first three emerging categories of this analysis have included bullying behaviours and what they comprise; the underlying power differentiation between the perpetrator

and the victim and the varying levels of impact the bullying behaviours have had on the outcome of bullying.

Category 4 – Stealth



The fourth and final category to emerge from the data is 'stealth'. Throughout the interviews, participants divulged the periods over which the bullying behaviours took place, but not only that, what also became apparent was that the targets did not often realise that they were a victim of bullying until many months, and sometimes years, of experiencing the behaviours by which time the target/victim alliance was very well established. The final category consists of the sub-categories timescales, recognition by others and resolution.

Timescales

In many cases, the participants described bullying behaviours that had been experienced over many years; in order for the researcher to gain some insights, participants were asked over what period of time the bullying behaviours had taken place. To highlight the extent of the timescales that bullying behaviours were exhibited against the participants, a variety of quotations are shown below:

Dea 'How long did the bullying go on for?' (1782)

Alexis 'about a year but it is a slow realisation isn't it? You think that you are incompetent and you try your best to improve and then suddenly you realise hang on this isn't right, I shouldn't feel like this.' (1783-1784)

Terry 'The initial phase was over a year.' (440)

Dea ‘How long had it been going on for?’ (2038)

Mike ‘Gosh a year or so, a good year and lots of staff were phoning in sick,’ (2039-2040)

Kim ‘I worked through it, errr, it did stop, I think after going through a year,’ (3193-3194)

Dea ‘so did you not recognise it as being bullied?’ (3328)

Kim ‘when it was happening I did not see it like bullying but later I did see it like bullying.’ (3329-3330)

Recognition by others

In addition to the length of time that the bullying behaviours took place, for some there was no realisation that it was bullying or that they were being bullied until others including colleagues or family members suggested that this was the case. This is the subject of this next sub-category. Commentaries included details of family members suggesting that bullying was taking place, and also as highlighted below by Jasmine, colleagues noticing that the behaviours were crossing a boundary into bullying that was not acceptable.

Jasmine ‘they were the ones saying get out the policy, I didn’t even want to think about it.’ (291-292)

Jasmine ‘I was thinking she would be gone in a while and I can sit tight and I will be alright but you know my team were starting to say that you should get the bullying policy out and I thought I didn’t realise that they realised.’ (91-94)

‘Recognition by others’ highlighted the stealth-like nature of the bullying behaviours; it was highlighted throughout the narratives that the realisation that bullying was taking place only happened once it had been entrenched in the behaviours. How individuals resolved the bullying is covered in the category ‘escape’.

Resolution

The final sub-category under stealth is resolution. Resolution was a category that concluded the bullying experience and demonstrates how participants were able to get some release from experiencing the bullying behaviours they had described. This is

detailed under three sub-divisions namely reporting, bias of process and consequences as follows:

Resolution
i. Reporting
ii. Bias of Process
iii. Consequences

i) Reporting

The system is in place within hospital procedures to report bullying behaviours, as noted at the beginning of this analysis, and so once participants had explained their bullying experiences, it was put to them whether as part of a potential resolution the behaviours were reported by them to the hospital. A selection of their responses is illustrated below:

Dea 'Did you ever think of reporting it?' (1787)

Alexis 'yes I did try, I made an appointment to report it, and I made an appointment to say that I was finding it difficult and I didn't want this particular person to appraise me and I sat there thinking why, and I thought it's because I am being bullied……. I didn't have the courage to see her in the end, it's very difficult because you are being critical of your peers.' (1788-1797)

Jasmine 'I'm not sure I was feeling brave enough to actually say anything to anyone at the time……I wouldn't normally tell tales on anybody.' (195-196)

Gill 'if you get bullied there is not really any way you can come out of it unscathed and your career unaffected, you either stay quiet and lose your confidence and get injured or you speak up and get victimised further so either way you are damned.' (1299-1303)

Khalid 'it is so difficult to do any investigation into bullying in the workplace because the system needs a lot of proof and witnesses.' (3060-3062)

Dea 'so it is quite onerous?' (3063)

Khalid ‘yes so imagine that you are being bullied, do you have time to do all this information? no because your mind is in another scenario, another place because when you are being bullied, actually you are angry all the time, it is so difficult to wake up in the morning to go to the division to work, it is so difficult for me to do that, I do that at the moment because I have no choice at the moment, I have to.’ (3064-3071)

Dea ‘and did you report what happened to you?’ (3250)

Kim ‘I didn’t report it, I didn’t feel like talking, I was scared of everybody and believe me, when this started, the bitching, most people believed what they were saying, I didn’t feel confident talking to anybody, I was just thinking about leaving.’ (3251-3255)

Kim ‘I don’t think at the time I would have thought about reporting it, I didn’t think by telling somebody, maybe if you tell someone you are being bullied you can make things worse and I didn’t want to make things worse.’ (3422-3426)

These responses suggested a fear factor, and also an onerous and time-consuming procedure.

ii) Bias of process

For those who had reported the bullying behaviours, their responses were explored further. Many participants described how they considered the process of reporting to be biased away from the victim; this led to the sub-division of the category into a so called ‘bias of process’ as depicted by the participants.

Both Gill and Khalid gave accounts on the procedure for reporting and how the procedure was biased towards the perpetrator rather than the victim. Two of their own accounts are quoted below:

Gill ‘she investigated herself so it wasn’t really out in the open only me and her knew about it so it was still kept very secret so other people in the department didn’t really know, erm, so yeah after that just felt subtly victimised obviously she wasn’t going to push it too far because she knew that maybe I would turn around and do something about it but also just subtly keeping up that pressure as to your not welcome here.’ (887-894)

Khalid ‘the manager doesn’t need any proof to complain about any members of staff, the manager just has to say and that is enough, but when the members of staff need to make a complaint about the manager, they need proof, I need a day, I need a time, I need a person, I need a witness. I need everything because the system is created to protect the manager, not to protect all the people in the environment…… for that reason nobody wants to make any complaint regarding bullying in the workplace, because they know if they do, the manager will know straightaway the name of the person and the complaint because when you do complain on the system the complaint goes to your manager straightaway, this is ridiculous because the manager reads the complaint and decides if it is going through or not.’ (2749-2770)

iii) Consequences

Whilst some of the outcomes of the bullying behaviours were itemised under the category ‘escape’, others are more appropriately defined under the ‘consequences’ sub-division in the category of resolution. Some participants, namely Terry and Sarah, did report behaviours. As seen below, Terry advised that there was a behaviour change as soon as HR became involved. Sarah described a lengthy procedure, which eventually was resolved.

Sarah ‘I was going to leave but someone said don’t leave whilst the investigation was ongoing, and I thought why should I leave and let the bully win.’ (3697-3699)

Terry ‘the behaviour changed as soon as HR became involved.’ (440-441)

Others advised that the perpetrator had moved on and therefore the problem had been resolved for them in this manner.

Mike ‘I had applied for reduced hours because it was too much for me.’ (2051-2051)

Khalid ‘if I make a complaint, the complaint would be on my profile and if I try to get another job, they can see I am a troublemaker and they don’t want that type of person in their place, for that reason it is so difficult to try and solve these problems,’ (2782-2787)

Kim ‘what made the turning point, was that the lady who was shouting, shouting at me, I think that she had some issues so she left.’ (3195-3198)

Dea ‘What stopped you leaving?’ (3257)

Kim ‘what stopped me from leaving, well you know when you move from one job, you have this probationary period so if I had left I don’t think it would have been in my favour.’ (3258-3259)

3.5 Reflections on Qualitative Findings

The interviews were conducted over a three-month period and before the data analysis had begun on the quantitative data. This approach ensured, as far as possible, that the interviews were not influenced by the results of the questionnaire responses and that subsequent interviews built on responses from the previous interviews (Charmaz, 2014). The interviews and analysis should ideally take place before the literature review, so as not to contaminate the findings with preconceived ideas (Charmaz, 2014). In this study, a literature review was undertaken for the Doctorate programme a year before the interviews were conducted. A more thorough literature review took place after both the quantitative and qualitative analysis had been carried out.

Figure 3 is a flow diagram summarising the four core categories emanating from the grounded theory analysis and indicates how the categories emerging from the data start to form a theory on the individual bullying experience. The diagram begins with the category ‘stealth’, highlighting bullying behaviours that are described ‘post-event’ starting before the victim is consciously aware of what is happening. This stage, when viewed in hindsight, sometimes can continue for many years without the ‘victim’ recognising the behaviours as bullying acts. The victims describe the perpetrator as exerting their power over situations, resulting in the victim becoming consciously aware of the bullying behaviours that they are experiencing. The final category is the impact of these lived experiences.

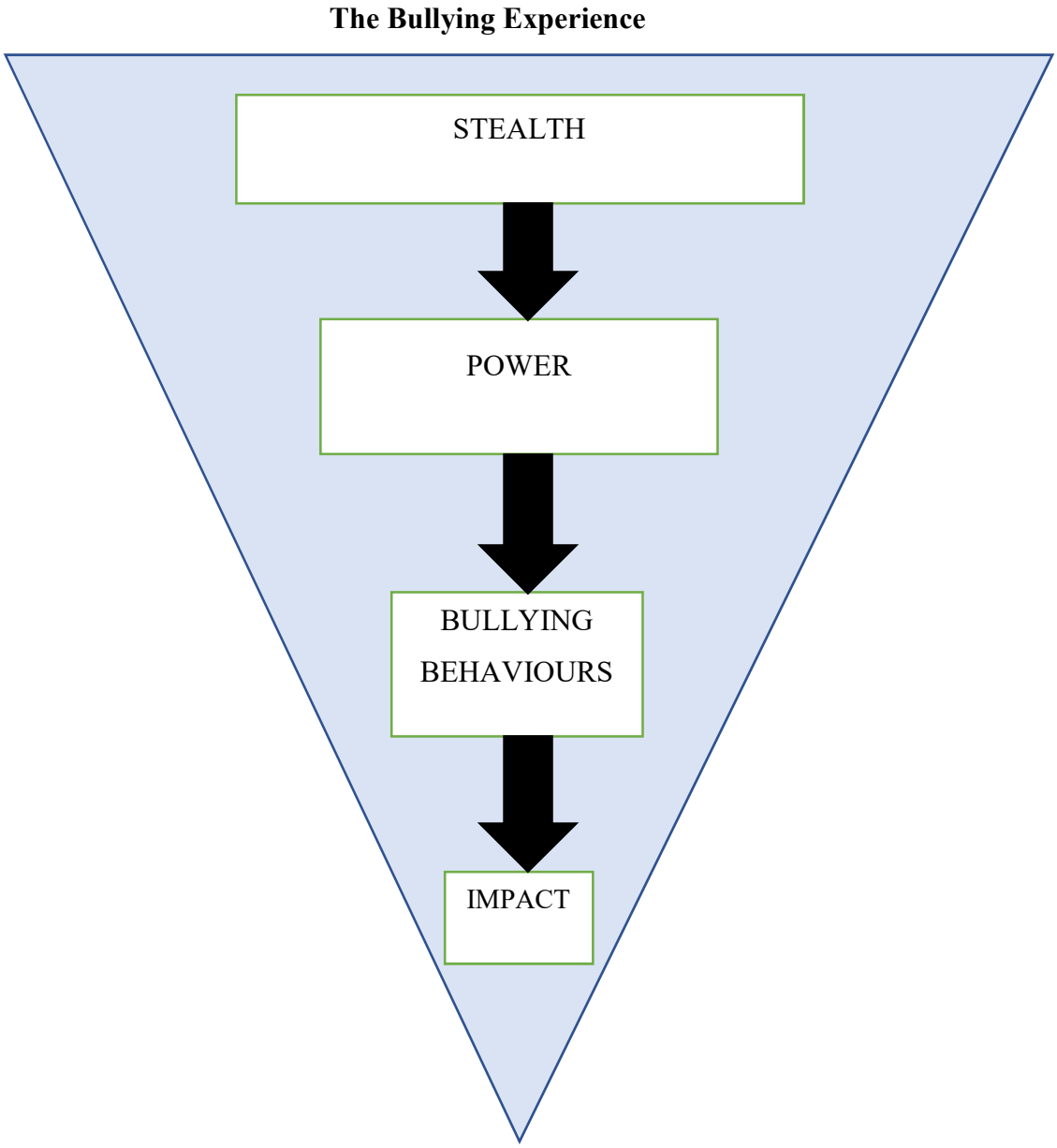


Figure 3 - Flow Diagram Representing the Qualitative Grounded Theory Analysis

In the previous sections of this chapter, the results of the quantitative and qualitative analysis have been considered in isolation from each other. The following aspect to the analysis compares and contrasts the qualitative and quantitative findings and highlights where the findings converge or not at this point.

3.6 Mixed-Methods Analysis Integration

3.6.1 Category – Stealth

QUALITATIVE	QUANTITATIVE
Timescales	Bullying Experience over the last six months
Recognition by others	Did not cover recognition by others
Resolution	Did not cover Resolution

The quantitative analysis and questionnaires related to the bullying behaviours experienced over the previous **six months,** whereas the qualitative analysis highlighted the whole bullying experience from the perspective of the participant. This analysis encompassed a much more complex situation than the mere reporting of the bullying acts. The category stealth included not only the timescales involved but also 'recognition by others' and potential 'resolutions' which were not part of the quantitative analysis.

3.6.2 Category – Power

QUALITATIVE	QUANTITATIVE
Control	'Being ordered to do work below your level of competence' was the fourth most reported experienced negative act.'
Vulnerability	
Helplessness	

The qualitative part of the analysis highlighted the category 'power' which was not apparent from the quantitative results by themselves.

3.6.3 Category – Bullying Behaviours

QUALITATIVE	QUANTITATIVE
Subtle behaviours	'Being ignored or facing a hostile reaction when you approach' was the fifth most reported negative act. 'Being exposed to an unmanageable workload' was the highest reported experienced negative act.
Unreasonable workload demands	'Excessive monitoring of your work' was the third most reported experienced negative act.
Them and us	'Having your views or opinions ignored' was the second most reported experienced negative act.

The most reported negative acts from the quantitative analysis were all present in the qualitative analysis under the categories 'power' or 'bullying behaviours', as can be seen above. The qualitative analysis, however, provided a deeper level of understanding of the subtleties that individuals were reporting as taking place, which were not captured by the quantitative analysis alone. These subtleties included the tone of communications and also the experience of being treated as a 'machine' rather than a 'human'.

3.6.4 Category – Impact

QUALITATIVE	QUANTITATIVE
Self-Esteem	There was a positive relationship between reporting experiencing negative acts as measured by the NAQ-R and higher levels of: Stress, Depression and Anxiety. Stress ($r=0.40$, $p < 0.001$). Depression ($r=0.42$, $p <0.001$) Anxiety ($r=0.54$, $p < 0.001$)
Health	
Patient Care	
Self-Blame	
Escape	

The quantitative analysis supported the hypotheses that the reporting of experiencing negative acts had a positive relationship with higher reported levels of anxiety, depression and stress. These impacts on health, when reporting experiencing bullying behaviours, were also found in the findings of the qualitative analysis. In addition, the qualitative analysis suggested other impacts such as lower levels of self-esteem, feelings of self-blame, the impact on patient care and also the impact of 'escape'.

The convergence of this mixed-methods design at the analysis stage highlighted areas of similarities; however, the qualitative analysis provided further depth and understanding of the whole meaning and experience of being bullied from the individual perspective that the quantitative analysis alone did not provide. To summarise the findings, a mixed-methods integrated flow diagram is illustrated below in Figure 4. This is followed by the discussion chapter.

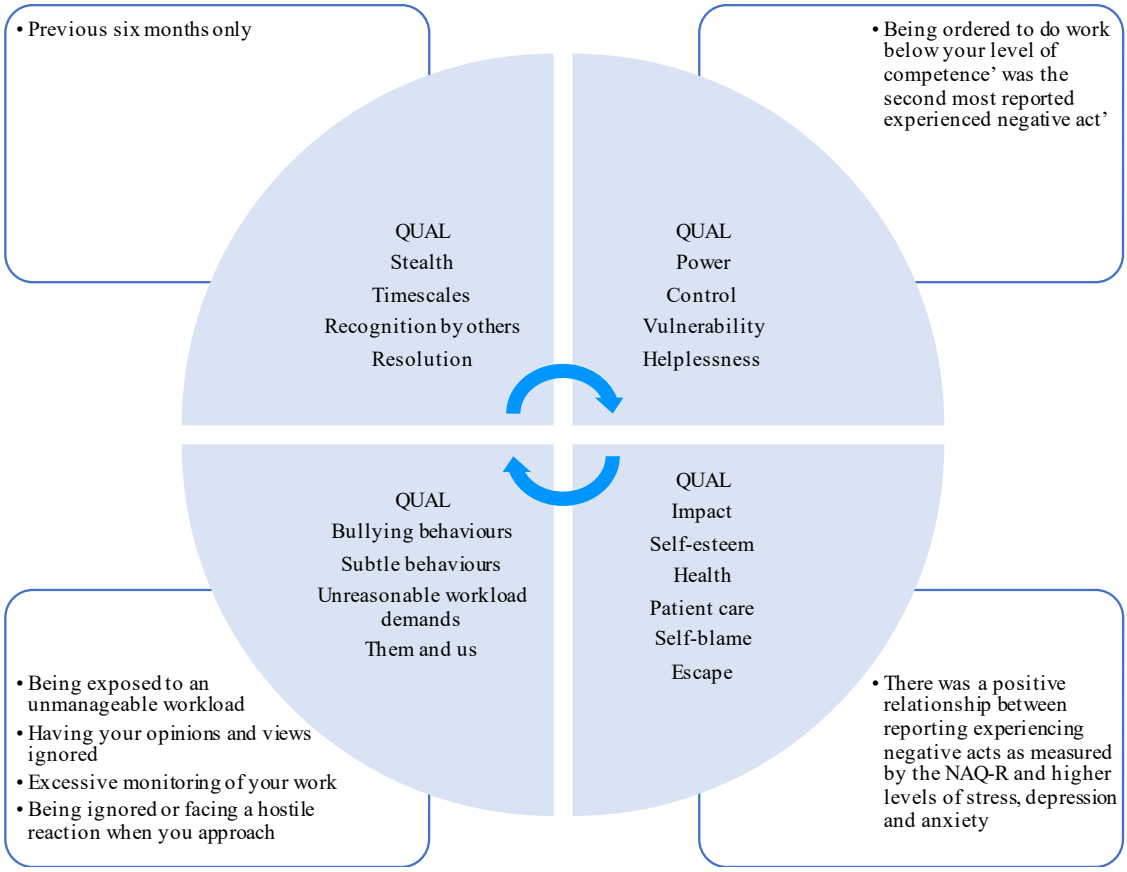
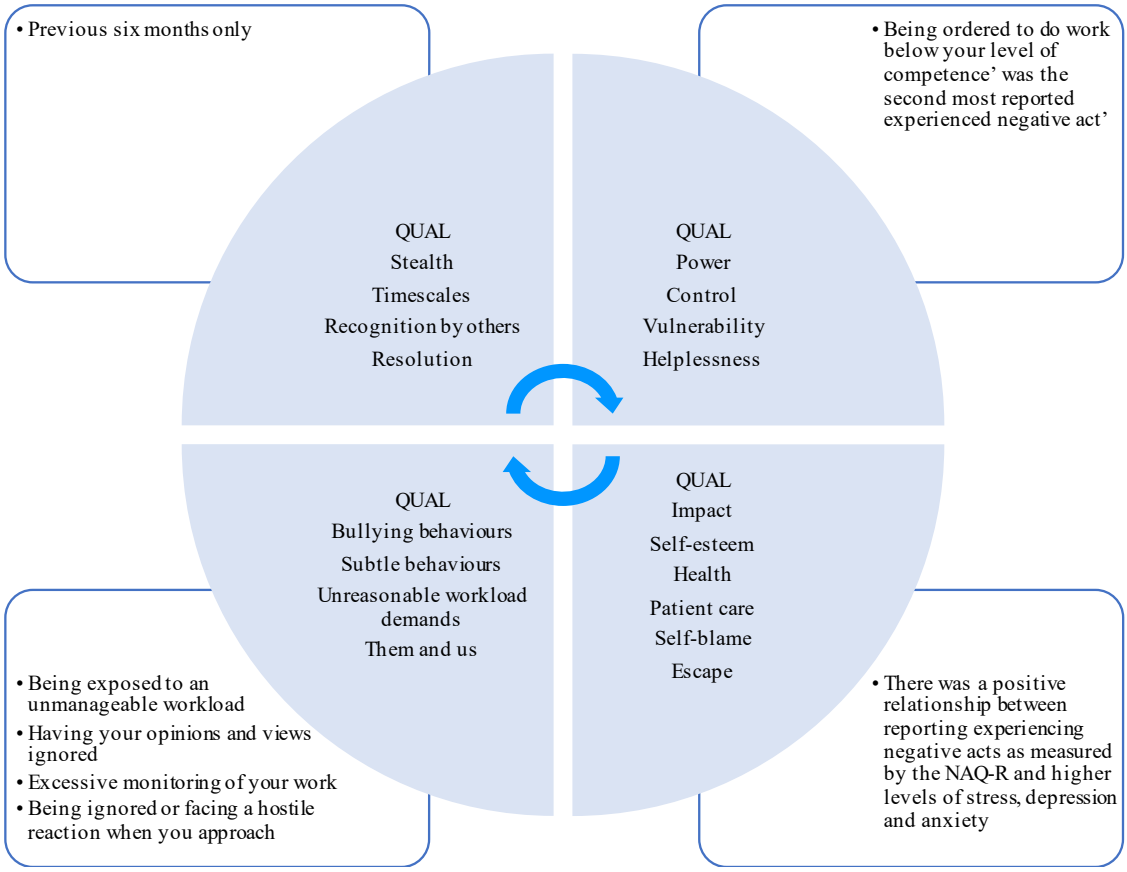


Figure 4 - Mixed Method Integrated Analysis Diagram

Chapter 4 Discussion

In this chapter, the emergent theory that was highlighted during the analysis stage will be compared and contrasted with the current research detailed in the literature review. The discussion will commence with an examination of the integrated analysis diagram at Figure 4, which is reproduced below for ease of reference.



This chapter will close with the strengths and limitations of this present study, future research ideas, potential changes to current working practice, personal reflexivity and implications for counselling psychology as a profession. This final chapter will be completed with concluding comments.

As can be seen from the above diagram, the emergent theory had four aspects. The analysis found that the bullying behaviours were preceded by a length of time, which could amount to years, and not just months, before the 'target' realised what was happening and could put a name to the behaviours experienced. On many occasions, other people close to the 'target' recognised the behaviour as bullying before the target did. This phenomenon was termed *stealth*, as it was often long-engrained before the target realised that it had happened. As the stealth stage occurred seemingly before the

bullying behaviours were experienced, it would not have been considered by way of a quantitative methodology alone. This is in a similar vein to the aspect of *power*, in that this would not have been captured as part of a quantitative methodology alone, although there were negative acts under this umbrella term. The actual *bullying behaviours* identified via questionnaires from the quantitative methodology were limited, but the qualitative methodology allowed participants to describe other behaviours that were not always as apparent from the defined tick boxes. The final aspect was the impact on individuals. The quantitative analysis considered the relationships in terms of psychological impact, whereas the qualitative analysis highlighted not only this but additional factors, such as self-blame, patient care and escape, which were not part of the quantitative analysis. The circular model detailed above, therefore, shows a robust constructivist theory and comprehensive pictorial representation of the bullying experience. A circular model is deemed more accurate, as the whole process of the bullying experience was found to be more complex than a linear model alone would depict. There could be an argument that states that the process starts with *bullying behaviours* as equally as it starts with *stealth,* as these are taking place at the same time as stealth; they are just not recognised as such in the early stages.

The affective events theory (Weiss and Cropanzano, 1996) also maintains that the length and intensity of the bullying is a prime factor of the bullying experience, rather than the individual bullying events themselves; however, the theory does not go as far as describing a stealth-like nature of the bullying whereby the individual is unaware of what is happening at the outset and sometimes for some considerable period after the onset. This current study has added to our understanding of the theory of the bullying experience in this respect. This present theory enhances the Weiss and Cropanzano (1996) theory and encompasses much more than the bullying events and the impact on wellbeing.

The current study found that bullying events experienced have a relationship with wellbeing as Weiss and Cropanzano (1996) theorise; however, as Nielsen et al. (2014) comment, the effect of bullying is dependent on how the victim experiences, evaluates and understands the exposure to bullying. It is their subjective experience that determines this (Weiss and Cropanzano, 1996); this current study has added to the literature in considering individuals' subjective experiences. This present study,

however, does not have an indication as to the wellbeing of individuals prior to their subjective experience of bullying, but it does have the benefit of in-depth face-to-face interviews.

Gaffney et al. (2012) considered a grounded theory approach to how nurses experience bullying and undertook their study by open ended questionnaires rather than in-depth interviews, and so did not have the benefit of refining their questions as the study progressed as did this current study. They start with a category of making things right, which details how nurses try and put things right and place the bullying in context. What the theory does not highlight is the stealth-like nature that can be described by individuals prior to accepting that they are potentially being bullied; this current study adds to the literature in this respect. Many of the bullying events that are described in this present study are in line with previous studies and also with the Gaffney et al. (2012) theory. Also, Gaffney et al. (2012) describe power differentials being present along with control as was evidenced within the current described theory. This present study included narratives from the wider healthcare workforce and was not limited to nurses only.

4.1 Stealth

The first category emanating from the grounded theory analysis was 'stealth', whereby bullying behaviours were experienced by individuals who, at the time, did not recognise themselves as such. Participants who came forward to take part in this study in the main had considered as having been victims of bullying behaviours which they did not necessarily recognise. By the time that the behaviour was recognised by themselves or others, they were already experiencing the adverse impact, which could include leaving the division concerned to escape the bullying. This stage could last for months or years, and only when 'resolution' was found were victims able to process the whole experience of what had happened to them. Einarsen and Hoel (2001) suggested that a six-month period rather than a one-off incident differentiates bullying from low-level negativity. However, this present study suggests that perhaps the bullying experience is a longer-lasting debilitating journey.

Mikkelsen and Einarsen (2001) suggested that victims can decline to be labelled as a victim, as the definition can imply weakness and passivity. This view was only partly borne out in this present study. What was more apparent was that the victim did not

recognise that they were a 'victim' at the time. Participants said that family members or colleagues had recognised the behaviours as 'bullying' before the victim themselves had the awareness to name the behaviours. During this current study, the participants who came forward to be interviewed had described experiencing the whole *process* of the bullying experience from start to finish as detailed in the emerging theory rather than describing being bullied in the present. This confirmed the study by Lutgen-Sandvik et al. (2007) describing a target having to self-identify as a target to engage in an in-depth discussion regarding the bullying experienced.

The stealth nature of the bullying experience was partly borne out by the quantitative data, where employees who had indicated that they had been working for ALT for less than one year reported experiencing significantly fewer negative acts than the employees who had been working for ALT for longer periods. However, the responses for this particular category, which was not a main focus of this present study, were limited to three timescales. This could be a consideration for any future studies.

It was found in the present study that, once the bullying behaviours were recognised by the employee, the victim was reluctant to report the behaviours for fear of retribution and of putting their careers in jeopardy. This pattern was also found by Cleary et al. (2010), along with the fear of being labelled a complainer or trouble-maker. This present study found that victims labelled the reporting procedure as biased towards the perpetrator rather than the victim. Bullying may further go unreported in the workplace due to staff being unfamiliar with the reporting procedure or believing that nothing would change, in addition to not wanting to be seen as a trouble-maker, as evidenced by Carter et al. (2013). The belief that nothing would happen was not borne out by this study; what was suggested in this research, was that participants did not have the courage, bravery or confidence to report what was going on. This suggested a fear factor rather than a thought that nothing would be done.

4.2 Bullying Behaviours

The five most prevalent negative behaviours reported in this study were: being exposed to an unmanageable workload; having your opinions and views ignored; excessive monitoring of your work; being ordered to do work below your level of competence and being ignored or facing a hostile reaction when approached. The mean score of out five for these five prevalent negative behaviours were 2.02; 1.86; 1.81; 1.69 and 1.68

respectively. Carter et al. (2013) found in their study that these behaviours had mean scores of 1.54; 1.52; 1.25; 1.47 and 1.33 in comparison.

These top five reported negative acts included representation of Bartlett and Bartlett (2010) work-related and personal bullying behaviours. The work-related negative acts refer to the excessive monitoring, being exposed to an unmanageable workload and being ordered to do work below your level of competence. The other two behaviours would be classed as indirect *personal* bullying behaviours and can be socially isolating for employees. The negative act of *having opinions and views ignored* was also identified by the qualitative analysis. In fact, the qualitative analysis provided deeper insights into these behaviours, and accounts gave examples of not only opinion being ignored, but also of not being listened to in the first place. These behaviours and the feelings of being excluded from the organisation were described as being subtle and far more convoluted than a descriptive 'being ignored' classification that was found within the questionnaire. In today's climate, with the emergence of so-called *cyber-bullying,* it may be that other categories of bullying behaviours are emerging that are not defined within the current 'negative acts' questionnaire. The negative act of 'ignoring' staff could be enhanced to include exclusion from 'email' trails, for which an example was given in this present study. NAQ-R does not consider emails or other effects of new technologies, such as omitting people from social networking groups. Burnes and Pope (2007) comment that if organisations and researchers only focus on countering/eliminating behaviour that is purely *perceived* as bullying, they are unlikely to be effective. Focus also needs to be on the full range of negative behaviours that employees report having experienced.

The negative act of *being ignored or facing a hostile reaction when approached* was the fifth most reported negative act in this study but did not appear in the top five negative acts in the Carter et al. (2013) study. This bullying behaviour that emanated from the quantitative analysis was also referred to in the qualitative analysis and was sub-categorised as 'subtle behaviours'. These behaviours were described by participants as not greeting each other in the morning, not saying goodbye to people when they leave and other subtle underlying criticisms. These bullying behaviours were described by Cox-Dzurec and Bromley (2012) as being emotionally confusing to workers who had come to the workplace just to work, and these behaviours could be seen as absurd to others who had not lived through the experience themselves. The

findings in this present study confirmed this view and, whilst an individual event would not seem hugely significant to the potential victim, with the accumulation of events over time by *stealth* the participant realised that they were or had been a victim of bullying.

4.3 Prevalence of Bullying Behaviours

A total of 53% of participants in this present study answered 'no' to the direct question as to whether or not they had been bullied in the previous six months against a definition. However, 47% of respondents answered that they had experienced bullying at work ranging from 'only rarely' to 'almost daily'. Similar to this present study, Quine (2001) found that 44% of nurses reported experiencing bullying in the previous twelve months in some form or another.

Notelaers and Einarsen (2013) provided recent evidence utilising the data collected from the NAQ-R, which assessed the potential frequency of negative behaviours that could be deemed appropriate for a victim to constitute the label of 'being bullied'. These present results highlight this issue where 26% of participants described that they were bullied but only *rarely.* It is difficult to quantify the term *rarely* and, as such, rather than only use the responses to this question, the authors of the NAQ-R have recently suggested (Notelaers and Einarsen 2013) that a 'cut-off' scale be used to identify the presence of bullying based on the responses to the 22 items of negative acts. Th cut-off points for this scale were for 'occasionally bullied' and 'victim' at a raw sum score of 33 and 45 or above (out of 110) respectively. The results of this approach were repeated at the analysis stage of this present study, and the results reported resulting in 58% (*N*=159) not bullied, 29% (*N*=79) were considered to be moderately bullied and 13% (*N*=35) were victims of workplace bullying. This 'new' approach resulted in the prevalence rate reported as 42% rather than the 47% from the direct question on the NAQ-R. That said, both approaches resulted in a significant level of reported experienced bullying. Lutgen-Sandvik et al. (2007) and Illing et al. (2013) surmise that prevalence rates can vary depending on the measurement methods used. The thinking was that a behavioural experience method would yield a higher prevalence rate, but this present study did not support this view.

When considering prevalence rates within the domains of this study and comparing them to the prevalence rates highlighted initially within the NHS staff survey, they are

reported as higher than the results of this present study at 42%. The NHS staff England survey for ALT (Key Finding 26: percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months) reported a finding of 31%. This could be due to the measurement method used; in the present study, the 42% prevalence is derived from the behavioural experience method. It could be that the divisions that took part in this present study were a contributory factor also. It would be a thought for any future replicated study of this kind to be undertaken for the whole of the hospital rather than five divisions to assess whether or not this is a factor.

Based on their meta-analysis, Nielsen, Matthiesen and Einarsen (2010) concluded that a worldwide average would be at least one in ten and possibly as many as one in five workers are exposed to bullying in the workplace. This present study highlighted a prevalence rate of 47%/42% (depending on the measured method) which is in line with the Quine (2001) study but is much higher than the Carter et al. (2013) study asking the same question. In Carter et al. (2013) (*N*=2,950), 20% (behavioural method) reported having been bullied in the previous six months and 43% reported having witnessed bullying in the same period. This present study did not consider the act of witnessing bullying.

One of the categories highlighted from the grounded theory analysis in this study was '*stealth*', which may go some way to explain the high number of participants answering the 'yes – but only rarely' classification if participants in the qualitative analysis were unsure whether they were subject to bullying behaviours or not. This statistic could be considered to be of more concern to management, as it could be seen as an indication of the start of the 'bullying experience' as shown in the integrated analysis design.

4.4 Gender Differences

In this present study there were no significant gender differences when considering the relationships between gender and total bullying score. In this respect this present study concurred with Hoel et al. (2001) who commented that the experience of bullying appears to be remarkably similar with most studies reporting few or no differences. Only in cases of being bullied by colleagues rather than people more senior did Hoel et al. (2001) find that gender played a role. However, in Salin and Hoel (2013), where empirical findings were reviewed, the authors suggested that gender differences were found when assessing prevalence rates and also when considering the way targets made

sense of and responded to the bullying experienced. Carter et al. (2013) reported that the overall mean score for the NAQ-R was significantly higher for males than females. The research in this present study and compared to other studies suggest that gender differences in experiencing bullying behaviours is still inconclusive as discussed by Hoel et al. (2001).

Similarly, in this present study, no significant differences were found between staff band grades and bullying behaviour scores. This aspect of the research was in line with the qualitative findings of this study where all staff bands were represented in the study. During the qualitative interviews and analysis, there were no indications that 'bullying' was due to gender differences, age or particular to certain staff bands, unless the 'bully' had a power differential. Allen (2015) stated that harassment tends to be focused on an individual's dissimilarity to someone else, whereas anyone can be a target for bullying. To this degree, the quantitative and qualitative data analyses from this present study were in agreement with Allen (2015).

4.5 Ethnicity Differences

While it was not a main focus of this present study to consider any racial differences, a topic for future studies of this type may be to examine the diversities of staff that are represented at ALT and other healthcare organisations. Ethnicity was not found to be a main contributor, but there were indications that in some situations that it may have been relevant. The quantitative analysis found that there was a significant difference in negative acts reported by the ethnic category 'any other Black/African/Caribbean background' when compared to certain other ethnic groups (White-English/Welsh/Scottish/Northern Irish/British, White-Irish, any other white background, any other Asian background and any other ethnic group not listed). There were no significant differences found between any of the other ethnicity groups.

In respect of racially-motivated bullying, this present study took place within ALT, which has a huge diversity of employees from around the world, whereas the Carter et al. (2013) was undertaken in the North East of England where the ethnicity of employees may not be as diverse. Carter et al. (2013) reported that 81.7% of respondents classed themselves as white British; in this present study, only 36% classed themselves as white British. This difference may or may not be a contributory factor to be explored further. Samnani and Singh (2012) comment that national culture can play

a part in how people react and interpret differing events and respond and may have an effect in a multi-cultural business. In the Carter et al. (2013) study referred to, no differences were found due to ethnicity. In the latest report on bullying and ethnicity in the NHS, the workforce Race and Equality Standards (Kline, Naqvi, Razaq and Wilhelm (2016), it was found that black and minority ethnic (BME) staff remain more likely than white staff to experience harassment, bullying or abuse from other staff although this statistic did go down from previous years findings. This present study with a focus purely on bullying and not harassment did not report ethnicity to be a major contributor.

4.6 Power

Power disparity was a central theme to the qualitative data, and the power disparity between the victim and the perpetrator was central to the grounded theory data analysis detailing the control exerted by the perpetrator and also the helplessness and vulnerability of the victim. The negative act 'being ordered to do work below your level of competence' was the fourth most reported bullying act. Although in the UK there is currently no legal definition of bullying, ACAS defines bullying behaviour as 'offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means that undermine, humiliate, denigrate or injure the recipient' (www.acas.org.uk). The power disparity between the target and the perpetrator is considered to be 'central to the definition of bullying', suggesting that the victim has no control or is helpless to defend against abusive power (Lutgen-Sandvik et al., 2007). This situation was found to be the case in all the interviews that were undertaken and during the analysis stage.

In one example, a participant described bullying by a network of colleagues rather than by a manager. Branch et al. (2013) contend that defending oneself against bullying suggests power; power is not just defined as top-down but can include educational power or a network of colleagues' power, both of which were evidenced in this present study. This power disparity was a common issue found by Bartlett and Bartlett (2010) in their integrative literature review; they stated that power created opportunities for the bully to exert power over the target.

4.7 Impact

The quantitative analysis strongly supported all three of the hypotheses, in that there was a significant positive relationship between reporting experiencing negative acts and each of depression, stress and anxiety. These findings were in line with previous studies of this nature, which considered bullying behaviours and the potential impact on psychological wellbeing. A review of 750 research articles (Nielsen, Magerey, Gjerstad and Einarsen, 2014) found that exposure to bullying consistently related to mental health problems and somatic symptoms over time. Verkuil, Atasayi and Molendijk (2015), in their systematic review and meta-analysis, found that there were positive associations between workplace bullying and symptoms of depression and stress-related psychological complaints (*N*=115,783).

The qualitative part of this study enabled a focus to go beyond the statistics, where the hypotheses were found to be supported but did not highlight the extent of the bullying experience or how long the impact can potentially last for all victims involved. The qualitative focus of this present study allowed deeper insight into the emotional and psychological effects of bullying on the individual and suggested not just the duration of the bullying behaviours but also the duration of their impact.

Participants said that bullying events took away their self-confidence and self-esteem and made them second-guess themselves into thinking 'am I going mad, am I this, am I that, is it just me?' Lutgen-Sandvik, Tracy and Alberts (2007) described targets of bullying at work as anticipating the day with dread and a sense of impending doom. This view was borne out by this present study. The Affective Events Theory (AET) (Weiss and Cropanzano, 1996) is based on the assumption that each bullying event will produce an 'affective' reaction. For example, putting someone down will produce an emotion such as sadness which, in turn, will affect subsequent behaviours, such as their attitude to work and wellbeing (Brotheridge and Lee, 2010). This framework details the length and intensity of the bullying as a prime factor, rather than the individual events themselves. The bullying events identified in this present study and the length of time that they were described as occurring over '*stealth included'* were found to be all part of the bullying experience which corresponds with the AET.

The impact of the bullying behaviours was not found to be limited to the psychological welfare of victims in this present study but went beyond that to include participants'

blaming themselves and describing how they must have 'let it happen' or how they 'could have/should have' been able to stop it in some way. The qualitative analysis also found that the impact was more far-reaching than affecting only the victim and that there were impacts on patient care. Thus, the bullying behaviours were suggested to have a two-fold impact, not only on the victim but also on their subsequent ability to care for the patients. This finding reinforces the view that, while bullying is taking place in many organisations, its occurrence within healthcare can be seen as more critical as the outcome of healthcare is human wellbeing (Katrinli, Atabay, Gunay and Cangarli, 2010).

Finally, the impact of bullying behaviours highlighted a form of escape from the whole experience. These *escape routes* were 'becoming the bully', 'not just me' and 'resigning/leaving'. There were examples of a person experiencing bullying when they themselves were then investigated for sending harsh emails. This aspect of the analysis went further than the quantitative analysis and allowed for and encapsulated the whole journey of the 'bullying experience' as found in participants' accounts. Initially, the research aim was to consider from participants their experience of what bullying behaviours 'consisted of' but, as the theory began to emerge from the data, it was noticeable that there was an outcome of the bullying behaviours that went even further than the 'psychological wellbeing' and 'patient care' impact. The escape from the experience of bullying was found to occur in three ways: by becoming the bully or the reverse, the protector of others; realisation that it was not 'just me', which diffused the feeling described of isolation; or the resignation of either the perpetrator or the victim to another position.

The combined mixed-methods approach adopted for this study was appropriate for the analysis and highlighted many more aspects of the complex nature of the whole bullying experience. The strengths and limitations of this present study follow.

4.8 Strengths and Limitations of Methodology and Present Study

A mixed-methods approach was a more pragmatic, thorough and appropriate methodology for this study. Pluye and Hong (2014) comment that by only using either qualitative or quantitative methods, researchers may miss important evidence. Brewer and Hunter's (1989) multimethod approach describes investigators being able to 'attack a research problem with an arsenal of methods that have non-overlapping weaknesses

in addition to their complementary strengths'. This present study confirmed the view of Pluye and Hung (2014). A quantitative study alone would have missed the whole 'experience' of bullying, as told by the participants and which indicated that bullying behaviours are more complex than the negative acts suggested.

This present study adopted the same mixed-methods design rationale as Carter et al. (2013) but differed in respect of the concurrent triangulation procedural strategy adopted. Carter et al. (2013) in their mixed-methods study adopted a telephone interview rather than face-to-face interviews which obtained a higher number of participants than this present study. In this present study, eight participants came forward to share their sensitive stories. The face-to-face nature of these interviews in this present study, however, enabled the researcher to interpret non-verbal as well as verbal features.

In a future study, consideration could be given to asking participants who are completing the questionnaire whether they would be willing to take part in an interview. This approach may have resulted in a higher number of participants for the qualitative part of the study and would have allowed for a closer match to the pure grounded theory approach that was originally sought.

The principles of grounded theory are that data is analysed as the research progresses, enabling the researcher to re-visit categories with future interviews and thus construct a theory. This process continues until 'theoretical saturation' is reached and construction of theory is possible. Once saturation has occurred and the researcher is satisfied that additional data is not necessary, data or theoretical saturation is said to be met (Glaser and Strauss, 1967). Aside from the point made above where the recruitment of participants could have been made easier, this study did benefit from having eight participants who represented all bands and divisions in ALT.

In addition, the researcher was able to analyse interviews as the research progressed, and this did allow categories to be re-visited as other categories emerged from the data. It occurred to the researcher that bullying was being experienced by the victim long before they recognised it as such, participants were therefore asked to describe how they first recognised that they thought bullying was taking place, this led to the sub-category of recognition by others and the overall category of stealth. Another example of this was after the coding of the first few interviews, I wondered why it was that

individuals remained in the workplace with such a high level of bullying behaviours that they were describing. This question was posed to future participants and became part of the overall bullying experience theory as the sub-categories of escape and resolution emerged from the overall category of impact. This was unexpected and provided a more comprehensive understanding.

Guest, Bunce and Johnson (2006) researched the question of how many interviews would be enough. Their findings after conducting interviews and analyses for each set of six interviews ten times (*N*=60), was that 80 (73%) of the total number of codes developed were from the first six interviews, and an additional 20 codes were identified within the next six interviews (cumulative 92%) (Guest et al., 2006). This result provided validation for the eight participants that were included within the qualitative part of this study. The aspect that did evolve was the inclusion of developed questions and subject matter as the interviews progressed. In line with theoretical sampling methods and grounded theory principles based on the categories emerging from the data, further interviews with subsequent participants were conducted exploring these newly identified categories (Charmaz, 2014). One such example was the length of time that participants were describing that the bullying behaviours had taken place over. In line with Guest, Bunce and Johnson (2006), the eight participants provided rich sources of data and enable data saturation to be reached.

4.9 Future Research

Smith (2012) commented that very few mixed-methods studies were published in the *Journal of Counselling and Development* and that only five per cent of research articles published in the period 2003 to 2010 was based on mixed-methods designs. One of the obstacles was considered to be the time and resources available to complete a dual study. By using either one of the qualitative or quantitative methods in isolation could, however, mean that studies fall short of providing findings applicable to real life situations (Smith, 2012). This issue was one of the considerations for this present study, and it was felt that using both methods was the best way of answering the research question, despite the timeframe and resources available under the constraints of completing research for a DPsych in counselling psychology. Future research, while recognising that a mixed-methods study is more time-consuming, may consider this as

a viable option to provide more enriched data. I believe that this current study demonstrates the viability and benefits of both methods.

An outside remit of this particular current study is the question as to what makes people behave in such an intimidating way or, on the other side of the coin, what potentially makes some people more susceptible to bullying than others. The authors of a Canadian study of nurses (*N*=1,205) (Hart, Brannan and De Chesnay, 2014) used a psychological capital questionnaire, which examined intrapersonal strength factors in combination with a measure of PTSD, and the NAQ. The results did not support their hypothesis that a high level of psychological capital would buffer the effects of bullying behaviours; they found that a higher level of reported experienced bullying behaviours resulted in higher level of PTSD symptomology, irrespective of the level of psychological capital. That said, the authors state that a higher level of psychological capital may protect some individuals from bullying (Laschinger and Noska, 2015). This area could be explored further in future studies. One of the comments from a participant was that the 'favourites' do not like the situation any more than the 'victims' of bullying. Future research in this field could consider interviews with employees who are not reporting experiencing bullying in addition to those who are, for a comparison of narratives.

Future research of this nature could look to include more structured data fields in respect of 'length of time' at an organisation for a more detailed analysis of whether the time at an organisation has an impact on being more susceptible to being a bullying target. This present studies aim was to consider the bullying experience; however, the quantitative analysis suggested a significant relationship between experiencing negative acts and the length of time in employment within ALT. Many of the narratives in this present study had references to examples of bullying that had happened when victims were 'new' into a role. Future research could consider this aspect in more detail, as Ekici and Beder (2014) found that younger and new members were more likely to have experienced bullying. In the qualitative interviews, all age ranges were represented and there were no examples of age being a factor for experiencing bullying behaviours. Age was not considered within this present study as time in job was deemed a more appropriate consideration for new members of staff. Whilst age was not a consideration for this study in relation to the bullying experience, it was found through the qualitative interviews that ages from across the range were represented. Future studies could

consider age differences alongside a more expansive range of time in job as a focus of study.

The participants who came forward for the qualitative part of this study had all spoken about their personal experience of being bullied from the outset until the conclusion – the whole bullying experience. Future studies could encourage individuals who were being bullied in the present, as their experience and what they said in the present may differ from post-event. This line of study could perhaps be achieved by specifically requesting that participants who are being bullied in the present come forward. The *stealth* nature of bullying identified, however, may preclude this from happening, as individuals are not always consciously aware that they are being bullied at the time of the initial events.

As an output from this study, a theory has been suggested as to the experience of the individual and individuals being bullied from their perspective. This theory includes the stealth nature of the bullying at the outset and follows the victim's journey through to the impact which it suggests is far more reaching than the impact of health and wellbeing alone. Whilst this present theory has not been tested further as part of this research, future studies could consider testing the theory by developing a questionnaire which includes questions considering the length of time bullying events had taken place and the potential other relationships of bullying behaviours such as patient care. The theory encompasses the whole bullying experience but is not necessarily limited to a healthcare environment, as is shown in this present study. It could be tested within school bullying or parental bullying and commented upon in the client study that follows this research chapter.

Future research could consider further analysis of the quantitative dataset provided within this study and undertake regression analysis, taking into account the divisional data and negative acts reported. Summaries of the data are included in this present research, but more detailed analysis could be undertaken. This analysis was outside the scope and aims of this present study, but this could be carried out at a later date.

Some thoughts on some positive potential changes to working practice follow, along with future plans to share this study with employees at ALT.

4.10 Potential Changes to Working Practice?

Since this study was conducted, the results of the latest NHS England staff survey 2016 have been released. Results for Key Finding 26 for ALT (the finding relating to 'the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months') has remained the same as for 2015 at 31%, which is still far too high.

Many of the participants described the entrenched nature of the 'bullying' culture, and this was borne out in this study and the integrated analysis. What could be done to change this situation? In the UK, nurses and midwives must uphold the professional standards set by the Nursing and Midwifery Council (NMC, 2015). These standards contain a section on working cooperatively, stating that nurses should respect the expertise and contributions of colleagues and be supportive of colleagues who may be experiencing health or performance-related problems (Wilson, 2016). One of the aspects that emerged from the qualitative analysis early on in the research, was the use of the word 'perception' of bullying rather than 'reality'. A small change in the use of this descriptive could make the victim feel more validated. Lokke, Vie, Glaso and Einarsen (2010) comment that there are benefits to participants of 'being heard' but also, and as this present study has found, 'being believed'.

Many participants said that meetings they attended had such large numbers of staff present that few people were able to speak out. This point was demonstrated in the following two examples:

'We go to these monthly de-brief sessions where bizarre things are communicated to us like how much we are in financial crises but I mean that is emphasised and things like the generator is working which I mean is relevant but you know things like the guardian service it's a one line sentence that is then brushed under the carpet, bullying is a massive problem, the only reason I knew that people were looking at it (bullying) more was because I was working across two sites and on the other site I get communication from the nursing staff…'

Dea 'If you could change one bullying behaviour what would it be?' (1007)

Gill 'I think having openness and transparency, it's very easy to hide and not be transparent and use lots of acronyms that people lower down won't understand, if there was just transparency and better communication that would help a lot.'

This view concurs with the General Medical Council's response to the Francis Review, where the vision is to create an NHS in which staff, doctors and other health professionals work in a culture where they feel empowered and supported when they speak up. The responses included in the data was suggesting that this is not the current situation.

Communication to staff could be enhanced with examples of what individuals are describing as bullying behaviours, such as those given in this study. This information could potentially create more awareness to victims to enable them to diffuse the 'Is it just me' thoughts and to perpetrators who may not be aware always that they are perceived as the bully. The improvements inferred would involve changing the culture by education as described by Longo (2013). Small workshops and groups would be more beneficial than safety briefings, where too many people attend. Without calling attention to these behaviours, a means for challenging them will not occur Longo (2013) commented.

Cleary et al. (2010) concur with this view, stating that an awareness campaign, with definitions and examples, could be helpful for both perpetrators and targets who do not understand what is reasonable or unreasonable for workplace behaviours, and also to give examples of the impact on individual staff members of persistent bullying behaviours. One participant, when advised that the interview would be confidential, surprised me by stating that he wished it was not as he would rather it could be publicised.

A summary of this study's results is to be shared with managers and staff of ALT in an attempt to increase awareness of the types of bullying acts that are being reported and of the learnings regarding the whole bullying experience process found in this study. In addition, the results can be arranged by division to provide valuable data to managers. When considering the top five negative acts that were reported, there was a combination of work-related acts and personal acts. These personal acts, such as not greeting each other in the morning or not saying goodbye when people leave on time, can be given as examples to staff. There are anti-bullying weeks when bullying behaviours are highlighted, and these could be enhanced with bullying examples. Another possibility would be for a message a week to be published and repeated so that the topic is always in the forefront of employees' minds. Staff training programmes

could include these examples as a preventative plan to bullying, when actions may still be in the *stealth* stage. These are minor changes to behaviours, but they could result in staff feeling less like a machine and more like a human.

The final reflections on this study and in particular the mixed methods approach adopted follow.

4.11 Reflections on Limitations of a Mixed-Methods Study

The answer that I sought was a holistic view of the context of bullying behaviours within ALT, and this had to include the adoption of a pragmatic approach whilst accepting the epistemological differences between the two methods of enquiry. I felt comfortable adopting the two methods and chose to integrate the findings during the analysis stage to provide a more comprehensive answer to the research question to satisfy my curiosity and the research question posed. The epistemological position, therefore, that I acquired for this project was one of pragmatism, and this matched my ontology of the truth being a combination of objectivity and subjectivity.

Mixed-methods research is characterised as having philosophical and technical challenges (Bishop, 2014). Historically, it is recognised that the positivist paradigm (or latterly post-positivist paradigm) underlies the quantitative methods and that the constructivist or interpretive paradigms underlie the qualitative methods (Tashakkori and Teddlie 1998). Tashakkori and Teddlie (1998) describe the emergence of peacekeepers between the two camps, and the compatibility perhaps of the two in the description of pragmatists. Theorists who are deemed to be pragmatically-orientated refer to such studies adopting both qualitative and quantitative methods to meet the research questions aims as ‘mixed-methods’. Paradigm purists may disagree with the mixed-methods concept due to the fundamental differences in the philosophies underlying them.

Qualitative study prioritises depth of understanding over the breadth of coverage (Cooper, Camic, Long, Panter, Rindskopf and Sher 2012). This present study recognises that this element is important to answer the research question set. However, the researcher believes that both objective and subjective points of view were valid for this particular study and, therefore, a breadth of coverage was required which could only be added via a qualitative element. Cornish and Gillespie (2009) argue that pragmatism gives priority to people’s everyday experience, and Brewer and Hunter

(1989) called for a more integrated methodological approach focusing on the need for individual researchers to combine methods in their investigations.

The research cycle (cycle of scientific methodology) discussed in Tashakkori and Teddlie (1998) describes research travelling through a cycle of discovery and learning at least once before it ends. This present study, with two components comprising the methodological design, had two starting points. The first concerned the hypothesising of expectations of the quantitative part of the study, and the second moved from grounded results through inductive logic to general inferences, such as theory. Pragmatists accept that there will be a choice of inductive and deductive logic in the course of research; this present research adopted these principles.

4.12 Implications for Counselling Psychology as a Profession

Findings from this present research suggest that some victims of bullying may not recognise that they are being bullied, but are experiencing the psychological impact such as depression, anxiety or stress or a combination of all three, and are therefore seeking psychological help from our profession. Counselling psychologists with this awareness may be able to help victims of bullying recognise what is happening to them and assist in a positive manner.

The assistance from this particular study and personally will start with the delivering of presentations of the summary of results to the same divisions that I originally presented to obtain the data. It is considered important for practitioners to make victims of bullying aware that their exposure to bullying has little to do with them as individuals, but their reactions to bullying may fuel more bullying or at least a stronger perception of being bullied (Einarsen and Nielsen 2014). Counselling psychologists can help with victims by working with the cognitive theory of trauma and rebuilding victims' assumptions about themselves and the world in a positive way (Einarsen and Nielsen 2014).

The questionnaires asked staff to describe whether they had experienced negative acts over the preceding six months, such as 'being ignored or facing a hostile reaction when they approach' or 'persistent criticism of their work or effort'. In addition, staff were asked to complete questions regarding their mental health to enable the researcher to establish if there were any potential relationships between the levels of negative acts reported and mental wellbeing such as depression, anxiety or stress. The findings from

this study could provide insights to ALT management to help formulate future staff training programmes and provide the basis for further research within the trust. The results of this study could enable managers to ascertain whether there are any items from the NAQ-R that have – in the individual's perceptions – higher frequencies than others. If any particular negative act is highlighted as occurring frequently, management may be able to review its messages to staff via notices during *anti-bullying* week, for example, to create awareness to managers of instances they may not have considered as important or offending.

This approach in conjunction with the 'qualitative inquiry' could raise awareness for the future and offer opportunities to guide management practice. The results of the annual staff survey for ALT were evidence that some research in this area was necessary if a change was to be possible.

4.13 Conclusion

The mixed-methods design utilised within this study enabled further exploration into bullying behaviours than the questionnaires alone could provide, and the qualitative aspect (including semi-structured interviews and grounded theory analysis) provided a theory of the bullying experience which was not confined to bullying behaviours in isolation and was far more complex than the quantitative analysis would have provided. This approach resulted in a holistic view of the experience of bullying being theorised. This present study adds to the vast quantitative literature available on prevalence rates of bullying within healthcare environments and, more importantly, adds to the limited availability of qualitative analysis, theory and insights on the phenomenon of bullying.

The findings of this mixed-methods study, in line with other studies of this nature, by Quine (2001) and more recently Carter et al. (2013), found that bullying and bullying behaviours are a persistent problem within healthcare environments in the UK. This particular study in ALT highlighted the most reported negative acts as indicated by staff: prevalence rates of bullying by way of a pre-defined statement and behavioural aspects as to what bullying is; relationships between reported negative acts and levels of depression, anxiety and stress; and, finally, a theory on how staff perceive and experience bullying by way of the whole bullying experience.

The theory diagram depicted the whole nature of the bullying experience as described by staff and was captured from both the quantitative and qualitative data. This included

the four overriding aspects stealth, power, bullying behaviours and impact. The stealth category included examples of victims being unaware that they were being bullied but, as the behaviours intensified, and others started to comment, they became aware of what was happening to them. This process alone could last longer than the other three aspects in total in certain situations.

Adult bullying was said to have four main features: intensity, repetition, duration and power disparity (Lutgen-Sandvik et al., 2007). These four features were found to be inherent in the interviews that were conducted. Intensity and repetition were highlighted by the impact that individuals described that bullying had on them. Many authors would not consider a one-off act as an instance of bullying (Einarsen and Hoel, 2001). The duration of bullying described was found to be significant in this study within the core category of stealth.

One of the principal authors over the last thirty years in the field of workplace bullying, and referenced extensively throughout this study, is Stale Einarsen. It is his definition adapted from research in Scandinavia that states that, *'bullying is defined as a situation in which one or more persons systematically and over a long period of time perceive themselves to be on the receiving end of negative treatment on the part of one or more persons, in a situation in which the person(s) exposed to the treatment have difficulty in defending themselves against this treatment.'* (Einarsen, 2000) This statement or definition of bullying behaviours encompasses the four features of intensity, repetition, duration and power disparity detailed above. The words 'perceive themselves' are the ones that are subjective, and can have varying definitions and different interpretations applied, as was explored in this present study more fully by way of the qualitative interviews and subsequent analysis. The word 'perception' of being bullied was one that was used sparingly in the interviews, as participants said that it was not a *perception* but a *reality*. This is a suggestion for a potential change in focus for discussion.

The impact of bullying behaviours experienced was found to be more far-reaching than the psychological impact emerging from the quantitative analysis. The impact included not only an impact on the victim but also on patient care. The bullying behaviours described as being experienced included being excluded from email trails or social media, and subtle behaviours such as not saying hello in the morning. By themselves,

these behaviours are under the radar but, as a consistent experienced behaviour, can be demoralising and affect an individual's self-esteem and confidence.

There is relatively limited qualitative research available in respect of bullying behaviours, and even less in the realms of mixed-methods research. Whilst this approach is far more time-consuming, the end result provides new and fresh insights into the phenomenon, which can be seen in the results of this present study. Future mixed-methods research into the area of bullying could aim to close this gap even further to enhance the available knowledge.

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Appendices

A. NEGATIVE ACTS QUESTIONNAIRE-R

The following behaviours are often seen as examples of negative behaviour in the workplace. Over the last six months, how often have you been subjected to the following negative acts at work?

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

1	*2*	*3*	*4*	*5*
Never	*Now and then*	*Monthly*	*Weekly*	*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, excluded or 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	1	2	3	4	5

when you approach					
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

NAQ-R – Negative Acts Questionnaire-R

B. PATIENT HEALTH QUESTIONNAIRE 9 (PHQ 9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	not at all	several days	more than half the days	nearly every day
1.Little interest or pleasure in doing things	0	1	2	3
2.Feeling down, depressed, or hopeless	0	1	2	3
3.Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.Feeling tired or having little energy	0	1	2	3
5.Poor appetite or overeating	0	1	2	3
6.Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7.Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead Or of hurting yourself in some way	0	1	2	3

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from

Pfizer Inc.

C. GAD 7

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3

6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

D. PERCEIVED STRESS SCALE

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate by circling how often you felt or thought a certain way**.**

0 = Never 1 = Almost Never 2 = Sometimes 3 = Fairly Often 4 = Very Often

1. In the last month, how often have you been upset because of something that happened unexpectedly?..... 0 1 2 3 4

2. In the last month, how often have you felt that you were unable to control the important things in your life?..... 0 1 2 3 4

3. In the last month, how often have you felt nervous and "stressed"?..... 0 1 2 3 4

4. In the last month, how often have you felt confident about your ability to handle your personal problems? 0 1 2 3 4

5. In the last month, how often have you felt that things were going your way?..... 0 1 2 3 4

6. In the last month, how often have you found that you could not cope with all the things that you had to do? 0 1 2 3 4

7. In the last month, how often have you been able to control irritations in your life?..... 0 1 2 3 4

8. In the last month, how often have you felt that you were on top of things?..... 0 1 2 3 4

9. In the last month, how often have you been angered because of things that were outside of your control?..... 0 1 2 3 4

10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them? 0 1 2 3 4

E. COMPLETE QUESTIONNAIRE

Title of the Study: How do NHS staff experience bullying? A mixed methods study

I would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

I am currently on my final year of a Counselling Psychology Doctoral level programme of study at City University, London. In addition I am on a placement two days a week within ALT at the Staff Psychological Welfare Service. I am researching the experience of bullying behaviours that may exist within the NHS from the perspective of the employee. **All responses to questionnaires are confidential and names of staff who have taken part in my study will not be provided as part of my research**. The purpose of the study is to find out from staff any negative acts that may or may not have been experienced. The NHS (England) staff survey 2014 revealed that 30% of ALT staff report experiencing bullying. The findings of this research will meet the requirements of my doctorate but also be informative to management as to the type of bullying that may be experienced but not reported by staff. **Throughout this study no one individual will be identifiable by any responses given and total confidentiality will be maintained.**

Why have I been invited?

As an employee of ALT you are invited to take part in this important research.

Do I have to take part?

Participation in the project is voluntary, and you can choose not to participate in part or all of the project. It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form.

What will happen if I take part?

Your involvement will be to answer 48 questions plus some basic details about yourself.

What do I have to do?

You will be asked to answer a series of 48 questions plus the following :-

The demographic questions will be as follows:-

Male/Female

Age Range 18-24 / 25-34 / 35-44 / 45-54 / 55+

Division EDH / RNTNEH / MIT/NHNN /ICU/UCH Theatres

Staff Band (Optional) 3 / 4 / 5 / 6 / 7 / 8+

Time in Job less than 1 year / 2-5 years / 6 years plus

Ethnic Group

The researcher will ensure that no response/responses will be identifiable to an individual employee. If there are relatively few individuals making up a particular group then the researcher will not report such findings.

What are the possible disadvantages and risks of taking part?

The questionnaires will be asking questions regarding any experiences of negative acts that may have been experienced, and in addition some questions regarding your overall wellbeing. This could stir up

some emotions that were unforeseen. You will have access to support if needed from the Staff Psychological and Welfare Service and other organisations.

What are the possible benefits of taking part?

The benefits of taking part are that this study provides a basis for all voices to be heard by more than just a tick on an annual staff survey. This research has the full backing of the ALT and your participation will contribute to the limited knowledge of this sensitive subject area and could help management devise plans to improve the work environment in the future.

What will happen when the research study stops? All information will not contain any identifiable content and will remain anonymised and for the purpose of the research only.

Will my taking part in the study be kept confidential? The dataset will have no names, only department codes and demographic information such as age range and gender.

What will happen to the results of the research study?

The research study in totality as a thesis will be available for access via the City University library. A summary of the study can be provided upon request to the researcher. In addition elements may be published in academic journals.

What will happen if I don't want to carry on with the study?

As the questionnaires are anonymous once the questionnaire has been submitted to the researcher it is not possible to withdraw from the study.

What if there is a problem?

If you have any problems, concerns or questions about this study, in the first instance please contact the researcher:- Dea Ditchfield Trainee Counselling Psychologist Staff Psychological Welfare Service Dea.Ditchfield@ALT.nhs.uk

In the second instance please contact:- [redacted]

Thirdly contact can be made to:- Jacqui Farrants Academic Supervisor City University London J.Farrants@city.ac.uk

If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: How do NHS staff experience bullying? – A mixed method study You could also write to the Secretary at: Anna Ramberg, Secretary to Senate Research Ethics Committee Research Office, E214 City University London Northampton Square London EC1V 0HB.Email: Anna.Ramberg.1@city.ac.uk

City University London holds insurance policies which apply to this study.

If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Who has reviewed the study?

This study has obtained R@D Approval (NHS Permission) 15/0907 and has been approved by City University London Research Ethics Committee reference PSYETH (P/F) 15/16 22.

Further information and contact details Dea Ditchfield – Dea.Ditchfield@ALT.nhs.uk
Jacqui Farrants – J.Farrants@city.ac.uk
Thank you for taking the time to read this information sheet.

Please read and confirm your consent to take part in this study

	Please tick to confirm (1)
I agree to take part in the above City University London research project. I have read the participant information sheet. I understand this will involve answering a series of questions via on-line or hard copy questionnaires	❍
This information will be held and processed for the following purpose(s): To analyse all data collected to find out detailed information as to how staff report any negative acts that may or may not have been experienced and how these acts may contribute to overall wellbeing.	❍
I understand that my participation is voluntary and as the data is anonymous I can't withdraw once I have answered the survey questions.I agree to City University London processing the information gathered from the questionnaires. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.I agree to take part in this study	❍

Q1 Male/Female/Other?

Q2 What is your Age?

Q3 Which Division best describes your main workplace?

Q4 What is your current Staff Band?

- ❑ 3
- ❑ 4
- ❑ 5
- ❑ 6
- ❑ 7
- ❑ 8+
- ❑ Would rather not say

Q5 How long have you been working at A London Trust? please circle

less than 1 year 2-5 years 6 years plus

Q6 What is your ethnic group? Choose one option that best describes your ethnic group or background:-

- ❑ White - English/Welsh/Scottish/Northern Irish/British (1)
- ❑ White- Irish (2)
- ❑ White- Gypsy or Irish Traveler (3)
- ❑ Any other White background (4)
- ❑ Mixed/Multiple Ethnic Group - White and Black Caribbean (5)
- ❑ Mixed/Multiple Ethnic Group - White and Black African (6)
- ❑ Mixed/Multiple Ethnic Group - White and Asian (7)
- ❑ Any other Mixed/Multiple Ethnic Background (8)
- ❑ Indian (9)
- ❑ Pakistani (10)
- ❑ Bangladeshi (11)
- ❑ Chinese (12)
- ❑ Any Other Asian Background (13)
- ❑ African (14)
- ❑ Caribbean (15)
- ❑ Any other Black/African/Caribbean background (16)

- ❑ Arab (17)
- ❑ Any Other ethnic group not listed (18)

Q7 The following behaviours are often seen as examples of negative behaviour in the workplace. Over The last six months how often have you been subjected to the following negative acts at work? Please indicate where it best corresponds with your experience over the last six months

	Never (1)	Now and then (2)	Monthly (3)	Weekly (4)	Daily (5)
1.Someone withholding information which affects your performance	❑	❑	❑	❑	❑
2.Being humiliated or ridiculed in connection with your work	❑	❑	❑	❑	❑
3.Being ordered to do work below your level of competence	❑	❑	❑	❑	❑
4. Having key areas of responsibility removed or replaced with more trivial or unpleasant tasks	❑	❑	❑	❑	❑
5. Spreading of gossip and rumors about you	❑	❑	❑	❑	❑
6. Being ignored, excluded or being 'sent to Coventry' (Silence treatment)	❑	❑	❑	❑	❑
7. Having insulting or offensive remarks made about your person (i.e. habits and background), your attitudes or private life	Never ☐	Now and Then ☐	Monthly ☐	Weekly ☐	Daily ☐
8. Being shouted at or being the target of	❑	❑	❑	❑	❑

spontaneous anger (or rage)					
9. Intimidating behavior such as finger-pointing, invasion of personal space, shoving, blocking/barring the way	❑	❑	❑	❑	❑
10. Hints or signals from others that you should quit your job	❑	❑	❑	❑	❑
11. Repeated reminders of your errors or mistakes	❑	❑	❑	❑	❑
12. Being ignored or facing a hostile reaction when you approach	❑	❑	❑	❑	❑
13. Persistent criticism of your work and effort	❑	❑	❑	❑	❑
14.Having your opinions and views ignored	☐	☐	☐	☐	☐
15. Practical jokes carried out by people you don't get on with	❑	❑	❑	❑	❑
16.Being given tasks with unreasonable or impossible targets or deadlines	❑	❑	❑	❑	❑
17. Having allegations made	❑	❑	❑	❑	❑

against you					
18. Excessive monitoring of your work	❑	❑	❑	❑	❑
19. Pressure not to claim something which by right you are entitles to (e.g. sick leave, holiday entitlement, travel expenses)	❑	❑	❑	❑	❑
20. Being the subject of excessive teasing and sarcasm	❑	❑	❑	❑	❑
21. Being exposed to an unmanageable workload	❑	❑	❑	❑	❑
22. Threats of violence or physical abuse)	❑	❑	❑	❑	❑

<u>Q8 Have you been bullied at work</u>? 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 not 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**

Q9 Over the last two weeks how often have you been bothered by the following problems?

	Not at all (1)	Several Days (2)	More than half the days (3)	Nearly every day (4)
1. Feeling nervous, anxious or on edge	❍	❍	❍	❍
2. Not being able to stop or control worrying	❍	❍	❍	❍
3. Worrying too much about different things	❍	❍	❍	❍
4. Trouble relaxing	❍	❍	❍	❍
5. Being so restless that it is hard to sit still	❍	❍	❍	❍
6. Becoming easily annoyed or irritable	❍	❍	❍	❍
7. Feeling afraid as if something awful might happen	❍	❍	❍	❍

Q10 The questions in this scale ask you about your feelings and thoughts during the last month. Please indicate how often you felt or thought a certain way

	Never (1)	Almost Never (2)	Sometimes (3)	Fairly Often (4)	Very Often (5)
1. In the last month, how often have you been upset because of something that happened unexpectedly?	❑	❑	❑	❑	❑
2. In the last month, how often have you felt that you were unable to control the important things in your life?	❑	❑	❑	❑	❑
3. In the last month how often have you felt nervous and stressed?	❑	❑	❑	❑	❑
4. In the last month, how often have you felt confident about your ability to handle your personal problems?	❑	❑	❑	❑	❑
5. In the last month, how often have you felt that things were going your way?	❑	❑	❑	❑	❑
6. In the last month, how often have you found that you could not cope with all the	Never ☐	Almost Never ☐	Sometimes ☐	Fairly Often ☐	Very Often ☐

things that you had to do?					
7. In the last month, how often have you been able to control irritations in your life?	❑	❑	❑	❑	❑
8. In the last month how often have you felt that you were on top of things?	❑	❑	❑	❑	❑
9. In the last month how often have you been angered because of things that were outside your control?	❑	❑	❑	❑	❑
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	❑	❑	❑	❑	❑

Q11 Over the last two weeks how often have you been bothered by any of the following problems?

	Not at all (1)	Several days (2)	more than half the days (3)	nearly every day (4)
1. Little interest or pleasure in doing things	❍	❍	❍	❍
2. Feeling down, depressed or hopeless	❍	❍	❍	❍
3. Trouble falling or staying asleep or sleeping too much	❍	❍	❍	❍
4. Feeling tired or having little energy	❍	❍	❍	❍
5. Poor appetite or overeating	❍	❍	❍	❍
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	❍	❍	❍	❍
7. Trouble concentrating on things such as reading the newspaper or watching television	❍	❍	❍	❍
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	❍	❍	❍	❍
9. Thoughts that you would be better off dead or of hurting yourself in some way	❍	❍	❍	❍

Thank you for taking part in my study.

I would like to take this opportunity to explain the rationale behind my research. This current study is to assess any experiences of any negative acts that may or may not have been experienced within the workplace and any potential relationship these may have with overall wellbeing. The questionnaires that you have answered may have caused some concerns for you, if so and you would like further support, please contact the staff psychological and welfare service on [redacted]

In addition help and guidance can be sought from

www.acas.org.uk

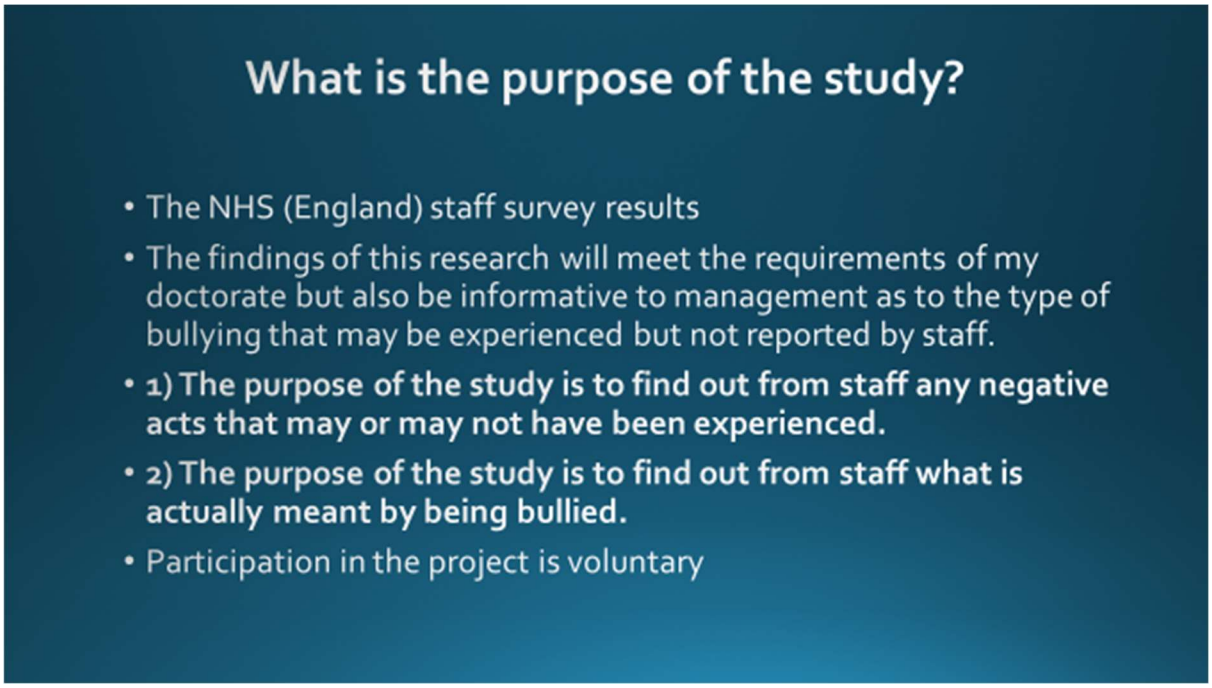
I hope you found my study interesting. If you have any other questions please do not hesitate to contact me or my supervisors:-

Dea Ditchfield
Trainee Counselling Psychologist
Staff Psychological and Welfare Service
Dea.Ditchfield@ALT.nhs.uk
In the second instance please contact:-
[redacted]

Thirdly contact can be made to
Jacqui Farrants
Academic Supervisor
City University London
J.Farrants@city.ac.uk

Ethics approval code: PSYETH (P/F) 15/16 22
This study has obtained R@D Approval (NHS Permission) 15/0907

F. POWERPOINT PRESENTATION TO STAFF



Quantitative - What does it involve ?

- Your involvement will be to answer 48 questions plus some basic details about yourself either via Qualtrics on line or by completing a paper copy and returning to the researcher.
- The researcher will ensure that no response/responses will be identifiable to an individual employee. If there are relatively few individuals making up a particular group then the researcher will not report such findings.

Questionnaires

- Health and Wellbeing questions
- 22 Negatives Acts such as :-

Being ignored

Silence Treatment

Gossiping

48 questions total – 12/15 minutes on line or paper copy

Next Steps .....

Questionnaires
Email Link to Qualtrics
Paper Copy available for completion during break

Interviews
Contact – Dea Ditchfield 07745 914091
Leaflet

G. OUTLINE INTERVIEW SCHEDULE

Setting

Do you feel you have been given a space to talk at the moment?

You may or may not have seen this questionnaire as part of the wider context of the research (show a copy of the NAQ-R). If you were to look at the descriptions of 'negative acts'. Would this accurately reflect your experience? Would you like to add any 'acts' that don't appear on this list? What would be your top three that affect you on a day to day basis?

Actual events

If a friend asked you about the type of bullying that may be experienced within the NHS, how would you describe this?

If I didn't know what bullying was, how would you describe it to me?

What actual event/s happened to you that you could describe in your own words?

Frequency of bullying over last 6 – 12 months?

Victimisation?

Powerlessness / trying to resolve by self – How was this done? When did you realise that what was happening was bullying?

What made you realise that this was 'bullying'?

Did bullying take a different form / escalate?

Gradually over time?

What subtle things were happening / are happening?

What to do

If you had a friend who was thinking about joining the NHS, how would you describe the procedure and process to report bullying?

Impact

I would like you to imagine that you could tell your bully exactly how it makes you feel, what would you say?

If someone said to you that they had never been bullied before, how would you describe to them what it might feel like?

Changes

If you were to wake up tomorrow morning and everything had changed for the better. What would it feel like?

If you could change one aspect of your day, what would it be?

What would a non-bullying day look like? What would be different?

H. QUALITATIVE ADVERT

Department of Psychology
City University London

PARTICIPANTS REQUESTED FOR DOCTORAL RESEARCH INTO THE EXPERIENCE OF BEING BULLIED WITHIN THE NHS

I am looking for volunteers to take part in a study on the experience of being bullied from the perspective of NHS employees. You would be required to take part in a confidential individual semi-structured interview which would take place at a mutually agreed time and location.

Your participation would involve about 60 minutes of your time.

In the first instance or to find out more about how you can take part in this study please contact me Dea Ditchfield directly on 07745 914091.

This study has been reviewed by, and received ethics clearance through the Research Ethics Committee, City University London. Ethics approval reference PSYETH (P/F) 15/16 22.

This study has obtained R@D Approval (NHS Permission) 15/0907

Appendix I

De-Brief from Qualitative

Debrief Sheet for Qualitative study

How do NHS staff experience bullying? A mixed methods study

DEBRIEF INFORMATION

Thank you for taking part in my study. I would like to take this opportunity to explain the rationale behind my research. This current study is to report the experience of being bullied from the perspective of the NHS employee. The interview that you have taken part in may have caused some concerns for you, if so and you would like further support, please contact the staff psychological and welfare service on 0203 447 9800 or email on staffpsychologicalwelfareservice@ALT.nhs.uk

In addition help and assistance can be sought from

www.**acas**.org.uk

I hope you found my study interesting. If you have any other questions please do not hesitate to contact me or my supervisors:-

Dea Ditchfield
Trainee Counselling Psychologist
Staff Psychological and Welfare Service
Dea.Ditchfield@ALT.nhs.uk
Tel 07745 914091

[redacted]

Thirdly contact can be made to
Jacqui Farrants
Academic Supervisor
City University London
J.Farrants@city.ac.uk

Ethics approval code: PSYETH (P/F) 15/16 22

J. Focused Coding

Perpetrator

Lacked listening skills - 1
Didn't get to know us – 1
Disregard of previous knowledge - 1
Lack of understanding - 1
Unreasonable demands -1
Coming from a different planet -1
Manager not listening to what I was saying - 1
Authoritarian approach – 1
Directive tone used -1
Lack of knowledge about dept - 1
Imposing - 1
Selective bullying - 1
Did not understand the workings of the department - 1
Picked on individuals – 1
Tried to impose views by dictating rather than collaboration - 1
Managers lack of understanding - 1
Rule by dictating - 1
Verbal bullying – belittling - 1
Doubting me - 1
Demeaning what I said - 1
Gunning for me - 1
Bullying was subtle - 1
Rule by verbal force - 1
Dismissive of my work - 1
Ruling by force - 1
Dismissive of experience - 1
No insight or emotional intelligence into what was happening - 1
Overbearing behaviour - 1
Lack of emotional intelligence - 1
No sympathy or empathy - 1
Not interested in our opinions - 1
She barged in / guns blazing - 1
Hassling behaviour - 1
No recognition of good work or experience - 1
No respect for us - 1
No recognition of experience - 1
No concept of the effect she was having - 1
Work with us not against us - 1
She had no empathy - 1
Constantly undermining my experience and knowledge - 1
Did not take time to get to know us or our job roles - 1
No respect for our abilities or expertise -1
Expect more from people than the job description states – 2
Expectation to work beyond hours – 2
Inappropriate workload – 2
Constant pressure on you to do more – 2

Verbal pressure – 2
Constant high expectations to deliver imposing targets – 2
Constant pressure to do more than job description – 2
Asked to work beyond contractual hours – 2
Taking away freedom of decision making – 2
Micro-Management – 2
Tone of voice/email – 2
More and more requests for information without reasons why needed – 2
Intense pressure – 2
Unreasonable demands for information – 2
Contact outside of work – 2
Not saying goodbye if you leave on time – 3
Ignoring people when they come into room – 3
Inappropriate feedback given – 3
Threatening feedback received rather than constructive – 3
Inappropriate comments from management – 3
Manager making inappropriate comments about me to other people – 3
Punitive feedback received – 3
Belittling feedback received – 3
No constructive feedback received – 3
Pressure to agree with management – 3
Collusion between colleagues who have known each other for long period of time – 3
Rejected from a course without explanation – 3
Subtle behaviours – hard to prove – 3
If question anything more likely to get bullied – 3
Subtle – not saying goodbye if you leave on time – 3
Deny training opportunities – 3
Not encouraged to take annual leave or sick leave as too busy – 3
Subtle behaviours – undermining people in meetings/ignoring people/exclusions from emails–3
Non-clinical work after hours – 3
Ideas not encouraged so culture of fear and worry created – 3
Don't speak out for fear of job security – 3
No time during work for admin – 3
Undermining behaviour – 3
No support – 3
Management not interested in the staff or staff opinions – 3
Bullying is withholding information – 3
Staff can't ask questions due to high workload – 3
Suggestion for promotion for friends rather than merit – 3
No appreciation for hours worked both in and out of work hours – 3
Scape-goating – 3
No regular staff updates – 3
Kept in the dark about what is happening around the hospital – 3
Management not interested in what is going on – 3
No eye contact – 3
No greeting each other – 3
Slamming things on desk – 3
Subtle criticisms – 3
Not encouraged to speak – 3

Opinions not valued – 3
Being talked over -3
Not being listened to – 3
Subtlety of bullying behaviours- withholding information - 4
Areas of responsibility removed - 4
Repeated reminders of mistakes – 4
Opinions not wanted rather than ignored – 4
Contract not doable is biggest bullying behaviour – 4
Bullying from people more senior to you – 4
Corporate bullying – 4
Not being listened to – 4
Opinions ignored – 4
Emails business like – short and sharp – no tone – 4
Treated like a workhorse not a human – 4
No respect for employees – 4
Bullying behaviours from top down – 4
Machines not humans – 4
Mixed messages regarding my work – 4
Do admin in own time as not enough hours in the day – 4
Treated differently at ALT from National average regarding admin work – 4
Have to be seen to be doing work – 4
Can't ask for more time as this is not the culture – 4
Incessant monitoring – 4
Left to struggle with workload by self – lack of support – 4
Treated like a machine rather than a person – 4
If I say something wrong I will be pounced on – 4
Fine line between bullying and directive – 4
Unmanageable workload – 4
Picked on – 4
Behaviour was over critical – 4
Subtle looks from management when talking in the corridor – 4
Grumpy faces – 4
Disapproving faces – looks as if could kill – 4
Management scowling – appearing like they are in a mood – 4
Management being grumpy – 4
Only negative feedback received – 4
Behaves like factory not human hospital – 4
Machine environment not humans – 4
Not just unrealistic demands but unrealistic without support – 4
Lack of support – 4
Lack of meetings where people feel able to speak out or ask questions – 4
Opinions not heard – 4
Meetings are stifled – 4
Not being listened to - 4
Opinions not being asked for or acknowledged – 4
No credit for work being done – 4
ALT not human – 4
Change of boss and previous working arrangements not adhered to – 5
Not being asked for opinions regarding changes – 5
Tone of communication – 5

Threatening language – 5
Tone of letter – 5
Communication letter described as intimidating by union – 5
Manager not wishing to attend a meeting with me – 5
Concerns pushed aside – not given time – 5
Avoidance of issues by management – 5
Difficulty to get any redress – 5
Not being consulted regarding change management – being ignored – 5
No response acknowledged for requests for meetings – 5
Over-heard changes – not consulted or explained just imposed upon us – 5
Not listened to staff until mentioned in CQC – 5
No credit given for first-hand experience on the ward – 5
Hard workers are rewarded with more and more work – 5
Asking staff to lie for the manager regarding time keeping – 5
Patient ratio is when it crosses to bullying from over work – 5
Belittling of concerns made – 5
Opinions not being asked for or respected – 5
Condescending remarks from management – 5
Inconsistency from manager over treatment of their staff – 5
Listening but falling on deaf ears – 5
Inconsistency of treatment of staff – 5
Bullying is when refused day off but others allowed – 6
Being ridiculed by other members of staff – 6
Racist element to favouritism for certain members of staff – 6
Management employing people of same race over and above others – 6
I was declined a job in favour of another person based on the grounds of race not experience – this is bullying – 6
Jobs and annual leave given to people based on their ethnic origin not merit or fairness – 6
Subtle – body language; not having help for me on my working days but for others on different days there is help – 6
Constant calling for me when I can't do all jobs at once – 6
Making me work like a donkey – 6
No consideration for people – 6
Victimised due to race compared to others – 6
No respect for opinions – 6
Managers have their own rules not policy – 6
Collusion between members of staff – 6
Managers not signing transfer forms to block you leaving division – 6
No equality or diversity in this division – 6
No respect or consideration for bands lower than 5 – 6
I was new person on ward and there was no respect for this and I was treated as if I was stupid – 7
Talking behind your back – 7
Talking about you – belittling – 7
Calls at home on my day off – 7
Micro – managed – 7
Being shouted at – 7
Shouting at me in front of others – 7
Shouting at staff – 7

Being humiliated in front of staff and being shouted at – 7
Being ridiculed and humiliated – 8
Ridiculed from other members of staff – 8
Singled out – 8
Singled out for comments at work – 8
Strange looks – 8
Over-checking of my work – 8
Colleagues not wanting to take over from me for coffee break – 8
Treatment of staff differs – not consistent – 8
Agency rota staff person giving shifts unfairly or not at all or over loading with patients – 8
Singled out – 8

Timescale/Others noticing
I am the other Side of bullying – 1
9 months of bullying behaviour -1
Team noticing bullying of me - 1
Realisation that people knew - 1
Was told by others that I was being bullied – 1
A year of bullying before resolved – 2
Bullying escalated – 2
Bullying over a period of time – 3
Bullying experience was started two years ago – 3
When realised I could cope no longer I realised that it was bullying – 4
At the time don't realise that it is bullying – only when you look back do you realise – 4
When in the midst of it – react inappropriately – 4
Realisation that it is not your fault – 4
Subtle bullying over time – 4
Once you realise that you are being bullied – can recognise it everywhere – 4
Bullying behaviour for a year – slow realisation - stealth? – 4
Afterwards realised it was bullying – 4
Once the realisation of bullying was apparent – weight lifted – a name for it – 4
Self-blame for two years – 4
Recognition of bullying and not my fault – 4
Could only cope for so long with excessive work demands – 5
A year of being over worked – 5
Confirmation from another that this was bullying behaviour – 5
Once supported don't feel so alone and isolated – 5
Once recognised and acknowledged as bullying – not so alone and feel more supported – 5
Bullying period lasted 6 – 8 months – 7
Recognition lifted feelings of anxiety and stress – 7
Some support released tension – 7
Bullying behaviour stopped so I didn't have to leave – 7
Didn't think it was bullying at first – 7
Bullying was three years ago but I can still remember details and thinking that I shouldn't have put up with it – 7
Stronger now three years on to stand up to bullying – 7
Bullying event from over a year ago – 8

3 months before I realised that behaviour was bullying – 8
Investigation a long time – over a year – 8
Once accepted bullying it was worse as I knew I had to deal with it – 8
17 months ago but the memories still remain fresh – 8

Power
Power difference - 1
She has power over me -1
Power over me by grade - 1
'perceived' power - 1
Feeling powerless against authority – 1
Had power to resolve – 2
Powerlessness became the norm for people – 3
Power culture to new members of staff – 3
Feeling of powerlessness – 3
Very powerful lady that was bullying – 3
Controlling – 3
Too frightened to disagree with manager – 3
We have no power – 3
Powerlessness – 3
More junior – more likely to get bullied – 3
They are powerful and non-accountable – 3
People too frightened to talk out about bullying that goes on – 3
Feelings of powerlessness that no one will listen – 3
There is no-where to turn – 3
Power games – 3
Staff don't speak up and feel powerless to do so – 3
Bullying behaviours from top down – 4
Bullying culture from above – 4
Powerlessness – 4
It was being done to me – no power to stop – 4
Disconnect between management and employees – 5
Differing opinions between how management think the ward is run and the reality – 5
Far of management to deal with particular staff members – 5
Controlling – 5
Power equals control over you which makes the victim feel vulnerable – 5
When the person knows they have the power – 6
Power used for personal benefit – 6
Power and control of others – 6
Power imbalance – no respect from nurses – 6
New staff are more vulnerable and need support – 7
Didn't have any power as a new starter but once established in role have power – 7

Impact
Sleep disturbance - 1
Wanted to leave - 1
Worry waking me up - 1
Sleep pattern disturbed - 1
Feeling powerless against authority - 1
Would resign if it carried on - 1

Made me feel small and useless and incompetent at my job – 1
Created self – doubt – 2
Did I cause it – self blame – 2
Took enjoyment out of job – 2
Stopped doing extra work for trust as a result – 2
Residual negative feelings against ALT and individuals over a year later – 2
People scared to talk out – 3
Self – blame – 3
Felt belittled – 3
Felt frightened – 3
Took all comments personally – 3
Can't be a human being must be a machine – 3
Vulnerability of health – 3
Bullying is life changing – 3
It makes you lose sleep, create anxiety, distressed, takes away confidence and self-esteem as you constantly ask yourself about your own abilities – 3
Takes away staff morale and spirit – 3
Bullying is life changing – 3
Changes your own opinion of the NHS – 3
Feel isolated, lonely, tearful – 3
It's all consuming and takes over your thought patterns – 3
Lack in confidence and abilities – 3
Bullying affected my physical health – 3
Trying not to become the bully – 3
Left because of bullying – 4
Left because of bullying – 4
Concern over patient safety – 4
Proactivity not encouraged – 4
Too much pressure and so patient care affected – 4
No time to do the admin – 4
Bullying behaviours passed on – tone in emails to colleagues from victim – 4
Both victim and bully thought they were being picked on – 4
Over work caused stress/tiredness and risk to patient safety – 4
Victim became perpetrator without realising – 4
Feelings of incompetence – 4
Negative affect on health – 4
I have been made to feel incompetent – 4
Self-blame – 4
Bullying is belittling and you feel incompetent – 4
Couldn't face appraisal – 4
Fearful of facing manager – 4
Self-blame of your own incompetence – 4
Lack of self-worth – 4
Lack of self – esteem – 4
Lack of confidence – 4
Tearful/upset/cross – 4
Looking over your shoulder – 4
Fearful of more criticism – 4
Not being valued – 4
No team spirit or comradery – 4

Feeling part of a wider team not experienced – 4
No team morale – 4
Was going to leave due to over work and not coping – 5
Applied for reduced hours – 5
Patient care effected – 5
Patient safety affected – 5
Negativity in workplace as 'what's the point attitude manifests as staff are not heard – 5
Nearly left – 5
Doubt over own capabilities and self-esteem – 5
Bullying made me less approachable and friendly. All the niceties from work conversation went and so work was for tasks and nothing else – 5
Unsure about self and how to react – 5
Backed into a corner – 5
Bullying makes you feel singled out/victimised/fills you with self-doubt – 5
Bullying behaviours led to trying to take my own life as I was not supported – 6
Feel cant complain – only leave when I can – 6
I would rather be transferred to another division and a lower grade rather than stay in current role – 6
Panic attacks experienced – 7
Fearful and anxious about hat the day would bring – 7
Considered leaving – 7
Too scared to talk to anyone – 7
No confidence – 7
Felt I couldn't leave as was new and in my probation period – 7
Bullying caused feeling sad/low/unwanted – 7
Sleep disturbed – 7
Bullying affected the care of patients – 7
Impacted on emotional wellbeing – sensitive to comments – 8
Affected my work – 8
Dread of coming to work – 8
Traumatised – 8
Disturbed sleep/crying/not wanting to socialise – 8
Evidence of staff leaving because of bullying – 8
Impacted sleep / eating and not giving family time – 8

Feeling Frustrated with Situation
Frustrating Manager - 1
I felt frustrated by her not listening - 1
I doubted my own ability – 1
Built up frustration from staff over short staffing – 5
Feelings of bullying were frustration and anger and resentment – 5
Bullying led to feelings of frustration/anger/resentful/negative about work – 5

Obvious target – 1
Eased when realised not just me – 1
Improved when realised it wasn't just me – 1
Did not have courage at time to report – 1
Resilient personality – 2
Strong social support – 2

Individual resilience gets people through – if not people suffer – 2
Bullying becomes the norm – 2
People do not accept that employees have time constraints and should be able to finish on time – 2
Tried to resist bullying – 2
Eventually got it resolved by HR – 2
Tried to resolve by self at first – 2
Quick resolution once reported – 2
Suggestion of ethnic clash but considered this worse than bullying so didn't want to face it– 2
Recognition that it is difficult to change bully's personality – 2
Bullies investigated bullying themselves – 3
Line manager not coping with workload – 3
I was new member of staff – 3
Didn't want to repot for fear of career – 3
Probationary period whilst bullied – 3
Left with no choice but to report – 3
Bully investigated self – 3
Bullying is a cultural set of behaviours – 3
Management not interested in patient care – 3
Would change to openness and transparency – 3
Better communication needed – 3
Staff need information about job security /future/ where the service is going – 3
No transparency of what is going on around the rest of the hospital – 3
Lack of communication across the whole hospital – 3
New guardian service for bullying was on-line – 3
No regular staff updates – 3
Justification of behaviours such as they are under pressure – excuses for bullies – 3
Bullying becomes the norm and is passed down to other people. Behaviour is copied, if belittling is the normal then others learn, - social learning behaviour? – 3
Victims made to feel it is their own fault – self blaming culture – 3
Procedure for reporting bullying not known – 4
Fearful to report for fear of repercussions – 4
Difficult to report and be critical of your peers – telling tales – 4
Lack of courage to go and report – 4
If she felt she were being a bully she would be horrified – 4
Becoming the bully without realising it and being punished – 4
Get more from people if treat differently – 4
When reported behaviours- whistle blowing team only interviewed managers – 5
Not resistant to change for the better – but no explanations of why the change or consulted – 5
The word perception of bullying makes it seem not real – 5
Differing views of bullying between target and perpetrator – 5
Bullying is real and not a perception – 5
Stress management needed for all levels – 5
What policy says and the reality is different – 6
System created to protect manager – 6
Double standards – if complain about a manager need proof. If they complain about a member of staff no proof needed – 6
If a complaint is made – the victim is branded a trouble maker – 6

Fear over complaining because as soon as this is done, the complaint is sent to the manager – 6
A complaint for bullying would be a bad mark against me for future career opportunities – 6
If bullying reported nothing happens and nothing changes – 6
The policy at ALT does not work for employees – 6
If you complain – this impacts on your own future prospects – 6
When bullied the emotion is anger – can't think to take notes of times/dates/events
Reporting it could have made things worse – 7
Blame culture within the department – 8
Need evidence and witnesses for bullying to be upheld – 8
After reporting bullying did stop being so aggressive – 8
Investigations not fair to victims – 8
Impartiality important for investigation – not received – 8
Length of contract and patients stopped me from leaving – 8
Witnessing of bullying behaviours of new starters – 8
Justice after reporting but a long time coming – 8

K. EXAMPLE OF MEMO

Memo 1 – Thoughts following first two interviews and before coding

Both interviews were completed in the same week. The gender difference was good in the fact that so far one male and one female. Both had been bullied or experienced bullying behaviours over 6 months ago and were re-telling their own experiences. Both were also from senior management roles.

The first participant described being bullied by a change management person who had come in to look at moving a department. She described that she felt 'powerless' and described events of not being listened to and that her opinions and those of her staff were not taken into account. She described not being listened to and that the many years of experience that she had built up were not considered relevant. From the interview I got a sense of the 'frustration' that was felt from the participant not over the changes but of the lack of respect for her and her role and that of her staff and of the patients requirements. She gave a sense of the fact that she was not included in the discussions and was being asked to tell her staff things that would change before it had been decided whether or not they would change.

As an aside to the research I wondered what made people in management behave in this way, was it their insecurity or lack of management training – certainly there appeared to be a lack of empathy. The participant blamed herself and also tried to contain her own thoughts but described how she would experience a sense of dread when the 'perpetrator' approached her. Only when she realised that the 'bullying' was not just to herself did she believe that it wasn't necessarily personal. The fact that it wasn't victimisation provided a level of comfort.

The participant mentioned that whilst she was dealing with the situation herself, others had suggested that she consult the handbook and procedures over bullying. Until this point she had thought that she was containing her wellbeing but others had noticed. She described her state of mind as effecting her sleep at home – I did not dwell on these aspects too much as the research was trying to focus on the process of what bullying was rather than how it made people feel.

The second participant was also senior, the two participants had both come forward in response to my advertising and both were senior and for both the bullying had happened over 6 months ago. Both described how at the time they would not have been able to talk freely about what was going on but now after the event they were able. The two narratives differed however in the content – the first was showing elements of 'frustration' and 'powerlessness' and was describing situations of not being listened to and her opinions not just ignored but not being heard. The second participant was expressing a situation whereby he was asked to complete an ever increasing workload that was way above his contracted hours. He had attempted to resolve himself via line management and eventually did seek assistance via reporting the behaviours. He described that once he had done this the situation was resolved. I wonder whether it was resolved so quickly due to the seniority of his position. He also described himself as having a great inner ability of resilience to deal with the situation and of the good level of family support he had at home.

Further Questions to pose at this stage following initial two interviews:-

Frequency of bullying over last 6 – 12 months ?

Victimisation?

Powerlessness / trying to resolve by self – How was this done? When did you realise that what was happening was bullying?

What made you realise that this was ‘bullying’?

Did bullying take a different form / escalate?

Gradually over time?

What subtle things were happening / are happening?

The Professional Practice Component of this thesis has been removed for confidentiality purposes.

It can be consulted by Psychology researchers on application at the Library of City, University of London.

Section C: Client Study

[redacted]

Section D: Publishable Paper

The requirements for the BMJ Open journal are that the word count is circa 4,000 words. The journal article presented in this section of my portfolio follows this requirement, with the main headings matching the format requested by BMJ Open (Appendix A) and published by Carter et al. (2013).

Article Title: How do Hospital Staff Perceive and Experience Bullying Behaviours? A Mixed-Methods Study

ABSTRACT

Objectives:

1. To consider the prevalence and types of bullying behaviours reported within an NHS trust and their relationships with staff wellbeing and, in particular, with stress, depression and anxiety.
2. To obtain accounts of the experience and perception of being bullied from the perspective of the target and with a view to constructing a theory.

Design: Cross-sectional questionnaire and semi-structured interviews.

Setting: NHS Acute Trust.

Participants: 303 participants completed the questionnaires, and eight participants each took part in a semi-structured interview.

Main Outcome Measures: The prevalence and types of bullying behaviours were measured utilising the Negative Acts Questionnaire (NAQ-R); the relationships between bullying and stress, depression and anxiety were measured using the Perceived Stress Scale (PSS), Patients Health Questionnaire (PHQ 9), and Generalised Anxiety Disorder 7 (GAD 7). A theory of the bullying experience was developed combining the results of the quantitative analysis with the constructivist grounded theory from the qualitative data (Charmaz, 2014).

Results: Overall, 42% of respondents reported being bullied to some degree, with the main negative acts being both work-related and personal bullying types. The qualitative interviews supported this data; however, combining both methodologies at the analysis stage resulted in a theory of the whole bullying experience which included the categories stealth, bullying behaviours power and impact.

Conclusions: Any bullying behaviours should be considered unacceptable, and the level of bullying events reported is still far too high within the NHS. The bullying experience encompasses far more than the prevalence of negative acts over a six-month period and, in many situations, can be under the radar for a substantial amount of time before the victim is

APPENDIX A

Research submissions should have a clear, justified research question. All articles should include the following; The article title should include the research question and the study design. Titles should not declare the results of the study.

- A structured abstract (max. 300 words) including all the following where appropriate
    - objectives: clear statement of main study aim and major hypothesis/research question
    - design: e.g. prospective, randomised, blinded, case control
    - setting: level of care e.g. primary, secondary; number of participating centres. Generalise; don't use the name of a specific centre, but give geographical location if important
    - participants: numbers entering and completing the study; sex and ethnic group if appropriate. Clear definitions of selection, entry and exclusion criteria
    - interventions: what, how, when and how long (this can be deleted if there were no interventions)
    - primary and secondary outcome measures: planned (i.e. in the protocol) and those finally measured (if different, explain why) – for quantitative studies only
    - results: main results with (for quantitative studies) 95% confidence intervals and, where appropriate, the exact level of statistical significance and the number need to treat/harm. Whenever possible, state absolute rather than relative risks
    - conclusions: primary conclusions and their implications, suggest areas for further research if appropriate. Do not go beyond the data in the article
- An 'Article summary' section consisting of the heading: 'Strengths and limitations of this study', and containing up to five short bullet points, no longer than one sentence each, that relate specifically to the methods of the study reported. They should not include the results of the study and should be placed after the abstract.
- The original protocol for the study, where one exists, as a supplementary file.
- A funding statement, preferably worded as follows. Either: 'This work was supported by [name of funder] grant number [xxx]' or 'This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors'. You must ensure that the full, correct details of your funder(s) and any relevant grant numbers are included.
- A competing interests statement. See this advice from the BMJ on what to include.
- Articles should list each author's contribution individually at the end; this section may also include contributors who do not qualify as authors. Please visit the ICMJE website for more information on authorship.
- Any checklist and flow diagram for the appropriate reporting statement, e.g. STROBE (see below).
- Please provide a data sharing statement such as: "Technical appendix, statistical code, and dataset available from the Dryad repository, DOI: [include DOI for dataset here].

  We recommend your article does not exceed 4000 words, with up to five figures and tables. We also recommend, but do not insist, that the discussion section is no longer than five paragraphs and follows this overall structure (you do not need to use these as subheadings): a statement of the principal findings; strengths and weaknesses of the study; strengths and weaknesses in relation to other studies, discussing important differences in results; the meaning of the study: possible explanations and implications for clinicians and policymakers; and unanswered questions and future research.

  At upload you will be asked to choose one general subject area that applies to your article – it will be published under this banner on the main table of contents. You will also be asked to select further subject headings to be used for the 'Browse by topic' section, and specific keywords for help with identifying reviewers.