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# **Workplace Bullying Among Nurses in Saudi Arabia: An Exploratory Qualitative Study**

A 152.800 thesis presented in partial fulfilment of the requirements of the degree  
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## **Abstract**

**Background:** Health-care professionals are among the groups persistently exposed to hostile behaviours in the workplace. It has been well documented that nursing staff in particular are often exposed to workplace bullying, and this is often associated with their stressful and challenging work conditions. Most research on workplace bullying has been undertaken in European countries, North America or Australasia. However, in the Arab region, particularly Saudi Arabia, there is little or no research addressing workplace bullying.

**Aim:** The purpose of this cross-sectional study was to conduct a preliminary investigation into the issue of workplace bullying among nurses working in Saudi Arabia, and gain an understanding of their experiences and perceptions of this issue.

**Method:** Thirty semi-structured interviews were conducted in five public hospitals in Riyadh, Saudi Arabia, with a sample of full-time nurses who had been employed for at least six months. The interviews covered selected concepts derived from relevant literature including work relations; understanding the workplace bullying concept; perceptions of prevalence; antecedents; targets and perpetrators; impact; and management's response. Interviews were transcribed and thematically analysed using Nvivo 10 computer software.

**Findings:** The study indicated that bullying is a prevalent problem among nurses. There are common meanings attached to bullying and bullying comprises mostly direct or indirect verbal acts. Specific targets of bullying were perceived to include new nurses, certain nationalities, and staff members who were quiet and accepting. Bullying was perceived to be the result of hierarchy and power, discrimination, the work environment, and the targets' silence. Bullying impacted

nurses through psychological outcomes and work- and patient-related outcomes. Different coping strategies, as well as different management responses, were identified in the study.

**Conclusions:** Findings from this study provide evidence for the existence of workplace bullying; participants had both experienced and witnessed bullying as they sought to fit into challenging workplaces. Overlooking the triggers of bullying might put the recruitment and retention of nurses in Saudi hospitals at risk. Management and policy makers in hospitals may benefit from a deeper understanding of workplace bullying, and could help the problem by formulating and implementing prevention strategies. This study serves as a starting point for further research in Saudi Arabia and the Arab region in general.

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# 1 Introduction

## Background

Workplace bullying is a relatively new field of study that has attracted considerable attention from both scholars and the public worldwide. Based on empirical evidence, workplace bullying has been identified as a serious social problem that has damaging consequences on those being targeted, as well as the organisation, and society in general (Einarsen, Hoel, Zapf, & Cooper, 2011). Adding to the importance of studying this issue, a group of pioneers in this field reported that the majority of workers, at some stage in their careers, will be exposed to workplace bullying either directly as targets, or indirectly as bystanders (Einarsen, Hoel, Zapf & Cooper, 2003).

The prevalence of bullying varies across industries, with some professions facing a greater risk of exposure than others (Zapf, Einarsen, Hoel, & Vartia, 2011). Nursing is one of these professions, with the prevalence rate varying in different countries: 13% in Portugal (Sá, & Fleming, 2008), 21% in Turkey (Yildirim, 2009), 27–31% in the United States (Johnson, & Rea, 2009; Simons, 2008), 44% in the UK (Quine, 2001), and 50–57% in Australia (Rutherford & Rissel, 2004). Workplace bullying, which is often called *lateral/horizontal violence* in nursing studies, has been found to have a great impact on the physical health and well-being of individuals, health-care organisations (Einarsen, 1999; Quine, 2002; Zapf & Einarsen, 2003), and patient safety (Abe & Henly, 2010; Yildirim, 2009).

Although international studies have examined workplace bullying extensively, scholars in the Arab region have not given this phenomenon much attention. For

example, workplace bullying has been explored by Western researchers, mostly in European countries (Einarsen et. al., 2003; Leymann, 1996; Rayner, Hoel, & Cooper, 2003; Zapf, 1999) with growing interest in North America (Keashly & Neuman, 2004; Lutgen-Sandvik, 2003; Tracy, Lutgen-Sandvik, & Alberts, 2006) and Australasia (O'Driscoll, et. al., 2011), but when it comes to the Arab region, and particularly Saudi Arabia, research on workplace bullying is almost non-existent. This has created a gap in the literature and hindered our understanding of this workplace issue and any potential interventions and management. The lack of such understanding also makes it difficult for employees in Saudi Arabia to recognise and react to negative behaviours, such as workplace bullying. Therefore more research and investigation is required.

### **Study purpose and significance**

The purpose of this qualitative research study was to explore nurses' perceptions, experiences, and understanding of workplace bullying, and to assess its prevalence, development, impact, and response to it, in a Saudi Arabian context. The majority of studies on workplace bullying among nurses report that nurses who have experienced bullying are more likely to leave their current workplace, or the nursing profession, as a result (Daiski, 2004; Griffin, 2004; Lewis, 2006; McKenna, Smith, Poole, & Coverdale, 2003; Quine, 2001; Rutherford & Rissel, 2004; Simons, 2006). This can impact health-care providers that are already challenged by a shortage of nursing staff (Simons, 2006). A secondary purpose was to discover if conceptualisation of bullying in Saudi Arabia is in line with the majority of studies that have been conducted in Western countries.

This study is significant because it fills a gap in the existing literature where knowledge about workplace bullying in the Arab region, and particularly Saudi Arabia, is lacking. A study is also significant when it provides an opportunity to targets and witnesses of bullying to voice their thoughts and concerns. Exploring and identifying workplace bullying in a new context adds to the importance of this study, where leaders and managers may be able to use the findings to help prevent and manage the problem.

Gaining an understanding of the impact of workplace bullying on nurses working in Saudi's hospitals may help provide direction on how to protect them and ensure their rights are preserved. Taking into consideration the staff shortages that health-care organisations face, this study's findings may provide advice on areas of concern that impact on the quality of the work environment, and result in improvements, which may produce better nurse retention.

This study explored and identified meanings and acts that were perceived as bullying; it explored the perspectives and experiences of both targets and witnesses, and the actions taken to deal with bullying. The study interviewed 30 full-time nurses working in five major hospitals in Riyadh, Saudi Arabia, using a semi-structured format.

This study adopted a qualitative research design, as this allows for an examination of participants' stories, perspectives and meanings (Taylor & Bogdan, 1998). According to Salin (2003) more qualitative research studies need to be conducted in order to advance our understanding of how workplace bullying develops. In addition, adopting a qualitative design is advised when little is known about a specific research area (Eisenhardt, 1989), which was the case in this study.

## **Research question**

This study aims to contribute to the existing body of knowledge on workplace bullying among nurses by exploring this issue in a new cultural setting. It focuses on exploring nurses' perceptions, experiences, and understanding of workplace bullying, in major Saudi hospitals, in an effort to provide detailed information about this issue. Therefore, the research study question that was addressed was:

What are the experiences and perceptions of nurses working in Saudi Arabia in relation to workplace bullying?

The following sections of this thesis are organised as follows: chapter two presents a review of the literature of workplace bullying, bullying in nursing, a general overview of Saudi Arabia as it relates to this study, and nursing in Saudi Arabia. Chapter three sets out the justification for the methodology and design used in this study, the data collection phase, and data analysis. Chapter four reports on nurses' perceptions and experiences of workplace bullying and presents them in terms of themes and categories. Chapter five discusses the findings and relevant explanations. The implications, significance and limitations of the research are presented in chapter six.

## **2 Literature review**

This literature review is divided into four sections: workplace bullying; bullying in the nursing profession; Saudi Arabia as a country; and nursing in Saudi Arabia. The chapter begins with a review of the diverse body of literature on workplace bullying, which is mainly comprised of Western studies. This section examines the definition, typology, targets' and perpetrators' status, the impact on individuals and organisations, antecedents, and management responses. In addition, attention is drawn to the impact of national culture on the prevalence of bullying, as well as reviewing the limited literature on workplace aggression in the Arab region. The second section focuses on workplace bullying in relation to the nursing profession and specific concepts that are commonly reported in nursing literature, which includes issues of definition, behaviours of oppressed groups, and bullying as a learned behaviour. The third section provides an overview of the cultural, social, and economic background of Saudi Arabia against which workplace bullying among nurses can be understood. The final section reviews the overall nursing situation in Saudi Arabia and pays particular attention to the nursing shortage and the efforts to deal with this shortage.

### **Workplace Bullying**

#### **The concept of bullying**

In the literature, there are multiple, closely related terms that are used to describe systematic aggression in the workplace, such as bullying, harassment, emotional abuse and mobbing (Mathisen, Øgaard, & Einarsen, 2012). Aside from these terms, some scholars have tried to group these behaviours into general constructs, such as

workplace victimisation (Aquino & Thau, 2009) or workplace aggression (Barling, Dupre', & Kelloway, 2009). This study will mainly focus on examining workplace bullying, which is commonly regarded as negative acts that occur on a regular basis over a long period of time (Einarsen et al., 2003).

There has been extensive debate over the definition of workplace bullying (Einarsen et al., 2011), and although there was lack of an agreed definition within the literature, some commonalities did exist. Most definitions included three elements, which were the impact on the target, negative effects, and the persistence of the act (Quine, 2001). For an action or situation to be identified as bullying, bullying behaviours must occur constantly, or on a regular basis (weekly), over a period of time (around six months). This means bullying is not a one-off event; rather it is a practice that escalates as it develops, where the target is in a weak position and becomes systematically targeted with negative behaviours (Einarsen et al., 2003). It is important to understand that it is more about the *persistence* of the bullying act, demonstrated by its frequency and duration, not the negative act itself. These continuous negative acts distinguish bullying from other similar constructs, such as conflict, harassment, and workplace violence.

This study utilised an adapted definition of bullying devised by Niedhammer, David, and Degioanni, (2006):

A situation in which someone is exposed to hostile behaviour on the part of one or more persons in the work environment which aim continually and repeatedly to offend, oppress, maltreat, or to exclude or isolate over a long period of time. (p. 252)

## **Bullying typology**

In the literature, bullying acts were diverse, and included different negative and undesirable behaviours that occurred relatively often in the workplace (Leymann, 1996). Bullying acts varied from subtle and covert, to overt acts (Lewis, 2006; Quine 2001), but were often hidden, making them difficult to identify and prove. These behaviours, according to Rayner and Hoel (1997), could be classified into five major categories (see Table 1 for examples): threats to professional status; threats to personal standing; isolation; overwork; and destabilisation.

Typically, bullying acts were described as verbal, and had a psychological effect on targets and bystanders, whereas physical aggression was uncommonly reported in studies (Einarsen, Raknes, & Matthiesen, 1994). However, this is true from a Western perspective; more research is needed to examine this issue in the Arab cultural context. It is important to note that acts bullies do not actively perform are also a component of bullying, such as withholding information like meeting dates; this adds to the complexity of examining bullying.

**Table 1**  
*Types of Workplace Bullying Acts*

<b>Category</b>	<b>Examples</b>
Threat to professional status	Belittling opinion, public professional humiliation, accusation regarding lack of effort
Threat to personal standing	Name-calling, insults, intimidation, devaluing with reference to age
Isolation	Preventing access to opportunities, physical or social isolation, withholding information
Overwork	Undue pressure, impossible deadlines, unnecessary disruptions
Destabilisation	Failure to give credit when due, meaningless tasks, removal of responsibility, repeated reminders of blunders, setting up to fail

*Note.* From (Einarsen, Raknes, & Matthiesen, 1994, p. 183)



### **Status of perpetrators and targets**

With regard to the status of the bully, Hoel, Cooper, and Faragher (2001) found that most participants in their study reported being bullied by a person with superior organisational status, or top-down bullying (74.7%), whereas only 36.7% of participants were bullied by co-workers. Similarly, in the UK and Ireland, studies found the majority of bullying was directed from superiors towards workers (O'Moore, Seigne, McGuire, & Smith, 1998). Yet a study by Einarsen and Skogstad (1996) on Norwegian employees found that all groups reported bullying equally. This indicates that bullying is not only confined to top-down bullying, rather employees at all organisational status levels are similarly at risk of being subjected to bullying (Zapf et al., 2011).

However, studies have mainly focused on examining the organisational status of the perpetrators of bullying, rather than the targets (Zapf et al., 2011). A study by Einarsen and Raknes (1997) on males employed in a Norwegian engineering plant found no difference in the experience of negative behaviours between workers, supervisors and managers. Another study by Hoel et al., (2001) on British employees, which looked extensively at this issue, also produced similar results, with little difference existing between the different groups. This indicates that all organisational levels are alike in terms of being exposed to the risk of being bullied (Zapf et al., 2011).

### **Impact of bullying**

It has been shown that workplace bullying has a considerable negative impact on targets. Such impacts could be classified into two categories: emotional and psychological outcomes; and physical outcomes. Studies have found that targets tend

to have increased levels of depression, anxiety, negative core self-evaluation (Mikkelsen & Einarsen, 2002) and burnout (Einarsen, Matthiesen, & Skogstad, 1998). Studies have also claimed that targets of workplace bullying could show severe symptoms that match those of post-traumatic stress disorder (PTSD) (Einarsen & Mikkelsen, 2003; Leymann, 1996). However, due to certain diagnostic criteria, those targets are not referred to as having PTSD (Einarsen & Mikkelsen, 2003).

Studies have shown that bullying can also have potential consequences on targets' physical health. Targets showed an increased number of stress-related complaints, such as headaches, fatigue, insomnia, stomach problems, backaches, and alcohol use (Brodsky, 1976; Lewis, Coursol, & Wahl, 2002; Richman, Flaherty, & Rospenda, 1996; Rospenda, 2002). In addition, a number of studies by Kivimaki and colleagues found that targets tend to have a higher body mass index, chronic disease, risk of cardiovascular disease, and absenteeism due to sickness (Kivimaki, Elovainio, & Vahtera, 2000; 2003).

The negative outcomes of bullying were found to impact not only the target, but also the work group as a whole. Bullying is a dynamic process that involves everyone and has a ripple effect (Coyne, Seigne, & Randall, 2000). Bystanders who witnessed bullying also reported negative health effects, such as high stress levels and low job satisfaction (Burnes & Pope, 2007; Cooper, Hoel, & Faragher, 2004; Lutgen-Sandvik, Tracy, & Alberts, 2007). Witnesses of bullying acts could therefore be considered secondary targets, as it also impacts on their wellbeing (Jennifer, Cowie, & Anaiadou, 2003; Vartia, 2001, 2003).

Workplace bullying also impacts organisations negatively. Studies have reported an increased number of work mistakes (Paice & Smith, 2009), work not completed on time (Gardner & Johnson, 2001), and low creativity (MacIntosh, 2005) among targets

of bullying. In addition, organisations could potentially suffer from decreased productivity due to absenteeism (Kivimaki et al., 2000; Namie, 2007), and reduced performance (Baillien, Neyens, De Witte, & De Cuyper, 2009; Yildirim, 2009). This in turn, will increase costs incurred by the organisation as a result of absenteeism, and incur extra costs to deal with these issues.

### **Antecedents of bullying**

In the literature, there were two main views that diverged in explaining the causes of workplace bullying. One focused on the individual factors of targets and perpetrators (Coyne et al., 2000), and the other focused on the psychological work environment and organisational climate where bullying occurred (Leymann, 1996). The majority of studies examined antecedents of bullying from the targets' perspective (Zapf & Einarsen, 2003). Since it is highly unlikely that a bully will admit engaging in bullying, it is hard to gather valid data from the point of view of the perpetrators. It is important to note that workplace bullying is a complex and multidimensional issue that involves an interplay of different factors (Salin, 2003; Zapf, 1999).

#### ***Individual factors***

##### ***Target***

With regard to a target's individual characteristics, studies have suggested that signs that signal weakness – like certain personality profiles – are significant in predicting workplace bullying (Vartia, 1996). From this perspective, targets of bullying have been linked to shyness (Einarsen et al., 1994), anxiety and depression (Zapf, 1999), low social skills (Zapf, 1999) and neuroticism (Mikkelsen & Einarsen, 2002; Vartia, 1996; Zapf, 1999). A study in the UK by Coyne et al., (2000) examined the relationship between a target's status and personality profiles. They found that the targets in their sample were less extroverted and independent, as well as being more

unstable, than those in the sample of non-victims. Their findings suggest that those who have certain personality profiles in an organisation are more likely to be exposed to bullying, and those profiles are a risk factor for bullying. In addition to personality, being the target of bullying has been related to inefficient coping (Einarsen et al., 1994) and the management style of conflict avoidance (Zapf, 1999).

### *Perpetrator*

With respect to perpetrators, the literature refers to a number of different hypotheses and explanations as to why individuals engage in hostility towards others, particularly bullying at work. One explanation that has been suggested is that perpetrators engage in bullying because of a lack of self-esteem, poor social skills, inadequate leadership skills, and behaviours related to gaining power – for example, to further one's career (Glaso, Nielsen, & Einarsen, 2009; Zapf & Einarsen, 2003). Also, perpetrators seem to show narcissistic personalities, with authoritarian and vindictive leadership styles, and to direct their anger and blame onto others (Braithwaite, Ahmed, & Braithwaite, 2008; Glaso et al., 2009). In addition, they often do not perceive their actions as damaging and harmful (Braithwaite et al., 2008).

However, these studies were all cross-sectional (looking both at targets and perpetrators), which means it is difficult to know whether the personality traits that had been delineated were inherent, or affected by the bullying (Glaso, Matthiesen, Nielsen, & Einarsen, 2007). This in turn questions the validity of accepting an individual's characteristics as the sole explanation of the development of workplace bullying.

### *Work environment factors*

The work environment hypothesis has received considerable support from studies; it examined workplace bullying and attributed such misconduct to deficits in the work

and social environment (Zapf, Knorz, & Kulla, 1996; Einarsen, 1996; Vartia, 1996). Studies have empirically examined and identified various factors in the work environment that correlate with workplace bullying, which can be presented in three dimensions.

First, role stressors related to job design, such as role conflict (Einarsen et al., 1994), low autonomy (O'Moore, Lynch, & Daeid, 2003), high workload (Zapf, 1999), job ambiguity (Vartia, 1996), forced cooperation (Zapf et al., 1996) and lack of goal clarity (Vartia, 1996), have been associated with the presence of workplace bullying. Second are factors related to the team level; these include increased competition between co-workers (Seigne, 1998), poor social support from co-workers (Zapf et al., 1996), and leadership styles characterised as autocratic, laissez-faire and task-oriented (Seigne, 1998; Vartia, 1996). Finally, on an organisational level, hierarchy and culture were found to be the most important antecedents of bullying (Einarsen et al., 1994; Rayner et al., 2003). For example, it was found that goal-oriented workplaces described as having formal power relations, task-oriented leadership styles, and directive communication, displayed greater rates of workplace bullying. Whereas workplaces characterised by supportive climates reported far lower rates of bullying (Baillien, Neyens, & De Witte, De Cuyper, 2009).

From the perspective of the work environment hypothesis, culture is perceived as a filter through which positive and negative workplace behaviours pass, and are either permitted, ignored, rewarded, or confronted, depending on the type of culture an organisation fosters (Jennifer et al., 2003).

Leymann (1996) in particular has strongly emphasised that work conditions are considered the main source of negative behaviours, and that personality profiles are irrelevant when studying workplace bullying. In his view, there is no such thing as a

‘victim personality’, but rather there are certain circumstances that encourage bullying and anyone could end up being a target. The logic behind this view is that organisations have the power to control their work environment, and all efforts should be directed at improving its quality to solve and prevent this problem from happening (Hoel & Cooper, 2001). This view is supported by studies on the work environment, which generally found that those who were targets and bystanders of bullying reported more negative work environments than those who were not bullied (Baillien, Neyens, & De Witte, 2009; Einarsen et al., 1994; Hauge, Skogstad, & Einarsen, 2007; Vartia, 1996).

#### *A combination of both types of factors*

Increasingly, scholars are recognising that bullying is a consequence of a combination of both individual and environmental factors, both of which play interchangeable roles in the development of bullying (Aquino, Grover, Bradfield, & Allen, 1999; Neuman & Baron, 1998; O’Leary-Kelly, Griffin, & Glew, 1996; Zapf, 1999; Øgaard & Einarsen, 2012). This, in turn, calls for more research to look into the experience of bullying from a multidimensional level, taking both factors into consideration.

#### **Management responses**

Research into the subject of intervention and management of workplace bullying is still scarce and is in its initial stages of investigation (Saam, 2010). Recently, studies have tried to repeatedly examine this area after research has shown that the interpersonal management strategies offered to targets are ineffective in preventing bullying incidents (Zapf & Gross, 2001). In order to achieve comprehensive workplace prevention strategies, it has been argued that primary, secondary and tertiary approaches aimed at the organisational and individual levels should be used as described below (Vartia & Leka, 2011):

- Primary stage interventions are intended to prevent bullying from happening in the first place and are typically executed at the organisational level.
- Secondary interventions are intended to resolve the bullying once it has occurred.
- Tertiary interventions provide redress directed at the individual level.

### *Primary stage*

As a first step, establishing an anti-bullying culture was found to be fundamental for any workplace prevention strategy to succeed (Duffy, 2009; Needham, 2003; Yamada, 2008). To achieve this culture, organisational commitment to cultural change is key, along with implementing anti-bullying policies through continued education and training of management, administration, and workers about the benefit and significance of a positive workplace culture, as well as giving examples of what constitutes appropriate work behaviour (Duffy, 2009).

Developing anti-bullying policies is one of the most common approaches to dealing with bullying (Branch, Ramsay, & Barker, 2013). Both practitioners and researchers have recognised the importance of developing anti-bullying policies in order to create zero tolerance for bullying, and raise overall awareness (European Agency, 2002; Hubert, 2003; Mathieson, Hanson, & Burns, 2006; Richards & Daley, 2003; Vartia, Korppoo, Fallenius, & Mattila, 2003). Aside from slight variance in researchers' accounts, there seems to be agreement on a number of topics that should be included in a policy (Salin, 2008). Generally, policies should contain a definition of what constitutes bullying and what does not, along with a statement of the organisation's promise to remove or reduce bullying, the responsibilities of managers, an outline of a complaint process, and consequences for breaching standards (Duffy, 2009; Holme,

2006; Pate & Beaumont, 2010; Rayner & Lewis, 2011; Vartia & Leka, 2011). However, a written policy against bullying on its own is not sufficient to successfully eliminate bullying (Salin, 2008). A process of communication through training and socialisation of management and staff should also be implemented (Duffy, 2009; Harvey, Treadway, & Heames, 2006, 2007; Holme, 2006; Rayner & Lewis, 2011).

### *Secondary stage*

Once bullying has developed in an organisation, conflict or dispute resolution processes, such as direct negotiation, mediation, adjudication, and arbitration might be needed (Hoffman, 2006; Fox & Stallworth, 2009). Care should be taken when using mediation, adjudication, or any form of dispute resolution, since the involvement of any third party might result in the further victimisation of targets (Zapf & Gross, 2001).

According to Ferris (2004) the effectiveness of mediation in particular is questionable due to power inequality between the targets and perpetrators of bullying; mediator lack of experience; and misunderstanding of the difference between bullying and interpersonal conflict (Saam, 2010). Therefore, organisations should give particular attention to training internal and engaging external staffing professionals, who are required to act on bullying incidents. These include human resource personnel; mediators and arbitrators; counsellors; attorneys; and union agencies (Fox & Stallworth, 2009).

### *Tertiary stage interventions*

At the tertiary level there are number of options that can be made available to targets to help them recover from the damage caused by bullying. Counselling can provide targets with help and support through the process of investigation and intervention by their organisations. A number of studies found this proved effective (Ferris, 2004;



Lockhart, 1998). However, counselling is often suitable only for short-term issues; it is not a solution for ongoing bullying (Lewis, Coursol, & Wahl, 2002; Rammsayer, Stahl, & Schmiga, 2006). Organisations should assist targets to receive counselling for any psychological outcomes, and provide access to health-care services for any physical outcomes (Meglich, Sespico, Faley, & Knapp, 2007). Training related to the issue of bullying can also assist targets to cope with, and address outcomes of bullying, such as dysfunctional teamwork and normalisation of bullying in the workplace (Altman, 2010).

### **Prevalence of bullying and national culture**

Studies have suggested that cultural beliefs and values might impact the way individuals identify with, and react to, negative acts (Hoel et al., 2001; Rippon, 2005; Salin, 2003; Tepper, 2007). Although little is known about how this might occur, it has been suggested that bullying should be examined in the context of the elements of society, such as culture, law, environment, and socio-economic factors (Lewis, Giga, & Hoel, 2011). According to Salin (2003), in some cultures bullying is actually perceived as an acceptable and useful way to get assignments and tasks done, whereas other cultures perceive it as intolerable.

Some studies have used different approaches to understand the impact of culture on organisational values, but the approach used most commonly is based on Hofstede's cultural dimensions theory. Hofstede (1983a; 1989) in his studies on 50 countries and three regions has identified four cultural dimensions related to work in which an individual's behaviours can be explained. These dimensions are power distance; individualism versus collectivism; uncertainty avoidance; and masculinity versus femininity (see Table 2 for definitions).

**Table 2**  
*Hofstede's Measures of Cultural Dimensions*

<b>Hofstede's dimensions</b>	<b>Definition</b>
Power Distance (PD)	The extent to which the members of a society accept that power in institutions and organisations is distributed unequally.
Uncertainty Avoidance (UA)	The degree to which the members of a society feel uncomfortable with uncertainty and ambiguity, which leads them to support beliefs promising certainty and to maintain institutions protecting conformity.
Masculinity (MAS)	Stands for a preference for achievement, heroism, assertiveness, and material success, as opposed to <i>Femininity</i> , stands for a preference for relationships, modesty, caring for the weak, and the quality of life. In a masculine society even the women prefer assertiveness (at least in men); in a feminine society, even the men prefer modesty.
Individualism (IDV)	Stands for a preference for a loosely knit social framework in society in which individuals are supposed to take care of themselves and their immediate families only; as opposed to <i>Collectivism</i> , which stands for a preference for a tightly knit social framework in which individuals can expect their relatives, clan, or other in-group to look after them, in exchange for unquestioning loyalty.

*Note.* From Hofstede, 1985, p. 347

In the literature, evidence suggests that bullying rates actually seem to differ based on national culture. For example, according to Mikkelsen and Einarsen, (2001) Scandinavian countries have lower bullying rates than the UK, which could be explained by Hofstede's (1980) theory regarding cultural dimensions and their impact on work values. Particularly, Scandinavian countries have low power distance, and a feminine, egalitarian culture, which may contribute to lower rates of bullying (Einarsen, 2000; Mikkelsen & Einarsen, 2001; Salin, 2001). That is because perceived power inequality is an element of bullying, and it would be expected that lower rates of bullying occur in regions that have low power inequality, such as Scandinavia, than in the UK (Mikkelsen & Einarsen, 2001; Zapf, Einarsen, Hoel, & Vartia, 2003). In

addition, the culture of the Scandinavian region is classified as feminine and places more emphasis on the quality of interpersonal relationships (Newman & Nollen, 1996), which makes acts, such as bullying, less tolerated than in masculine cultures, such as the UK, that emphasise individuality and accomplishments (Mikkelsen & Einarsen, 2001). Further investigation into the role of culture on workplace bullying is needed.

**Table 3**  
*Hofstede's Country Scores for the Arab Cluster*

<b>Cultural dimension</b>	<b>Arab Cluster</b>
Uncertainty avoidance	68
Power distance	80
Masculinity	52
Individualism	38

*Note.* From (Hofstede, 1983b)

With respect to the Arab region, Hofstede (1983) has examined seven Arab countries (Egypt, Lebanon, Libya, Kuwait, Iraq, Saudi Arabia, and the United Arab Emirates), and reported a single score on the four cultural dimensions. They all scored high on power distance and uncertainty avoidance, low on individualism, and in-between on masculinity and femininity (see Table 3). This means there is a general tendency in Arab countries to comply with authority, follow the expectations of those in superior social roles, view organisations as a 'pyramid of people', and unite with a group, tribe or other form of association (At-Twajjri & Al-Muhaiza, 1996). Although Arab countries score just slightly above average in terms of masculinity, this may seem unexpected given the strict rules and policies for women that are normally derived from Islamic principles (Fischer & Al-Issa, 2012). Therefore, it might be expected that workplace bullying and aggression would be highly prevalent in cultures where

power distance is relatively high. However, further research is needed to examine workplace bullying in this regard.

### **Studies on bullying in the Arab region**

Although workplace bullying is well documented in Western countries, studies are still scarce in Arab countries, including Saudi Arabia. Most studies that have looked at negative workplace behaviours in the Arab region focused on aggression and violence in general, with no research on workplace bullying in particular. A study by Mohamed (2002) on work-related assaults among nurses in Saudi Arabia found that more than half of nurses experienced workplace violence. Of these, 93% were exposed to offensive language, almost 33% reported verbal threats, 16% experienced physical threats, and 17% experienced sexual harassment. Similarly, a Kuwaiti study of 5,876 nurses found that 48% of the participants were exposed to verbal violence, and 7% reported physical violence in the last six months before the study (Adib, Al-Shatti, Kamal, El-Gerges, & Al-Raqem, 2002). Workplace bullying was also reported in Jordan (AbuAlRub & Al-Asmar, 2011), Lebanon (Alameddine, Kazzi, El-Jardali, Dimassi, & Maalouf, 2011), Iraq (AbuAlRub, Khalifa, & Habbib, 2007), and Egypt (Abbas, Fiala, Abdel Rahman, & Fahim, 2010). However, almost all studies on workplace violence and aggressive behaviours that were reported in the Arab region were centred on examining these behaviours in relation to the health-care sector, leaving other industry sectors lacking in both research and knowledge.

## **Workplace Bullying in the Nursing Profession**

### **Prevalence in nursing**

Internationally, workplace bullying has been identified as a major problem in the health-care sector (Di Martino, Hoel, & Cooper, 2003; Nielsen et al., 2009;

Strandmark & Hallberg, 2007). Specifically, previous studies have indicated that hostility and bullying is more prevalent in some professions, such as nursing, than others (Zapf et al., 2003; Hutchinson, Vickers, Jackson, & Wilkes, 2006). According to a study conducted by Niedl (1996), 26.6% of investigated nurses indicated that they had been exposed to hostile behaviours at least once a week over the past year. There are a significant number of studies in the West documenting the harmful issue of bullying among nurses in different countries. In a British study conducted in the health sector, 44% of nurses and 35% of other staff had been exposed to 'peer bullying' in the year prior to the study (Quine, 2001). In Australia, Rutherford and Rissel's (2004) study found that 50% of the nurses had been exposed to bullying acts at least once within the previous year. In Finland, a survey of more than 5,000 hospital workers found that 5% stated they had been bullied; 50% of those surveyed were nurses, a group that experiences the highest rates of bullying among hospital professionals (Kivimäki et al., 2000).

### **The Issue of Definition**

Research integration in the nursing literature is hindered due, firstly, to the absence of a universal and agreed term to describe systematic aggression. The second difficulty is the use of various overlapped terms in research studies (Embree & White, 2010). In nursing literature, acts of aggression or verbal assaults are seen as triggers of interpersonal conflict that develop into workplace bullying (Stevenson, Randle, & Grayling, 2006). From this point of view, workplace bullying is understood as a form of conflict and often referred to as horizontal violence, lateral violence or *oppressed group behaviour* (Hutchinson, et al., 2006). These different terms have been used in nursing literature to describe bullying between co-workers with equal status within the organisational hierarchy (Duffy, 1995; Dunn, 2003; Randle, 2003). However,

literature on bullying describes incidents where real or perceived power differences exist between the bully and the target (Yamada 1999; Jackson, Clare, & Mannix 2002). This lack of a standard and well-defined term makes it difficult to compare findings of studies from nursing research and other research areas (Johnson, 2009).

In the nursing literature there are multiple explanations of why bullying occurs in the workplace. In particular, it has been argued that bullying in the nursing profession is an incident of horizontal – or lateral – violence, an act that Freire (1971) referred to as violence directed toward colleagues with equal status who are part of an oppressed group (Curtis, Bowen, & Reid, 2007; Daiki, 2004; Lee & Saeed 2001; Simons, 2006).

### **Oppressed group behaviour**

The theory behind oppressed group behaviour, or ‘oppression’, according to Freire (1971) is that in a culture where the dominant advocate that the qualities they display are the valued ones, the dominated group feels devalued. In particular, those who are oppressed will grow to believe they are inferior, develop low self-esteem and lack pride. It is theorised that the oppressed group, instead of facing this problem – which might result in leadership retaliation – start venting their annoyance and anger on their co-nurses (Sheridan-Leos, 2008). For nurses to succeed in this type of culture they start to change in order to resemble their oppressors (Memmi, 1968), and in doing so, become ‘marginal’. They are called marginal because they are on the border of the culture they belong to (nursing), yet are not quite part of the dominant group (which could be medical staff). To sustain these behaviours, rewards and positions that have some power are given to those marginal individuals that support the view of the powerful group. As a result, leaders in oppressed groups usually support the dominant group over the culture they belong to.

However, although oppression theory has provided some understanding of workplace bullying – and various studies believe that it is the trigger of workplace bullying (Duffy, 1995; Friere, 1972; Griffin, 2004; Randle, 2003; Ratner, 2006; Roberts, 1983) – it has been argued that it is limited in providing a precise evaluation of the nursing work environment. In particular it fails to account for the number of different environmental and organisational problems that influence work conditions where bullying becomes virtually normalised and tolerable (Hutchinson et. al., 2006).

### **Bullying as a learned behaviour**

When nurses are still students or newly hired they may be socialised into the culture of bullying. Even though they may have been targets of bullying early in their career, when they have more power and status they will often become bullies themselves (Curtis et al., 2007; Daiski, 2004; Farrell, 2001; Lewis, 2006; McKenna et al., 2003). As nurses transition into the profession they start learning this behaviour from each other (Lewis, 2006). Those nurses who feel that they are incapable of changing the culture, and that bullying is contrary to what they have been taught in school about the values of caring, frequently quit their jobs within the initial few years of training (McKenna et al., 2003; Simons, 2006).

To help understand workplace bullying in a Saudi Arabian context, the section below presents an explanation of the population, religion, culture, and social structure of Saudi Arabia. It is important for the reader to understand the health-care sector, and the challenges of working in the country.

## **Saudi Arabia**

### **Culture and religion**

Workplace bullying is an international issue that can be influenced by the traditions and characteristics of certain cultural settings, and Saudi Arabia is no different. While modernisation and industrialisation have guided major changes, Saudi Arabia is still characterised as a strongly traditional culture that consists of religious and tribal institutions. The royal family, Al Saud, are monarchical rulers and govern by Islamic principles (Luna, 1998). Islamic tradition is incorporated into every aspect of living, making it the only recognised religion in this country. The Saudi government has striven to raise the standard of living of the nation, as it takes into account the religious, cultural, and moral principles that bring the diverse Saudi tribes together.

In Saudi Arabia, gender segregation is enforced by the government and endorsed by society. The genders are not allowed to mix, interact, or work together unless necessary; and separation is then ensured by allocating separate places. However, in medical schools, both genders are permitted to mix based on the law of necessity; the cost of building separate medical schools would be too expensive, and the need for female doctors to treat Saudi females will eventually become a must (Somers & Caram, 1998). Adult females are not allowed to drive or travel unless permission from a male guardian is obtained; this guardian may sometimes be younger than her.

Saudi Arabia is a highly patriarchal society, which affects women's employment and advancement in their careers. The Saudi workforce consists of only 10% women (Winckler, 2002), which is largely due to a lack of opportunities, not interest (Al-Mandhry, 2000). This aspect of society is characteristic of other Arab countries to varying degrees. As Sidani (2005) explains:



While codes and actual practice became more relaxed in some countries like Egypt, Lebanon and Iraq, other countries (e.g. Saudi Arabia) retained strict control over women [*sic*] economic and political participation. (p. 500).

A number of studies on Arab working women have attributed the low rate of female participation in the workforce to the patriarchal power of their families and general attitudes toward women (Mostafa, 2005; Jamali, Sidani, & Safieddine, 2005; Al-Lamki, 2007; Omair, 2008). These attitudes are derived fundamentally from religious and cultural norms.

### **Accelerating change**

Saudi Arabia has undergone rapid changes in its socio-economic structure as a result of the accumulation of oil wealth, which has enhanced the health and lifestyles of Saudis. Oil wealth has improved standards of living through offering free education, universities and hospitals, and a tax-free state. The government has invested large amounts of its income into advancing health care and provides free services that can be accessed by every Saudi and expatriate working in the public sector. Although health care for expatriates working in the private sector is covered by the organisations they work for, health-care funding in Saudi Arabia is mainly provided from the government budget (Al-Yousuf, Akerele, & Al-Mazrou, 2002). Since the establishment of this health-care system, Saudi Arabia has largely relied on expatriate nurses to deliver health-care services. Today there are 89,395 expatriate nurses working in Saudi Arabia (Ministry of Health, 2011).

### **Education of female Saudis**

Formal education of females started in 1959, and was opposed, at first, by the religious leaders in the country. In their view, women's education meant challenging the traditional norms where women were expected to stay home and take care of the family, a tradition linked very tightly with family reputation and honour (Al-Suwaigh, 1989). This step was perceived as a social uprising, one that would require women and girls to leave the house every day to go to school. Yet resistance did not last long, and soon enough schools for females started spreading across the country. By 1976 nearly 50% of females aged six to twelve were attending school (Parssinen, 1980). Literacy rates for both genders have increased, which could be due to the increase in schools for women and girls. In the 1970s, the female literacy rate was about 2%, rising to 48% in the 1990s, and up to 78% in 2005 (Miller-Rosser, Chapman, & Francis, 2006).

### **Nursing in Saudi Arabia**

The Saudi health-care system has been mostly dependent on expatriate nurses. Only 33.6% of the nursing workforce in all three sectors (public, military, and private) are Saudi nationals (Ministry of Health, 2011). The majority of nurses recruited in Saudi hospitals come from the Philippines and India, while the rest come from Malaysia, Australia, North America, the United Kingdom, South Africa and other Middle Eastern countries (Aldossary, While, & Barriball, 2008).

Saudi Arabia has suffered from a chronic shortage of nurses due to national and international factors. First, Saudi hospitals are highly dependent on expatriate nurses, but there is a lack of staff retention because the majority only work in Saudi Arabia temporarily in order to gain experience before moving on to developed countries,

such as the US, UK, Canada, and Australia (Alamri, Rasheed, & Alfawzan, 2006; Alhusaini, 2006). Although expatriate turnover is a critical issue that health-care managers are concerned about, no statistics have been published in regard to this matter. Second, on the national level, there are an inadequate number of Saudi nurses graduating from medical and nursing schools, coupled with an increasing number of nurses who drop out or leave the nursing workforce shortly after employment (Al-Mahmoud 2007; Al-Mahmoud, Mullen, & Spurgeon, 2012).

### **Saudisation policy**

In an effort to fill the Saudi unemployment gap, the Saudi government has introduced a national policy called *Saudisation*. This policy aims to replace expatriates working in Saudi Arabia with qualified Saudi nationals. Although the policy was issued in 1992, the health-care sector has failed to achieve the targeted number of Saudi nationals year after year. Since nursing is the largest group in terms of number of employees, the Ministry of Health (MOH) has directed its efforts to recruiting Saudi nationals, making it the largest sector engaged in the Saudisation process (Aboul-Enein, 2002).

The main challenge the Saudisation policy faces is the image of nursing care perceived by Saudi nurses themselves, and society in general. Considerable research into the perception of nursing among Saudi nurses has suggested that it is affected by the role of religion, sociocultural values, the perceived negative image of nursing, challenging work conditions, and lack of flexible work options to balance work and family life (Rawaf, 1990; El-Sanabary, 1993; Tumulty, 2001; Al-Omar, 2004; Miller-Rosser et al., 2006). A study by Jackson and Gary (1991) found that the nursing profession was ranked at the bottom of the list of suitable jobs for women. The study attributed this to the following factors: limited financial rewards; inflexible working

hours; and the type of work involved. Although some of the religious and social implications are making Saudisation challenging for the nursing profession, the economic need to work is attracting Saudi women into the nursing workforce.

Recruitment and retention of nursing professionals is a key challenge in countries like Saudi Arabia where the supply of domestic nurses falls short of the demand of health-care providers (Bozionelos, 2009). In particular, organisations that rely on expatriate employees face a critical situation because of the global nursing shortage (World Health Organisation, 2006). This means that retaining nurses is crucial, as well as attracting a domestic supply of nurses. In terms of retaining nurses and improving patient care, several studies have highlighted the role of creating better care environments, improving staffing, and shifting to a better educated workforce (Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Shamian & El-Jardali, 2007).

### **Health-care facilities**

The MOH is responsible for the health-care sector in Saudi Arabia. According to the Ministry of Health (2011), the total number of hospitals in the country was 415: 251 operated by MOH, 34 by other government agencies and 130 by the private sector. The total number of nurses working in all three sectors was 134,632, of which 33.6% were Saudi nationals. The MOH was responsible for 60% of the total number of hospitals; the remainder was comprised of military hospitals, Ministry of Interior hospitals, referral hospitals for special care – such as King Faisal Specialist hospital – and private hospitals (Ministry of Health, 2011).

### **Salaries**

The nursing force in Saudi Arabia is diverse and multinational, which means contracts, salaries and benefit packages vary accordingly. Contracts are based on each

country's standard of living and dependent on the staff member's country of origin. For example, experienced nurses in the Philippines earn between US\$110–250 monthly, while in the US even newly hired nurses earn US\$3000–4000 monthly (Overland, 2005). This difference is reflected in the salaries of nurses from different countries when they sign their contracts in Saudi Arabia. All expatriate nurses benefit from tax free wages, annual round tickets to their home country, furnished accommodation, health insurance, and free transportation to the hospital from housing compounds (as females are not allowed to drive in Saudi Arabia) (Miller-Rosser et al. 2006).

### **Language of communication**

Most health-care professionals working in Saudi Arabia, including nurses, communicate in English, although most patients and their families are Saudis who speak Arabic as their mother tongue (Aldossary et al., 2008). The issue is that many of the expatriate nurses working in Saudi Arabia do not have English as their native language, and are not proficient in speaking Arabic (Simpson, Butler, Al-Somali, & Courtney, 2006). A study by Mebrouk (2008) emphasised the benefits of patients and national nurses communicating in Arabic: increased patient and family satisfaction and better health-care outcomes.

### **Literature Review Summary**

The first part of this literature review outlined the foundations of bullying as a negative aspect of current workplaces. It covered different types of bullying, the organisational status of targets and perpetrators, the impact of bullying, and interventions. Attention was also drawn to the role of culture on the rate of bullying, along with examples of countries that had different rates of bullying. The lack of

relevant research in the Arab region has been highlighted, whereas the topic has been fairly well covered in Western countries, attracting considerable research effort.

As the largest and most visible profession in health care, nursing has been identified as one of the groups most exposed to workplace bullying. The lack of standard, or agreed terms, in the nursing literature to describe systematic aggression, such as bullying, has made it hard to compare studies within the nursing profession with other professions. Workplace bullying in nursing is mostly understood in terms of oppressed group behaviour. Although this theory provided a useful explanation on why bullying develops, it does not answer all the questions.

This chapter has also provided an overview of the social, cultural and economic backgrounds through which workplace bullying among nurses in Saudi Arabia might be understood. Emphasis has been placed on the nursing shortage Saudi Arabia faces, as well as the Saudisation policy and the challenges this produces.

This review of the literature has highlighted the lack of research into workplace bullying in the Arab region, and in Saudi Arabia in particular. It has also provided the base from which this research study was developed. The literature that was reviewed provided evidence that there is a need for qualitative studies to explore the perceptions, understanding, and experiences of the diverse Saudi nursing population. There is a need to involve different industry sectors, in addition to the health-care sector, in studying workplace bullying in Arab countries, a region that has been previously excluded from studies on workplace violence. There is also a need to examine the impact of workplace bullying on the recruitment and retention of nurses in Saudi Arabia.

# 3 Methodology

The purpose of this chapter is to justify the use of qualitative research design as a methodological framework. It covers a review of the research method and design suitability, and a discussion of participants and the sample. In addition, this chapter gives a detailed description of the data collection phase, ethics considerations, and data analysis.

## **Study Aim**

The purpose of this cross-sectional research study was to conduct a preliminary investigation into the issue of workplace bullying as perceived and experienced by nurses working in major hospitals in Saudi Arabia. This study sought to gain new insights into workplace bullying in the nursing profession and uncover a new area of research. The study was intended to ‘fill a gap or void in the existing literature and examine the topic more thoroughly and give a voice to the victims and witnesses, which is lacking in the current literature’ (Creswell, 2005, p. 64).

## **Research Design Overview**

### **Qualitative approach**

The main purpose of this research was to serve as an introductory investigation into workplace bullying as perceived by nurses working within major hospitals in Saudi Arabia. The study sought to explore the experiences and perceptions attached to workplace bullying by nurses. Qualitative research provides researchers access to people’s understandings, perceptions, and experiences (Taylor & Bogdan, 1998) An exploratory qualitative design was adopted because there have been a relatively small

number of in-depth qualitative research studies exploring workplace bullying from the perspective of nurses (Sunderland & Hunt, 2001; Hutchinson, Vickers, Wilkes, & Jackson, 2010). Prior to this study, there had been no specific examination of workplace bullying among nurses in the Arab context, particularly in Saudi Arabia. Therefore, there is limited knowledge on the nature and prevalence of this problem. Little is understood, for example, about whether nurses are exposed to workplace bullying or not, and what factors contribute to its development.

While several studies in nursing research have found a wide range of behaviours that describe workplace bullying (Lewis, 2001, 2006; Quine, 2001), there have been a limited number of qualitative studies into the experience of bullying (Yildrium & Yildrium 2008; Hutchinson et al., 2010). The lack of a descriptive context for investigating the experience of workplace bullying makes recognition and intervention difficult. In particular, those who experience or witness bullying may not be aware of the full extent of bullying behaviour, especially subtle and covert types of bullying acts. Therefore, this study was designed to address this lack by building an in-depth qualitative understanding of the perceptions and experiences of nurses working in Saudi Arabian hospitals, and to deliver detailed descriptions of the nature of the problem under study.

### **Why interviewing?**

According to Byrne (2004), interviewing is a suitable method for exploring people's attitudes and values, as it provides access to their understanding, judgements, experiences, and how they make sense of events. Since this research was centred around understanding what is it like for nurses to be bullied, what their experiences have been, and what meaning they attribute to these experiences, in-depth interviewing was determined to be the best method of inquiry (Seidman, 2012).



Therefore, semi-structured interviews were utilised to grasp the full picture of workplace bullying as perceived and experienced by nurses working in Saudi Arabian hospitals.

## **Sampling Strategy**

### **Access and recruitment**

Initially, before commencing data collection, I submitted a research proposal to recruit participants via a particular government-owned, agency hospital in Riyadh. I was then granted approval to conduct the study. Based on this approval my formal sponsor, the Saudi Ministry of Higher Education, and – on behalf of my sponsor – the Saudi Cultural Attaché in Auckland, allowed me to travel to Saudi Arabia to undertake fieldwork. However, when I arrived there I was surprised to discover that miscommunication between the Hospital Institutional Review Board (HIRB), the Nursing Department, and me (the researcher), made this attempt a failure.

The issue was that the Nursing Department was hesitant to allow me to conduct the study. This hesitancy was based on concerns about anonymity, despite the clearly stated assurance I had made in the initial proposal I had submitted to the HIRB, that no reference would be made to the hospital, or to individual participants, in order to protect their identities. A representative of the Nursing Department from the HIRB reported that my interview questions seemed ‘like an interrogation of nurses’. They requested that I find a local supervisor working in the hospital who would be willing to be involved in the study to ensure the confidentiality of the hospital and participants. Luckily I found a supervisor who expressed interest, had relevant experience in this study area, and was willing to act as a local supervisor. However, after at least three weeks negotiation with the HIRB and Nursing Department, I was

informed I did not have permission to undertake a study of the nursing population, even with the help of the supervisor, which was a disappointment. The local supervisor advised me to apply to another branch of the same hospital in Jeddah, another city. Although this hospital welcomed me to do the study there, personal, financial, and time issues meant pursuing this option was not possible. Therefore I had to formulate a contingency plan in order to achieve my research goals and remain independent of any connection that might result in the progress of the study being hindered, or in suppression of publication of the findings.

Therefore, I decided to change my initial plan and recruit participants by advertising through social media, such as Twitter and Facebook. I also used *snowball sampling* to trace additional participants. Flyers and posters were created and disseminated through my personal contact and social media accounts (see Appendix A). These contained a brief description of the study and my contact details. Flyers and posters did not use the term ‘bullying’; instead the term ‘exploring workplace behaviours’ was used to refer to the study. It was hoped that this would help prevent preconceptions about the research and reduce any sample bias resulting from only those who had had experiences with bullying agreeing to participate in this study.

Data were collected through the use of semi-structured interviews over a period of ten weeks. Participants were recruited using *theoretical sampling*, a data collection process guided by emerging theory instead of predetermined population size (Draucker, Martsof, Ross, & Rusk, 2007). In this study, an initial sample was chosen and then the data were initially analysed before selecting another sample in order to enrich the categories emerging from the data. This process was continued until ‘data saturation’ was reached, or to the point where no new information was gained from sampling more people (Ritchie & Lewis, 2003). Initially, a sample of 10 participants

were interviewed and the interviews were transcribed and analysed. Interviews were then continued until the sample size reached 30 nurses in total, and this was where I decided to stop the data collection phase.

This study also used the criterion sampling method of *purposive sampling*. This involved selecting nurses via a set of pre-determined criteria to ascertain their suitability (Silverman, 2000). This was useful as it added to the depth and value of the understanding gained about workplace bullying among nurses in Saudi Arabia (Patton, 2002). All participants were selected from Saudi Arabian hospitals and had to meet specific criteria. The nurses needed to be:

- Nursing full-time,
- Employed for at least six months, and
- Working in Riyadh city.

The rationale behind choosing nurses that were employed for at least six months was that in the literature, for a situation to be considered bullying in most academic studies, negative acts must occur frequently (e.g. weekly), and over a long period of time (at least six months).

## **Participants**

A total of 30 full-time nurses in five major hospitals in the capital city Riyadh, in Saudi Arabia, were chosen purposively to participate in this study. From these five hospitals, two were directed by the MOH, and the rest were directed by government-owned agencies (see Table 4). The majority of participants were female (28 nurses) and only two were male; although gender distribution is not balanced, it is representative of the Saudi nursing population, where the majority of nurses are

females (McLaughlin, Muldoon, & Moutray, 2010). The selection of nurses was made to ensure male nurse participation, as well as representation of a range of different nationalities and age groups (see Table 5).

**Table 4**  
*Hospitals*

<b>Variable</b>	<b>Hospitals</b>	<b>Nurses</b>
<b>Hospital</b>		
Government-owned	2	4
Other government agencies	3	26

**Table 5**  
*Gender, Nationality and Age Group*

<b>Variable</b>	<b>Nurses</b>
<b>Gender</b>	
Female	28
Male	2
<b>Nationality</b>	
Saudi	11
Filipino	10
Malaysian	3
Jordanian	2
Czech Republican	1
New Zealander	1
South African	1
West Indian (did not specify further)	1
<b>Age group</b>	
20–30	12
31–40	11
41–50	5
51–60	2
61 & over	0

Participants were mainly staff nurses (23 nurses), two were patient-care assistants, and the remaining six held senior clinical positions and had some leadership role in the workplace. Participants were working in a range of different clinical areas (see Table 6). The experience level of the nurses ranged from 1 year to 30 years, with an average of 11 years. Selecting nurses with diverse experience meant that it was more likely the research question would be considered from a range of different

perspectives (Patton, 1987; Adler & Adler, 1998). The variety of genders, age groups, nationalities, positions and settings contributed to a richer understanding of the issue under study.

**Table 6**  
*Positions and Clinics/Wards*

<b>Variable</b>	<b>Nurses</b>
<b>Position</b>	
Patient Care Assistant (PCA)	2
Staff Nurse (SN)	23
Charge Nurse (CN)	2
Clinical Nurse Coordinator (CNC)	1
Nurse Manager	2
<b>Clinic/Ward</b>	
Operating Room (OR)	7
Outpatient Department (OPD)	4
Neonatal Intensive Care Unit (NICU)	4
Paediatrics	2
Administration Nursing	2
Trauma	2
Radiation therapy	1
Labour and delivery	1
Emergency Room (ER)	1
Plastic surgery	1
Critical care	1
Positron Emission Tomography and Computerised Tomography (PET/CT)	1

## **Ethics and Consent**

Due to the sensitivity of this topic there was a chance that some participants who had experienced bullying might have felt some emotional discomfort as they recalled incidents of bullying. Therefore participants were informed during the briefing that they could terminate the interview at any time, and there was no obligation to say anything they felt uncomfortable with. Counsellors external to the hospitals were contacted and their approval was obtained to provide participants with their contact details and counselling services if needed (see Appendix B).

Participants were recruited on a voluntary basis to ensure that only those participants who wanted to discuss their views and experiences were interviewed. A written consent was required from participants with their full names, signature and date (see Appendix C).

### **Ethics approval**

Full ethics approval was obtained from the Massey University Human Ethics Committee in Auckland, New Zealand (see Appendix D). Also, prior to data collection, ethics approval was obtained from one of the major hospitals in Riyadh, Saudi Arabia where I intended to conduct my study. However, due to the complications mentioned above, this approval was not utilised.

### **Materials**

Each interview began by asking participants to describe how they perceived their work relationships, in order to ascertain how satisfied they felt with their relations with others. Then they were asked about the term *workplace bullying* and what meanings or associations they had with the concept. This provided a general idea of whether they had some knowledge of, or were aware of this issue. Then they were given a definition of workplace bullying as follows:

A situation in which someone is exposed to hostile behaviour on the part of one or more persons in the work environment, which aims continually and repeatedly to offend, oppress, maltreat, or to exclude or isolate over a long period of time (Niedhammer et al., 2006, p. 252)

Each participant was asked if they recognised bullying and whether it occurred in their workplace. This allowed for a comparison between their responses before and after they were given the definition. The following questions asked them to describe whether they thought it was happening (or not), and why; to whom it was happening and why; and who was responsible and why. They were also asked about the effect they thought it had on targets and the people around them. By asking those questions I hoped to gain a full picture of their perceptions and experiences of the issue. Finally participants were asked to describe what actions had been taken in regard to workplace bullying and potentially what could be done to deal with it effectively. At the end of the interview, participants were encouraged to add anything they thought was important to help understand workplace bullying among nurses in Saudi Arabia. Copy of the interview guide is attached in (Appendix E).

## **Procedure**

After interested nurses contacted the researcher, an information sheet about the study (see Appendix F) was either emailed directly to them or, if they wished, a brief description was given over the phone. After they agreed to participate, a time and a place were chosen depending on the participant's preference. Interviews occurred outside the workplace and in the participant's personal time to ensure confidentiality of the participants and privacy of the content of the interview. Interviews took place in several locations including the participants' own homes, cafes and restaurants, their housing lobbies, and quiet public areas. Interviews were conducted only when it was certain that participants had made an informed decision and written consent was signed. Interviews were semi-structured and lasted for approximately 30–50 minutes, although participants were welcome to talk longer if they wished.

For each interview I prepared a copy of the information sheet, a consent form, and the participant's demographic sheet. The file with these documents also contained my question guideline and a written definition of workplace bullying. For those who preferred to do the interview in Arabic, a translated version of the definition was prepared along with the interview guideline. Interviews were recorded using a digital recorder, except for one participant who did not wish to be recorded; therefore notes were taken instead.

Prior to the start of the interviews, participants were given a printed copy of the information sheet to read and encouraged to ask any questions they may have had about the study. If they agreed to proceed with the interview, they were asked to sign and date a consent form with their full names. Participants were required to specify on the consent form whether they agreed to have the interview recorded or not.

At the beginning of each interview, I reminded participants that there was no right or wrong answer and that the whole purpose of the study was to gain some understanding of their perceptions and experiences of workplace bullying. In addition, a socio-demographic checklist was partly filled at the beginning of each interview with the date, location, and participant code (see Appendix G). At the end of the interview participants were given the sheet to fill in the remainder of their information.

During the course of the interviews I tried to systematically follow the question guideline; however, the sequence of questions was kept flexible depending on the participants' responses. Careful probing was utilised in order to provoke detailed accounts and to encourage participants to reflect on their perceptions and experiences of workplace bullying, as well as to clarify any unclear issues.



### **Interviewing male nurses**

As an interviewer I was aware of the sensitivity of interviewing participants of the opposite sex, particularly in a gender-segregated country, such as Saudi Arabia. Therefore, the arrangement was that I would only interview male nurses in public places near the hospitals they worked in. This was because people are more accustomed to seeing males and females (mainly medical and health staff) mix and interact in public near the hospital, and this would protect me, and the participants, from any public interference or discomfort.

### **Transcribing and Translating**

I started transcribing some of the interviews during the data collection phase; however, about two thirds were transcribed after the completion of this phase. In total, transcribing took about two weeks, with each interview taking an average of three to four hours. Interview voice recordings were transcribed using computer software (ExpressScribe) that had been recommended by a research colleague.

For each transcribed interview, the participant demographics, interview location, date of interview, and the participant code were added to the top of each document. Codes were generated depending on the sequence of the participant number, gender, and hospital group (e.g. 23F OG). While transcribing, pauses, gestures, and emotional expressions indicated by changes in voice tone were included for reference. All transcribed interviews were checked against the voice recordings for any mistakes.

The majority of interviews were conducted in English. However, three Saudi participants preferred to do the interviews in Arabic, as they felt more comfortable speaking their native language. To minimise the risk of losing the meaning of the participants' accounts when translated into English, I used the original Arabic

transcripts for data analysis, and then translated those parts of the interviews that would be used in the findings section of my report.

## **Data Analysis**

This study used *thematic analysis* for the qualitative data that was produced, in order to find, analyse, and report themes that appeared in the data (Boyatzis, 1998). In particular I used *template analysis* to thematically analyse the data, facilitated by a software package called Nvivo 10, which is designed for qualitative data management. The advantage of using Nvivo is that it allows the researcher to sort, connect, and match the data to answer the research question, and be able to access the original texts or interview transcripts (Bazeley, & Jackson, 2013). According to King (1998), template analysis, in particular, involves creating a coding ‘template’ that summarises the main themes the researcher finds important, and arranges them in a meaningful way. The coding structure emphasises hierarchical coding where broad themes contain narrow emerging ones.

### **Developing the template**

The first step in analysing the data was developing a priori, or predefined themes, based on the interview guide. The aim was to reduce the amount of data by developing broad categories using codes generated from the interview question guide (King, 1998). This yielded ten priori themes (see Table 7). The basic assumption behind developing these themes was that I expected to find information that related to and covered these areas, since workplace bullying literature had centred on those aspects.

The transcribed interviews, which yielded about 260 pages, were then entered into Nvivo 10 software. The process of coding began with reading a set of interviews and

labelling the data using the priori themes, where I dragged meaning units to the appropriate theme. Meaning units are defined as ‘words, sentences or paragraphs containing aspects related to each other through their content and context’ (Graneheim & Lundman, 2004, p. 106). Codes were added and modified each time a new concept emerged from the data set. For example ‘bullying typology’, ‘perpetrators’, and ‘effect of no bullying’ were some of the broad themes.

**Table 7**

*Priori Themes*

<b>Questions</b>	<b>Priori themes</b>
How would you describe the relationships at work?	Level of satisfaction
Have you ever heard of the term ‘workplace bullying’ before? What does it mean to you?	Meanings associated with bullying
Do you think this happens around your workplace?	Prevalence
Why do you think it is happening, or not happening?	Antecedents
To whom is it happening? Why?	Targets
Who do you think is responsible for the bullying? Why?	Who is responsible?
What effect does this have on people working in the hospital?	Impact
What is currently done in relation to workplace bullying?	Current interventions
What could have been done to deal with it effectively?	Possible interventions

After analysing all interview transcriptions and developing the template (see Table 8 for an example), a process of reflection and discussion with other researchers in the field and deliberation in light of research findings from the literature took place. This finally resulted in the formulation of the themes categories that best answered the research question of the phenomena under study.

**Table 8**

*Examples from the Template*

<b>Example from the Template</b>	<b>Meaning units</b>
<b>1. Impact</b>	

1.1 Psychological outcomes on the individual		
1.1.1	Depression	‘Basically during that time I felt really depressed I don’t know where to go and I don’t know whom to consult.’
1.1.2	Sense of isolation	‘Seating in the room doing her reporting does not want to mix with others or talk even if she got up, she just quiet.’
1.1.3	Fear	‘Scared to have a mistake, and scared to go and talk to her because as she is powerful.’
1.2 Work- and patient-related outcomes		
1.2.1	Making mistakes	‘You will be out of mind always. So you will do mistakes, carrying orders or giving medications.’
1.2.2	Leave the workplace	‘Because other people giving them hard time they resigned after the three months orientation, or some of them they finish only the one year contract then leave.’

## Conclusion

This chapter has laid down the justifications for using a qualitative design as a methodological framework for this study. It included a detailed description of the steps in the research process, starting from the choice of semi-structured interviews to the difficulties this research faced in gaining hospital access and recruitment. It described the process of considering the ethics involved in the study and gaining the necessary approvals. Finally, the data collection procedure was set out and the data analysis technique was discussed. The next chapter will look at the findings from participants’ responses.

# 4 Findings

The findings reported in this chapter are based on 30 semi-structured interviews with Saudi and non-Saudi nurses working full-time, for at least six months, in five major hospitals in Riyadh, Saudi Arabia. Comparisons were made between the accounts of the different groups of nurses, and between some of their individual socio-demographic characteristics. Direct quotes from the transcribed interviews are used where needed to illustrate and explain the findings, which adds to the analysis and supplements the descriptions. In order to protect the anonymity of both the participants and hospitals, details about specific programmes and identifiable information have been removed from participants' direct quotes.

## **Workplace Relations**

The 'how would you describe your work relations?' question was intended to be the starting point of the interview, and to get the participants warmed up to the topic. Generally most participants indicated that they were satisfied with their workplace relations. They mostly referred to it as being a friendly environment, and working for the team: '...we get on well. All about team work, yup, it is good' (Participant 20F OG). However some of the expatriate nurses mentioned that they had struggled in the beginning, but as time passed and they learned the rules and procedures of the workplace and Saudi culture, their relationships began to change. One nurse reflected on her experience when she first came to Saudi Arabia:

Actually when I came here ... it was like cultural shock because it is completely different ... [now] I started to get use to work [with] other nationalities ... I found it very interesting because it is multicultural and ... they give [me] different experiences (Participant 30F OG).

However, a few (three) nurses were unhappy with their relationships. For example, one participant was upset about racial discrimination, saying that 'There is a lot of discrimination but it is the same job. Not really [satisfied]. Salary-wise it is not okay; they [Western nurses] are higher than us' (Participant 4F OG).

## **Prevalence**

The majority of participants (26 nurses) had either witnessed, experienced or even been bullies themselves at some stage in their career, as nurses working in Saudi Arabia. Although bullying acts often occur behind closed doors and are hard to identify, participants still reflected on incidents of bullying. One participant explained, 'I have experienced it myself. I can say I am still experiencing it to some extent' (Participant 18F OG). Another nurse commented that, 'Yea in that definition, I encountered some of this but not me' (Participant 25M OG). Some perceived it to be low: 'Yea. I will say it happens. It is not high percentage but it is happening' (Participant 10F OG), and some thought it was only related to work: 'In my workplace I know it is only regarding about the work, related with work only' (Participant 27F OG).

**Table 9**

*Interpretations of Bullying Behaviours: Power Dominance, Intimidation, and Verbal or Physical Harassment*

<b>Sample of nurses' responses</b>	<b>Meaning</b>	<b>Nurses</b>
<ul style="list-style-type: none"> <li>• 'Maybe that who force their opinion on. I guess who force you to do something they want you to do' (Participant 17F OG).</li> <li>• 'It could be imposing their opinions or imposing their dominance, something like this. My direct manager could force his opinion by telling you to do things you don't want to do. He could be autocrat with you, will be a dictator' (Participant 14F G).</li> <li>• 'I can say what I found with some of the people they are bossy they try to use the power and maybe the environment' (Participant 30F OG).</li> <li>• 'Bullying is bullying. You know somebody being powerful over you like taking your power' (Participant 18F OG).</li> <li>• 'Sometimes if you are more experienced in this unit and there is a new nurse, it is like you are abusing them in one way or another. Like by telling them some orders' (Participant 5F OG).</li> <li>• 'Especially if you are new in the hospital usually the seniors would be abusing you. For example, lots of workloads' (Participant 6F OG).</li> </ul>	<b>Power Dominance</b>	13
<ul style="list-style-type: none"> <li>• 'My understanding of bullying is that intimidating others working with you in the area for many reasons: either you lack the trust, to stop people from asking questions or you lack knowledge, skills, jealousy a lot of things' (Participant 10F OG).</li> <li>• 'They will bully you just to intimidate you, to threaten you. I am your superior you have to respect me' (Participant 22F OG).</li> </ul>	<b>Intimidation</b>	5
<ul style="list-style-type: none"> <li>• '(Bullying) means anyone who [has] been verbally harassed physically harassed, and sort of caught in the spot like they sabotage their work or shouted at' (Participant 20F OG).</li> <li>• 'For me bullying is like harassment either by verbally or by behavioural' (Participant 1F OG).</li> </ul>	<b>Verbal or Physical Harassment</b>	4

## Interpretations of Bullying Behaviours

Study participants perceived bullying behaviours differently. This difference could be explained by the uniqueness of a bullying experience and how each person came to create meaning around these experiences. However, there was a pattern in their responses that could be categorised into three types as follows: power dominance; intimidation; and verbal or physical harassment. The study participants did not specifically mention anything about the frequency or duration of the bullying; rather emphasis was on the negative acts themselves, and the motives behind them. Four participants had not heard the term workplace bullying before, hence did not have any meaning associated with it. This could be due to language differences, as most of the nurses who were interviewed did not have English as their first language (see Table 9 for some of the nurses' responses and corresponding categories).

For the rest of the participants, bullying meant: passing on their work to others; making fun of others; and being unprofessional (see Table 10).

**Table 10**  
*Additional Categories of Interpretation of Workplace Bullying*

<b>Sample of nurses' responses</b>	<b>Interpretation</b>	<b>Nurses</b>
<ul style="list-style-type: none"> <li>• 'Want to like, fewer assignment jobs which is supposed to be for her, she wants you to complete her job, it is bullying' (Participant 4F OG).</li> </ul>	<b>Passing on Their Work to Others</b>	2
<ul style="list-style-type: none"> <li>• 'Bullying is making some fun out of somebody attitude or many reasons and everything, but people sometimes don't like or find it different' (Participant 2F OG)</li> </ul>	<b>Making Fun of Others</b>	1
<ul style="list-style-type: none"> <li>• 'Just like seeing things personally not really in regards to the work relationship' (Participant 7F OG)</li> </ul>	<b>Being Unprofessional</b>	1



## Bullying Behaviours

The nurses' descriptions of the impact of bullying enabled the division of bullying acts into two main categories: threats to personal standing and work-related behaviours. See Table 11 for the list of behaviours.

**Table 11**

*The Division of Bullying Behaviours into Two Categories Based On Nurses' Impact Statements*

Bullying behaviours	Nurses
<b>1. Threats to personal standing</b>	
Shouting and bad language	8
Rumours and gossiping	5
Laughing at you	3
Ignoring	2
Putting people down	1
Patient throwing things	1
<b>2. Work-related bullying acts</b>	
Not using English at work	6
Difficult assignments and loads	6
Reporting mistakes to manager	5
Favouritism	4
Giving orders	4
Excessive monitoring of work	3
Manager not listening	3
Low-level tasks	2
Sabotaging work	1
Refusing holiday leave	1

### Threats to personal standing

Many nurses reported that they had experienced or witnessed bullying in the form of abusive language and humiliation. Several nurses described being shouted at, for example: 'Our head nurse shouts at us a lot loudly, when it wasn't even our fault' (Participant 20F OG). Some have been humiliated by being laughed at, or talked to in a demeaning way, for example: 'Every time I endorse [hand the patient over] they

make jokes or make fun of me. So I was thinking did I do something wrong?’ (Participant 8F OG). Another nurse went on to say, ‘Sometimes they will say in Arabic words and she will understand [*ghabiyah*] that means you are stupid’ (Participant 24F OG). Other nurses have mentioned that rumours were spread about them and people talked behind their backs. One nurse reflected on one of the bullying incidents she witnessed, where one nurse got bullied to the point that they started ‘... [talking] on Facebook and chat ... and chatting with other nurse[s] about this nurse. This I feel it is destroying her reputation’ (Participant 15F OG).

Although all bullying acts reported by nurse participants were mainly psychological in nature, one nurse reported witnessing a physical bullying incident involving a nurse and a patient. This nurse reflected, ‘One [Saudi] male patient threw urine on another nurse. She was a Filipino [nurse]. She cried. And without words this patient threw urine’ (Participant 11F G).

### **Work-related acts of bullying**

Many nurses have felt, or witnessed, acts of bullying that were related to work. According to study participants’ descriptions, Filipinos were a common source of bullying against those around them, through speaking their own language and thereby excluding others from social dialogue. One of the nurses stated:

People tend to isolate you. They will be talking in whatever language they know that you cannot understand. It is another way of disrespecting somebody and isolating, which is part of bullying. Especially if somebody does something that they know they are not supposed to be doing, and then they will turn and defend it and say we are not talking about you or saying anything negative about you it is just personal. How can

it be personal but you are at work?! You are supposed to be discussing work. It is not an easy issue to deal with (Participant 18F OG).

Others have been bullied through excessive and difficult workloads that left them feeling upset and annoyed. For example, ‘They will put lots of workload if they know I am the one who is working just to make me frustrated’ (Participant 1F OG). Others experienced being watched and having their mistakes reported to their managers. Nurses who were new were given orders and little space to act in their own way. One nurse explained:

[The bullies] will search for your mistakes especially just to make you stressful in the workplace. You will just keep looking. [They will tell you] don’t do like that, do this. Follow us: we keep doing this for so many years. You are new you cannot find your way. Just copy us and after that you will find your way (Participant 25 M OG).

Some nurses felt that managers did not listen to them and were not available when they needed them to discuss their issues. For example, a nurse whose father had died and who went to her manager for holiday leave explained how her manager treated her:

If you have any problem and go to her [the nurse manager] she will not entertain you. She will just tell you do you have any appointment? Why just come in like this you must get an appointment first. I cannot entertain you even in case of emergency like this, and she will just hold the door like that [wave her hand] (Participant 3F OG).

## **The Characteristics of Targets**

Nurses have repeatedly reported that those who were new to the hospital, specific nationalities, and those who were quiet and accepting were most vulnerable to bullying. The following will explain each issue, illustrated with participants' quotes.

### **New or different**

A common theme in participants' interviews was the exposure to workplace bullying when they were still new and transitioning into the hospital system (13 nurses). Their experiences were often negative, especially when being new meant adjusting to fit into a new system, and they felt helpless and powerless. One nurse exemplified this experience when she said, 'You don't have the power to defend yourself. You just want time to pass and you want to learn so you have to low your pride sometimes' (Participant 25M OG). Many nurses were not aware that they had been bullied at that time; it was only when they looked back, after they had transitioned into their new workplace, that they recognised the bullying. For example, 'From the time this person will be adjusted to the system of the work that he might realise that what the older one is doing to him is not good' (Participant 21F OG).

Being 'new' does not refer only to a fresh graduate nurse, it also includes anyone who is a newcomer to the hospital and who has nursing experience from elsewhere. This transition is also harder for most nurses because the majority are expatriates coming from different countries and cultural backgrounds, learning the local language and cultural norms, while adjusting to the new job and its challenges. One nurse reflected on this:

When I came here as a newcomer in Saudi Arabia of course I need to have an adjustment especially on what is called transcultural relationships. Then I need to speak in Arabic, then there are different policies and procedures to be followed so that time I still need to adjust for workloads (Participant 26F OG).

Nurses who were perceived to be different, either through belonging to a minority group, or by simply refusing to engage in what others were doing, were more vulnerable to bullying. For example, team leaders and those who did not speak the same language as the majority in the unit were bullied more.

#### **Nurses having specific nationalities**

Many nurses (9 nurses) seemed to think that bullying was often directed toward nurses with specific nationalities. In particular, nurses who were from Asian countries, such as the Philippines, India, and Pakistan, were more likely to be bullied than others. Some nurses attributed this to how others perceived them: ‘They feel they are lower class or something’ (Participant 30F OG). Saudi families are largely dependent on domestic help from countries such as the Philippines and India, which might explain why ‘they are thinking that these people are the help for them because of this class of grouping staff’ (Participant 8F OG). Therefore they start to either ask them to do some things that are not part of their jobs, or to talk to them in an unacceptable manner. One nurse gave an example of this:

In the bullying case, if the Saudi staff go for a break ... she want the Filipinos or whoever nationality to take care of her patient. The worst thing is she will leave her patient to the Filipino staff with the patient passing motion that time or that their diaper is wet. She

knows already maybe 15 minutes before her break. She thinks I'll leave [the patient] and she will cover me. [This is] bullying indirectly (participant 8F OG).

However, bullying directed toward these nationalities was not only confined to local nurses, they were bullied by other nationalities as well. Some nurses thought that there was a cultural aspect to why these specific nationalities got bullied more. Nurses mentioned that those nurses 'Will say for everything yes, whatever is it. They are afraid to ask about their rights ... maybe they are scared to lose their jobs' (Participant 24F OG).

However, some nurses reported being bullied specifically by Filipino nursing staff for different reasons. Some of the bullying occurred through the constant use of non-English in the workplace, which tended to isolate those who did not speak their language. Others thought it was because they were usually the majority group and had dominance in the workplace.

### **Quiet and accepting**

Those who are perceived to have quiet personalities and seemed to be accepting of whatever others did to them were subject to more bullying than others (14 nurses). The bullies were perceived as being selective in choosing a target, and it was usually the quiet types of nurses whom they targeted. They would start bullying them to make them do what they want. One nurse described this succinctly when she said, 'Let say I am the bully when I saw you can't voice what you feel. Yea I will take advantage on you to make sure what I want I can achieve' (Participant 8 F OG).

Five nurses indicated that bullying could happen to anyone, it all depended on who the bully thought they could victimise. It could be a junior, a senior, a doctor, or even the head nurse.

## **The Development of Workplace Bullying**

### **Hierarchy and power**

#### *Perceived threat to perpetrator's position*

In this section the views of study participants were divided into two groups: Saudi locals and expatriate nurses. The reason for the separate treatment was because Saudi nurses had different, unique reasons as to why they were perceived as a threat.

#### *Saudi nurses*

In particular, Saudi nurses felt that they were bullied by their expatriate superiors because of a sense of threat to their positions (five nurses). Therefore, they turned to bullying in order to hinder the Saudi nurses from progressing and to make them quit their jobs. As one Saudi nurse put it:

Maybe they thought because we are Saudis we are really challenging their positions. They want to just make us like feel bad about ourselves that maybe we will leave the work. There will be no chance for them (Participant 1F OG).

Another Saudi nurse thought that because:

We are developing so fast ... for me I am in one year and now I am a team leader ... for them they spend six years and they are just ordinary nurses (Participant 25M OG).

However this same nurse commented on how expatriate nurses are scared to lose their positions saying, 'I think this is the trigger for bullying. They are scared of Saudis to take their places. I don't know from where this belief comes, because we are few.'

Another nurse thought it might be because 'we will become better than them or because most of us we are graduated as bachelor science not as high diploma as most of them' (Participant 28F OG).

#### *Expatriate nurse*

Five expatriate nurses also thought bullying happened because the bullies felt at risk of losing their positions: nurses in senior positions would put down, and badly treat their subordinates in order to protect their own jobs. This was especially thought to be the case if a highly qualified, new nurse was hired, because it is thought, 'Some day she is going to take my place ... and that is where bullying starts. They will start bullying you up to the point that you will get out' (Participant 22F OG). It was believed that nurses in specialised positions would not tolerate teaching new nurses because of the perceived threat to their employment.

#### *Seeking to gain power and control*

Some nurses' responses (14 nurses) indicated that the enduring battle for power between health professionals, including nurses and doctors, progressed to prolonged bullying in the workplace. Perpetrators of bullying were typically reported as nurses in senior positions (11 nurses), doctors and surgeons (6 nurses), older nurses (5 nurses), co-workers, and in some cases, patients, attendants and visitors (4 nurses). The nurses, in their interviews, referred to being put down by the perpetrator just to prove that they were better and more experienced. One nurse talked about her experience with a nurse who was once the head nurse, but later resumed being a staff



nurse. This person would treat the nursing staff as if she was still the head, giving them orders and dismissing their opinions. She reflected, saying,

When we work, the high tasks she will be the one doing it, the rest like organising stuff, needle injections like these she will let me do them. So she is the good level and I am the lower (Participant 13F G).

Typically, senior nurses would demand respect from new nurses and expect them to follow their orders without question; this preserved the status quo. For example, 'They say they are already senior from you, we are better than you. So whatever I say you must follow, you don't have the right to question anything' (Participant 27F OG).

Study participants reported that surgeons and some specialty group doctors had created themselves an image designed to distance them from the nursing staff; some would then take advantage of this and bully the nurses. Some nurses believed that, 'Some of the surgeon doctors are thinking they are of course superior, because they have higher education than the nurses, they try to preside (Participant 30F OG). Surgeons would usually shout at nurses if they were not satisfied with the nurses or report them to their managers. One nurse, who went through a bullying experience by a doctor, explained:

What he did to me is that he shouted at me. I responded that you have no right to do such thing to me. He shouted at me again so I shouted back. He did not respond, but the next day he communicated with my manager that I am not a good nurse. So they are giving me all those difficult patients and the difficult loads (Participant 19M OG)

### **Aggravated by discrimination**

In the interviews, some of the nurses referred to bullying being motivated by discrimination. Since hospitals have diverse nationalities working together, this has implications for how each group perceives the other and how they will be treated if they end up in a minority group. Discrimination occurred in different forms because of favouritism, wage differences, the negative image of Saudi nurses, or through being a female.

#### ***Favouritism***

One form of discrimination was the use of favouritism toward those who belonged to the same nationality. Nurses (4 nurses) would be bullied and denied some of their rights in order to please those whom the manager, or person in charge, favoured. For example,

One girl was told that she had her name down for annual leave and [then] she was told she couldn't have it because she does not overtime, and the nurse gave it to one of her own nationalities (Participant 20F OG).

Further, prejudice could be expressed through discriminatory hiring practices, where only those who fitted a particular cultural background were hired. Some perceived these acts as racist: 'I noticed some also they are very racial ... nurse managers like Australian she likes the same. They staff who are also Western' (Participant 3F OG).

#### ***Wage differences***

Four nurses mentioned the differences in wages based on nationality. Some nationalities were on lower salaries, although they all did the same work; this

offended the lesser paid. Those who received higher salaries felt that it was fair because salaries were relative to what a nurse would receive in their home country, and everyone was happy when they first signed the contract. Some of those who were not paid as much were not happy (after they signed the contract), and felt discriminated against. Nurses who were paid more reported being bullied through such acts as being assigned to higher workloads, or being left to do the job alone. For example, 'Because I am white and Western and got more money than they did I got the heaviest assignments, the busiest assignments, things like that' (Participant 20F OG).

#### *Negative image of Saudi nurses*

Saudi nurses (six nurses) in particular felt that they were being stereotyped as 'lazy', '[not wanting] to work', and 'always absent', which affected how other nurses perceived them. One Saudi nurse explained that the reason Saudis were perceived as not wanting to work was because Saudi nurses asked for too many rights. Such requests were generally made to balance their work responsibilities and family commitments; others in their work environment did not always recognise that they were under cultural pressure. In her response she says,

So I need to request – this is my right to request – it says three to four days. Other nationality [nurses] they are coming here just for working so they don't usually have their families. So I request four days this one will affect my evaluation, it will affect my work, and it will affect even their idea about me. Because I am asking lot of rights and they are not asking (Participant 23F OG).

She also reflects on her Saudi nurse colleagues that have been bullied because of the stereotype of Saudi nurses:

One of the things about the Saudi girl I was telling you about, she was always under supervision. So when she is the charge for the duty [the bully], she said I cannot work, because all the time I am stressed. I know she is supervising, looking at the files, and like that. They are all the time trying to find mistakes on Saudis, because they have this idea that they don't like to work (Participant 23F OG).

However, there are two sides to this matter: one is that some Saudi nurses, who were hard-working, felt they were overshadowed by the overall negative image that had been created about Saudi nurses. Alternatively, expatriate nurses felt that they were being indirectly bullied by Saudi nurses when the Saudi nurses did not finish their work, or were not there when needed, creating overload and pressure on others. One nurse reflects:

If I would describe bullying I would probably use them [Saudi PCAs] more because of the lack of proper work ethic and it can translate into bullying you know: not wanting to coordinate, not wanting to do what they need to do, not showing up when they should, not being around when you would like them to. [You would be] looking for them and they are just gone. If you say where were you? You are in long break! They would explode sometimes. I think in Saudi Arabia people feel – as I said – that if they are Saudis there is nothing that can be done about it. That is how people feel. I don't know if that is true all together (Participant 17F OG).

### ***Being female***

Some Saudi nurses felt discriminated against for being female in settings where male Saudi managers could abuse their powers and request personal favours. When the nurses refused to comply, they started bullying in numerous ways. One nurse stated:

It is hard to talk about this topic, but sometimes a person would ask you something or wants a favour that could be something personal and you refuse, especially [if] he is your direct manager and he is a male, when you don't give him the personal things that he requested which are not related to work, everything will be against you. Everything, your holiday leaves, rumours will spread, and lot of things (Participant 14F G).

### **Work environment**

Eight nurses attributed bullying to a difficult work environment where there were excessive workloads, understaffing, or a high-stress work unit such as Surgery, the Emergency Room, or the Labour and Delivery Room. One nurse reflected on her experience working in a surgery unit:

Like for me my experience ... this surgery is so long, like it takes more than nine hours ... and the next day they put me in something heavy also, another surgery it is heavy ... I cannot have enough time for resting ... the way they assign us I think it is unfair (Participant 28F OG).

Due to staff shortages, nurses in some units were assigned to a very high number of patients, which was frustrating for the nurses as this placed them under constant pressure. Some nurses even left the workplace as a result. For example,

According to our allocation all wards [are] supposed to have one nurse for three patients only. But what happened now only three nurses for 14 patients. So many nurses are resigning here so maybe they cannot take the bullying (Participant11F G).

What happens in this kind of context is that perpetrators start to bully the people around them in order to minimise the pressure and workload they are under. Nurses reflected on how bullying was a way to release workloads onto others, and to escape duties.

Maybe it is the workload for the nurses is too much sometimes. So they cannot finish their work. So this is the time they think about the way how to releases their work, how to get away from their responsibility. So they put it on people (Participant 9F OG).

### **Targets' silence**

Six nurses reported that bullying might result from a passive coping mechanism, specifically, not speaking up. Such coping mechanisms, in the view of some nurses, were likely to encourage perpetrators to continue bullying, knowing that the target would not speak up to stop the bullying. For them, allowing the bullying was the main trigger of the problem, because it gave the bully power to continue. For example, 'If somebody feels you are not strong yourself of course they might abuse this one, they

might continue' (Participant 30F OG). One nurse, who had been through a bullying situation, also thought one of the triggers lay within certain individuals:

From the person itself. If you do not allow it will not happen, like for me. Although it happened, I counter up with it. So my purpose of that is for not to happen again to others or for [the bully] to repeated to others (Participant 19M OG).

## **Impact of Workplace Bullying**

Workplace bullying impacts different nurses in different ways. This impact is divided into two categories: psychological outcomes for the individual; and work- and patient-related outcomes.

### **Psychological outcomes for the individual**

#### *Depression and sense of isolation*

The terrible psychological impact of bullying is evident. In their narratives ten nurses often referred to being depressed and having a sense of isolation after being exposed to bullying episodes. Nurses reflected on how they felt, that there was no one to turn to, and stated they did not know where they could get help for their situation. For example, one nurse reflected on their bullying experience:

Basically, during that time I felt really depressed. I don't know where to go and I don't know whom to consult (Participant 19M OG).

One Nurse reflected on a particular nurse colleague who she witnessed being exposed to bullying said that ‘I see her seating in the room doing her reporting does not want to mix with others or talk even if she got up, she is just quiet’ (Participant 8F OG).

### ***Stress and anxiety***

Seven nurses felt that they were more stressed as a result of experiencing bullying, and also more anxious. They felt that they must be more thorough in front of the person who was bullying them, and this made them feel ‘under stress most of the time’ (Participant 24F OG). Nurses who went through this reflected that ‘it puts [you] in more doubts if I really know this and it cause you to be anxious’ (Participant 18F OG). Many nurses reported that they had cried in the workplace as a result, and some, even while they were recalling the incidents, had teary eyes and the tone of their voice changed.

### ***Fear and hurt***

Eleven nurses described how bullying made them feel fearful and emotionally hurt. These nurses feared that confronting the bully would make matters worse and they would get bullied more. Reflecting on their experiences these nurses talked about how they were ‘scared to have a mistake, and scared to go and talk to her [the bully] because she is powerful’ (Participant 7F OG). These nurses thought that if they talked about what happened, nurses in senior positions would not help them because they were more powerful. So the nurses just absorbed it as time passed. One nurse reflected, ‘I need them to help me sometimes. So I just keep it. I did not go talk to them. I was scared of them; they are my seniors’ (Participant 8F OG). Nurses would even avoid asking the bully any questions, even if they wanted to because, again, they were afraid, especially when they felt nothing was going to change anyway. When



nurses observed that no action would be taken, they tended to become defensive and sometimes angry. Some think,

It changes your attitude, like you become defensive about everything even if they mean well. You will always think that they are there to attack you' (Participant 18F OG).

One nurse even thought that going through bullying experience would 'maybe push him or her [the target] too hard and become very angry and become aggressive and start becoming bully themselves (Participant 10F OG).

#### *Loss of self-confidence and self-esteem*

Being on the receiving end of bullying appears to reduce nurses' self-confidence and self-esteem. Seven nurses reflected on how bullying effected their personal standing and how they were made to feel helpless and inferior. For example,

Especially the bully will say you are very dumb and very stupid and you will put that in your brain wherever you go whatever you do, you will think yourself as dumb and stupid (Participant 22F OG).

This was especially true when bullying occurred in front of others. As one nurse said,

Sometimes the bullying [can] go to an extent where it is done openly, where other people can see or hear and it ... somehow affect your being. I mean become self-conscious and

you know people are seeing, people are hearing things and it can really affect your self-esteem (Participant 18F OG).

### **Work- and patient-related outcomes**

Threats to patients' safety as a result of bullying were a serious concern. Nine nurses reported making more patient care mistakes because they were stressed over an incident of bullying. For example,

You will not be focused in certain cases or procedures. You will be out of mind always. So you will do mistakes, carrying orders or giving medications (Participant 29F OG).

It was surmised that quality of patient care will eventually decrease as nurses continue experiencing problems with concentration.

Five nurses reported that they were not motivated to work, and did not want to come to work, because of bullying.

It make you don't like to go to work or, when you see your assignment with some of these people, you don't want to work, you are not enjoying your work (Participant 28F OG).

Bullying also decreased job satisfaction, resulting in nurses leaving or thinking of leaving the workplace, or transferring to other units or hospitals. Nine nurses said that

they had either transferred to other units as a result of being bullied, or had witnessed people transferring or resigning. Some resigned within the first year of work 'because other people giving them hard time they resigned after the three months orientation, or some of them they finish only the one year contract then leave' (Participant 28F OG). For some, transferring to another unit was the only possible solution to deal with the bullying in their situation:

But what happens for me is that they are connivance [socially connected] with the supervisors so I don't have any option but to go out of the unit (Participant 19M OG).

Bullying also disrupted group and team dynamics and created an overall negative work climate. Four nurses talked about how rumours and gossiping took a toll on team trust, which eventually resulted in a dysfunctional team: 'It does effect teamwork because you kind of retreat so it can be, not such a happy place for some people' (Participant 20F OG). Bullying, in the view of some nurses, was a problem that developed from the lack of, or ineffective, communication. In a profession like nursing, which is based on teamwork, patient care will be jeopardised as a result.

Bullying, in the view of some study participants (five nurses), was a learnt behaviour, where seniors who were training new nurses used bullying to enforce the rules and procedures of the workplace. Therefore some nurses learnt to engage in, or tolerate bullying, because bullying was normalised in these teams. For example,

The new ones, the majority ones who get bullied really in the unit, after months, few years, they become the bullies unfortunately. Not all of them, but some of them copy what they went through (Participant 10F OG).

Later, when those nurses have gained more experience and entered senior positions, some will misuse their authority, knowing that bullying will be tolerated. In addition, when bullies have some form of organisational alliance they will continue bullying others because they know they will be protected. One nurse reflected on his experience of bullying by saying,

I reported the incidents but after that I did not see any action. I did it legal and did a write up. But the doctor is still there. I don't know what happened, but I heard that not only me who felt bullied from him. I don't know why he is still around patients. Maybe because he was a backup of (x) this is like side by side, you know politics ... what happens for me is that they are connivance [socially connected] with the supervisors so I don't have any option but to go out of the unit (Participant 19M OG).

## **Responses Toward Workplace Bullying**

Since participants were working in different hospitals there were some differences in their responses regarding management of workplace bullying. Some hospitals were proactive and were taking the issue seriously, while others were blind and passive. In order to protect the confidentiality of the hospitals, details about specific programmes and any identifiable information has been removed from participants' direct quotes.

Overall, there was general agreement on some of the individual coping strategies and management responses toward workplace bullying.

### **Targets' coping strategies**

1. Tried to ignore the bully (do nothing)

Nurses described how they coped while being bullied, or how those whom they witnessed being bullied coped. Several said that they dealt with the situation passively by trying to ignore the bully. Many nurses, especially Filipino and Indian staff, chose avoidance of bullying, rather than confrontation or seeking help. See Table 12 for examples of some nurse responses:

**Table 12**  
*Examples of Nurses' Coping Strategies (Avoidance)*

<b>Examples of nurse responses</b>	<b>Participant code</b>
'If somebody shouted at us [Filipinos] we can deal with it in a passive way.'	(Participant 19M OG)
'[Filipinos] will just say fine. Will cope with it.'	(Participant 15F OG)
'You know like sometimes us Filipinos you don't want any problems. So you just [say] ok ok will just leave it like that.'	(Participant 3F OG)

This implies that many nurses who are targets of bullying remain silent, and this is part of being bullied. Some chose to change their workplace – 'one of my solutions is just to get out of that unit' (Participant 7F OG) – either because they were scared to face the situation, or because they had exhausted all possible ways to deal with the bullying.

2. Reported to a Human Resources or line manager, or made a formal complaint

Some nurses were more proactive and sought help through reporting bullying incidents to Human Resources, a line manager, or by filing a formal complaint. For example,

If sometimes it is out of my control or sometimes I cry so I have to bring it to my nurse manager. So one time, my nurse manager she calls me and other staff and asks what is really the problem. So that is the time we talked [about] it openly (Participant 8F OG).

However, most nurses were not satisfied with management action because it was usually only verbal and no serious action was taken against the bullies. For example, 'We already reported and told them everything, but there is nothing done. They couldn't change even the environmental, just stick to it' (Participant 4F OG).

Another nurse said,

Lot of incidents reports writing per day but now they stopped to write it because it is useless. We are action verbal really. Nothing really in paper, nothing well be documented in paper. And sometimes most of the problem is solved by verbal (Participant 24F OG).

In only a few cases did they witness a bully being dismissed or disciplinary action being taken against them. This implies that bullying is often tolerated. One nurse reflected on an incident:

You can make a letter complaint, but just only sometimes they will make actions; usually they don't. It happens they do and then that certain person was sent home, because this nurse manager was good when it comes to work but has attitude problem (Participant 3F OG).

Some nurses think that if the bully is a Saudi local than there is no point in reporting them because no action will be taken against them, and they are usually protected by the hospital system. Expatriate nurses think that Saudis have power because it is their country, and they know how to assert their rights if they experience a situation like bullying.

In one case, a Saudi nurse talked about a bullying incident from a non-Saudi doctor who used to bully other nurses verbally. This Saudi nurse took legal action against him after he verbally abused her. The incident involved the doctor using a swear word directed at the nurse, which she perceived as very offensive and not acceptable in a Muslim country, such as Saudi Arabia, especially since she was female. In her description she said,

After the investigation I received a letter from [the] security department saying they will not renew his contract because that contract should be renewed after three months. We [the hospital] will not renew for him his contract and he is not welcome after he finishes his contract with them (Participant 24F OG).

Nurses would usually initially report to someone who is in a higher position: so if the bully was a staff nurse then they would go to the charge nurse, or the nurse coordinator; if the bully was a charge nurse, they would report to the nurse manger. If no action was taken they would report to a higher authority.

### 3. Confront the bully themselves (assertiveness)

Few nurses have had tried to confront the bully themselves. One nurse described her experience saying,

There was this one lady ... all of a sudden she just started to ignore me ... then I just felt this now too much ... I approached her. She was like shocked ... to be honest with you, I think she is doing it on purpose. She was doing it to get a reaction from me (Participant 18F OG).

Although there were a few who would confront the bully themselves, the majority felt more comfortable confronting the bully after they had reported any incidents to a manager. Both parties would then be asked to talk about what happened and discuss the situation. The manger would 'ask that both parties to talk in one room and separate' (Participant 7F OG) as a way to resolve the bullying.

## **Management responses**

### 1. Supportive manager

Some nurses mentioned having a supportive manager who acted like a moderator, protecting them from the negative impact of bullying. Although having a supportive manager did not eliminate the bullying acts, nurses reported being more satisfied with work and perceived their work environment as more positive. Having a supportive



manager could act as a mediating, or moderating factor, for those who go through bullying experiences.

One nurse, who was affected by bullying incidents when she was new at the hospital, reflected on how the current unit she works at compared to the old one in terms of having supportive management:

But now at least we are able to stop it here because all our new nurses are under protection. You can really make sure that they got a good preceptor [instructor] to guide them. When they are on the floor we try to give them the easy patient, give them the good partner who can mentor them ... when [there is a bully on the floor] we will keep an eye on her so that we will know what she is doing ... so at least we hand over to the charge nurse to just keep an eye especially if a new girl is there. You will tell the charge nurse [to] keep an eye on this new girl (Participant 9F OG).

Those who did not have supportive managers, but had managers who did not listen or do much when nurses reported to them, were generally more affected by the bullying and were considering changing their units or workplace.

## 2. Workshops

In only two hospitals, nurses mentioned the use of workshops, and other related programmes, to train and educate nurses in an effort to raise awareness and assist nurses with how to deal with bullying. The same two hospitals were the only ones that had policies related to workplace bullying in place that most of the employees were aware of. However, nurses from these hospitals still reported that there was bullying in their workplace and management action was not satisfactory.

### 3. Not focusing on the issue

Four nurses reported that bullying was not generally a matter of concern for the units or even the hospital management, and that there was no action in regard to this issue. Whether there was a formal mechanism to deal with bullying or not, the fact that nurses were not aware of it and felt that they had no organisational support for workplace bullying, added to the problem.

### **Responsibility for Bullying**

When nurses were asked whom they thought was responsible for the bullying they experienced or witnessed, their responses varied. What is interesting is that none of the participants mentioned patients, attendants or visitors as responsible, although four nurses reported bullying incidents by patients or attendants. However, the majority thought that the hospital, or management, had a responsibility to create and enforce rules and raise the awareness level of hospital employees in particular, as well as patients and attendants, in relation to bullying.

**Table 13**  
*Responsibility for Bullying*

<b>Who is responsible?</b>	<b>Nurse (N)</b>
The bully	9
The manager	6
The target	4
The supervisor	3
Everyone is responsible	2
The hospital	2
The charge nurse	2
The nurse coordinator	2

## **Summery**

The findings in chapter four revealed that workplace bullying was prevalent within the workplaces the participants have worked in and that they associated the meaning of bullying with the idea of power or force, intimidation, and verbal or physical harassment. Targets appeared to be mostly new nurses, those who came from the Philippines and India, and those who tended to be quiet and accepting. The interviewees believed that bullying could be triggered by a struggle for power, the threat to perpetrators' positions, discrimination, working conditions, and targets not speaking up. Bullying has caused targets physiological and work-related consequences. Responses towards the issue of workplace bullying as perceived by the participants were categorised into two groups: targets' coping strategies and management responses. Targets' coping strategies included trying to ignore the bully (doing nothing), reporting to HR or line manager or making a formal complaint (seeking help), or confronting the bully on their own (assertiveness). Management responses included supportive manager, workshops and policies, and not focusing on this issue. The following chapter will discuss these findings in more detail with support from existing literature.

# 5 Discussion

It has been well documented that workplace bullying has devastating consequences on targets, bystanders and the organisation as a whole. Although there has been substantial research into the issue, little is known about its relevance in the Arab region. Therefore, this study explored workplace bullying in a Saudi Arabian context.

This study involved the exploration of workplace bullying as experienced by nurses working in Saudi Arabian hospitals. An understanding of the prevalence and nature of workplace bullying was obtained, along with identification of any similarities with studies conducted in Western countries. It is hoped the findings of this study will provide hospital management and policy makers an initial understanding of the issue, in order to help recognise, and ultimately discourage, workplace bullying. Chapter four provided a summary of the main findings, and an overview of the topic under consideration.

## **Interpretations of Workplace Bullying**

This study has focused on the perceptions and experiences of workplace bullying as described by thirty hospital nurses. The participants were asked at the outset to describe what the term workplace bullying meant to them. The findings in chapter four indicated that participants seemingly understood the term, and each description appeared to be closely related to their personal observations of either their own experience of bullying, or as a witness of bullying.

The majority of nurses associated the meaning of bullying with the idea of power dominance, intimidation, and verbal or physical harassment. This is consistent with current literature on what constitutes workplace bullying, as most definitions refer to negative acts, including intimidation, verbal and physical assaults, along with an element of power (Lyons, Tivey, & Ball, 1995; Randle, 2003; Gilmour & Hamlin, 2003). In particular, participants mentioned power more frequently, which may indicate that power imbalance plays a major role in workplaces such as nursing. Formal power differences between employees are one likely source of this imbalance (Salin, 2003); other sources can be the result of other individual, situational or societal characteristics (Cleveland & Kerst, 1993).

The emphasis participants placed on power and dominance to explain what bullying meant for them might indicate that bullying is far from being only an interpersonal concept, but rather that organisations play a major role through policies and procedures (Lewis, 2003; Liefoghe, 2003; Liefoghe & Mackenzie Davey, 2001, 2003; Lutgen-Sandvik, 2006; McCarthy, 2003). The reference to subtle acts, such as being given orders, or imposing opinions on others, indicates that, although some would regard this as an autocratic management style, participants perceived it as bullying (Liefoghe & Mackenzie Davey, 2003).

None of the participants clearly mentioned the persistence or frequency of the acts; rather, it was implied that the effect of bullying lasted for some period of time. In the literature, the two elements of bullying that have been mostly agreed upon are: (a) that it is an act of direct, or indirect, negative workplace behaviour, and (b) the negative effect on the target (Rayner & Keashly, 2005).

## **Bullying Behaviours**

Participants reported a number of different bullying acts. These included acts classified as threats to their personal standing, like shouting, gossiping, and laughing at them, and acts that were related to work roles and tasks, such as high workloads, not using a language all team members could understand, and reporting mistakes to the manager. These categories support previous research when comparing typology of workplace bullying in other industries (Beswick, Gore, & Palferman, 2006; Yildrium & Yildrium, 2008). Although bullying behaviours are commonly reported in literature as being psychological in nature, one nurse in this study mentioned a patient physically throwing liquid at her (urine). Studies also confirmed that workplace bullying can take different forms: verbal, nonverbal, and physical (Baron & Neuman, 1998; Einarsen et al., 2003).

It is interesting to note that many nurses perceived the constant use of language other than English in the workplace as indirect bullying. Most healthcare organisations in Saudi Arabia, due to their multilingual and diverse workforce, practise an English – only rule in the workplace. The majority of healthcare workers, including nurses, speak English as a second, or foreign, language. Research on diversity and language management suggest that although communications in a second shared language may positively influence knowledge sharing and performance, using a second language may result in a fragmented and less personal social environment because of the unease and discomfort of speaking a foreign language (Keating & Egbert, 2004; Tange & Luring, 2009). Interestingly the findings of this study suggest that socially, nurses using a language other than English isolated those around them who did not speak the same language, creating hostility in the workplace.

## **Characteristics of Targets**

Targets were mostly new nurses, those who came from the Philippines and India, and those who tended to be quiet and accepting.

A number of participants reported being bullied when they were new, or had witnessed new nurses being bullied in the workplace. This is supported in the literature, where it has been found that new nurses are at major risk of bullying (Begley, 2004, Boychuk-Duchscher & Cowin, 2004; Hegney, Eley, Plank, Buikstra, & Parker, 2006; McKenna et al., 2003; Randle, 2003), and that 60% of new nurses resign within their first year of practice (Griffin, 2004). Bullying may occur in these situations because new nurses are often younger and less experienced than their colleagues (Curtis et al., 2007; Desley, Plank, & Parker, 2003; Farrell, 2001; Jackson et al., 2002; Leiper, 2005; Randle, 2003). Also, senior nurses commonly engaged in bullying when there was a unit culture that supported testing a new nurse's ability to cope well with difficulties as a rite of passage. As a result, bullying becomes a learned practice by those who tolerate and accept it as part of their value system, and this further influences the unit culture (Lewis, 2006).

Many nurses seemed to think that bullying is often directed towards nurses of specific nationalities, particularly nurses from Asian countries, such as the Philippines, India and Pakistan. The literature indicates that group-based differences, such as race and ethnicity, often seem to be the reason for individuals being bullied (Branch, Ramsay, & Barker, 2013). Race and ethnicity are 'visible markers' of power and status, and can result in vulnerabilities (Salin, 2003). In this study, nurses referred to those specific nationalities as being more subject to bullying because of the stereotypical idea that people who are part of this social group are domestic maids. This prevalent

perception might be linked to Saudi Arabia's socio-economic development as a result of the discovery of oil in the 1970s. Saudi families from different social classes have at least one domestic maid, and most maids are workers from Far East Asia. Negative stereotypes toward people of different races and orientation can lead to the mistreatment of those social groups (Cortina, 2008).

In their interviews participants also mentioned that certain personality profiles, such as being quiet and submissive, made these people more vulnerable to bullying. Participants talked about targets who demonstrated the typical behaviours of bullied people, such as being silent, acting passively, and generally accepting of negative behaviours. This is in line with existing, research literature on targets of workplace bullying, which identifies that targets seem to be submissive, lacking in social competence and self-esteem and, in addition, could also be overachievers and conscientious (Coyne et al., 2000; Zapf & Einarsen, 2003). However, this does not mean the targets should be blamed, but rather, those who appear quiet or submissive should be protected. Identifying any personality factors as potential triggers of bullying does not disregard the role of organisations and professionals dealing with workplace bullying in taking responsibility to prevent and manage such problem (Zapf & Einarsen, 2011).

### **The Development of Workplace Bullying**

Nurses who were interviewed in this study, believed that bullying is triggered by a struggle for power, promotion or to maintain one's place in the hierarchy. Other identified triggers included discrimination, working conditions, and the target's silence. From the different responses of participants as to why bullying occurs in the workplace, there seemed to be an interplay between individual antecedents and those



existing in the work environment. This confirms the growing recognition in the literature of the need to examine the phenomenon of bullying from a multilevel perspective, taking into consideration, both individual and environmental factors (Aquino et al., 1999; Neuman & Baron, 1998; O'Leary-Kelly et al., 1996; Zapf, 1999; Salin, 2003)

## **Hierarchy and power**

### *Threat to position*

Some nurses attributed bullying to their superiors sensing a threat to their positions and jobs. Saudi nurses in particular thought that this sense of threat comes from the Saudisation policies that are currently being implemented in the health-care sector, which aim to replace expatriates with qualified Saudi nationals (Aboul-Enein, 2002). However, expatriates suggested that bullies generally engaged in hostile behaviours to protect their jobs when they felt a threat. This is line with a study by D'Cruz and Noronha (2010) that looked at the role of human resource management, and reported that perpetrators resorted to bullying those who they felt would surpass them, in an effort to hinder their progress and damage their image in the workplace. Perpetrators may bully those who threaten their sense of superiority (Yamada, 1999) or those who cause them to feel weak (Namie & Namie 2000).

### *Power struggle*

The findings of this study indicated that participants seemed to perceive perpetrators of bullying most commonly as nurses in senior and managerial positions. The present findings seem to be consistent with those of other studies, which frequently reported that perpetrators of bullying are commonly managers and senior nurses (Vessey, DeMarco, Gaffney, & Budin, 2009; Yildirim, 2009; Dellasega, 2011; Hegney, Eley,

Plank, Buikstra, & Parker, 2006). In addition, bullying was perceived by participants as being not only limited to nursing staff: doctors and surgeons, and in some cases patients, attendants, and visitors were common sources of bullying. Studies have also reported that both physician-to-nurse, and patient- and family-members-to-nurse bullying are also common (Birman, 1999; Farrell, Bobrowski, & Bobrowski, 2006; Hegney et al., 2006).

The struggle for power among both nurses and physicians suggests that there is a misuse of authority and processes to intimidate others into doing what the perpetrator wants. The literature indicates that nursing remains largely hierarchical, and studies have identified this as a factor that allows and maintains a bullying culture (Curtis et al., 2007; Daiski, 2004; Farrell, 2001). Young (1990) argued that the hierarchical nature of the majority of workplaces dominates employees by eliminating their sense of control, consequently leaving them feeling helpless. Bullying, in this sense, is used as a way to preserve order and support current power structures (Daiski, 2004; Hutchinson et al., 2006).

### **Discrimination**

Some of the nurses, in their interviews, talked about bullying that they believed was motivated by discrimination. Participants described such behaviours as favouritism towards a particular group or nationality, thinking of Saudi nurses in terms of a negative stereotype, or unequal wages. The content of the nurses' interviews provided evidence of discriminatory and racist bullying, hence it can be argued that bullying in some cases was triggered by discrimination and racism. This type of bullying should be particularly tackled as a form of discrimination or racism (Allan, Cowie, & Smith, 2009). Saudi Arabia lacks legal measures against discrimination, and there are no

official laws that ban such acts. However, in the current nursing research there is very little exploration of cultural differences, or any examination of influences on work relations, such as race, gender, social class, and ethnicity (Culley, 2006; Mulholland, 1995).

### ***Favouritism***

Findings from this research suggest that favouritism, as a form of workplace bullying, is used widely within the nursing profession in Saudi Arabia. The literature indicates that certain leadership styles, characterised by favouritism, have been linked to workplace bullying (Agervold & Mikkelsen, 2004; Magerøy, Lau, Riise, & Moen, 2009; Skogstad, Einarsen, Torsheim, Aasland, & Hetland, 2007). The multidimensional model of workplace bullying developed by Hutchinson, Wilkes, Jackson, and Vickers (2010) suggests that informal alliances within an organisation can serve as a means through which bullying is permitted, as legitimate authority is misused. Informal connections within the workplace can function as protection for perpetrators, and enable them to misuse this power, knowing that bullying will be tolerated.

In Saudi Arabia, and Arab countries in general, the use of '*wasta*', an Arabic word for connections or relations, is widespread (Loewe, Blume, & Speer, 2008). '*Wasta*' is basically favouritism, which can be defined as providing preferential treatment to relatives and friends at work (Hutchings & Weir, 2006). Studies have widely considered favouritism and personal connections in employment as a key influence on many Arab's decision-making (Abdalla, Maghrabi, & Raggad, 1998; Ali & Al-Kazemi, 2005; Kalliny, Cruthirds, & Minor, 2006). Favouritism is a form of corruption, and is toxic to the workplace, leading to conflict between employees

(Kalliny, et al., 2006). To reduce the effect of favouritism on employees, and the organisation as a whole, the government needs to impose rules and regulations that reduce and prevent unfair practices such as discriminatory employment acts, unfair promotions, and protecting lawbreakers in the workplace.

### *Negative image of Saudi nurses*

In the findings of this research, Saudi nurses believed that they felt bullied because of the negative image expatriate nurses have of them. Lovering (1996), in her research examining the career choices of four Saudi female nurse leaders, suggested that expatriate nurses tend to perceive Saudi nurses as irresponsible, or spoiled, because of the day shifts, flexible working hours, paid or unpaid leave they were granted, to fulfil their family responsibilities. This is similar to what some of the Saudi nurses mentioned in their interviews.

Another factor that adds to this perceived discriminatory bullying is the reverse discrimination exercised against national nurses on account of expatriate nurses receiving housing, free tickets and travel subsidies; benefits from which Saudis are excluded. These incentives, given to international nurses, are sometimes perceived as a form of discriminatory treatment against national nurses (Payne, 2003).

### *Wage differences*

According to the literature, for years the salaries and benefits of expatriate nurses contracted for employment in the Middle East have depended on what part of the world they came from, or received their education in (Kingma, 2006). This has led to nurses receiving variable rates of pay. Several nurses in their interviews mentioned how unfair this was. Discrimination, with respect to wages, is supported by Kanovsky et al.'s (1986) study, which found that Asian employees working in Gulf countries

were discriminated against in terms of wages and remuneration when compared with local nationals and Westerners who were assigned the same duties.

Several participants indicated that this practice has created a hot area for conflict between the different nationalities. In particular, those coming from developed countries, such as the US, UK, and Australia, were paid higher salaries compared with those coming from the Philippines, or India, although all are employed as qualified nurses with the same work conditions, and frequently, the same job responsibilities. The majority of nurses coming from developing countries accepted this lower pay as a condition of employment and hence the practice has remained unchallenged (Kingma, 2006). Part of the reason for choosing to stay and work, despite receiving lower pay, was the fact that they are still earning much more than they would back home. Nonetheless, this is still a violation of the principle of 'equal pay for equal work', which leads to frustration and dissatisfaction amongst some expatriate nurses (Atiyah, 1996). Consequently, this perceived injustice in the workplace might contribute further to the development of workplace bullying.

### **Working conditions**

This study also showed that nurses in units such surgery, the emergency room or labour and delivery room, were exposed to bullying that was related to workload and stressful working conditions. Similarly, Vessey et al. (2009) found that nurses in units such as intensive care, emergency, surgery, and obstetrical areas of care were exposed to higher rates of bullying. The reason for this could be that in these types of units, nurses are under pressure to work quickly and without error, creating opportunities for bullying (Efe & Ayaz, 2010).

The organisational pressures upon nurses to increase their workload and productivity

also contributes to an organisational climate where bullying can develop (Farrell, 2001; Hutchinson et al., 2006; Lewis, 2006). Studies in other occupational settings have demonstrated that bullying develops in workplaces identified as negative and stressful environments, and is characterised by role conflict and role ambiguity (Hoel & Salin, 2003). This can be seen in high pressure and stressful environments, such as emergency and operating rooms. Also Lee, Gerberich, Waller, Anderson, and McGovern (1999) found that a high patient-to-nurse ratio was linked to an increased risk of violence, which is in line with the findings of this study.

### **Nurses' silence**

Participants believed that nurses' silence of the mistreatment they received in the workplace contributed to the development of workplace bullying. Campaigns against workplace bullying, such as 'zero tolerance' campaigns, evidently demand active or passive collaboration with others to systematically report incidents to authorities, including police and legal systems (Jackson, Clare, & Mannix, 2002). According to Jackson (1996), nurses could resist hostility and regain power in the workplace by speaking up; even if only one nurse in any given workplace chose to say 'no' to mistreatment, a better work environment would be the outcome. Being a change agent in the workplace could be an effective way to reduce bullying and gain a better work environment. However, the issue in Saudi Arabia is that rules and regulations concerning the health and safety of the workplace are either missing or ineffective.

### **Impact of Workplace Bullying**

Bullying has produced both physiological and work-related consequences for targets. The physiological outcomes included depression and a sense of isolation, stress and

anxiety, fear and hurt, and loss of self-confidence and self-esteem. This is consistent with existing literature, which found that the impact of workplace bullying on targets results in lowered self-esteem (Randle, 2003), and depression and anxiety (Hallberg & Strandmark, 2006; Hutchinson et al., 2006; Quine, 2001). Studies have also found that targets of bullying eventually feel socially isolated and ignored at work, as if they were suffering a social death (Einarsen & Mikkelsen, 2003; Lewis & Orford, 2005).

The work-related outcomes that were reported by participants included leaving work (or the intention to leave work), making mistakes, lacking motivation to work, a negative work climate, and bullying as a learned behaviour. Most studies on workplace bullying among nurses have found that nurses who experienced bullying in their jobs considered quitting their current job – or nursing as an occupation altogether – because of their harmful experiences (Daiki, 2004; Farrell et al., 2006; Griffin, 2004; Lewis, 2006; McKenna et al., 2003; Quine, 2001; Rutherford & Rissel, 2004; Simons, 2006). A study by Quine (2001), found that nurses who have been bullied tend to have a greater negative perception of the organisational climate, lower job satisfaction, as well as a higher intention to leave their work, compared to nurses who were not bullied. Therefore, workplace bullying can have a serious impact on health-care providers that are already experiencing a shortage of nursing staff (Simons, 2006).

Patient care can also be negatively affected by workplace bullying, as nurses tend to make more mistakes as a result. A study by Farrell et al. (2006) on workplace aggression among nurses in Australia found that two-thirds of the participants reported making mistakes in their care because they were hurt after experiencing, or witnessing, aggression. Another study in the US by Rowe and Sherlock (2005) on

verbal abuse among nurses reported that 13% of participants stated they made a mistake as a result of this abuse.

The impact of bullying includes the normalisation of bullying among nurses' work teams. This normalisation is the result of the development of a learned behaviour within nurse groups (Lewis, 2006). Lewis (2006) argued that bullying is not the result of psychological deficiencies within perpetrators; rather it develops through learning the bullying behaviour from others. This phenomenon is not exclusive to nursing; other professions have also been identified with a process of socialisation into a culture of bullying (Hoel & Salin, 2003). Nurses may learn to be part of, or accept bullying as a normal and routine practice in their jobs, even though it may clash with professional standards they follow and accept, because it has become part of their team norms (Hutchinson, Jackson, Wilkes, & Vickers, 2008).

## **Responses Towards Workplace Bullying**

### **Targets' coping strategies**

Ignoring the bully, reporting to HR or a line manager, making a formal complaint, and confronting the bully were the coping strategies reported by this study's participants. This is in line with the four groups of coping strategies described by Olafsson and Johannsdottir (2004), where coping strategies were positioned on an active-passive continuum, depending on the intensity or length of bullying episodes. They categorised their groups of strategies as assertiveness; seeking help; avoidance; and doing nothing.

In particular, ignoring the bully was one of the coping strategies employed by most nurses in this study. According to Høgh and Dofradottir's (2001) study, avoidance



and leaving one's job were used more often than problem solving by those who were exposed to bullying, when compared to those not exposed to bullying. Avoidance could be perceived by those nurses employing it as a way of being rational, not escalating the conflict, but calming down the situation through their behaviour (Zapf & Gross, 2001). Rayner (1997) found that 27% of those who did nothing and did not seek support eventually resigned from their jobs.

The other coping strategy used by participants was being active, through either reporting to HR or a line manager, or by making a formal complaint. However, the responses they received were not always satisfactory. The literature indicates that internal reporting and management systems are often unsuccessful. This is especially so with other organisational misconduct, such as fraud, theft, and insider trading practices, which are resolved through informal alliances (Hutchinson, et al., 2008). This is similar to what some of this study's participants reported about favouritism and using informal relations in the workplace. What health-care providers could do to overcome this issue is to consider implementing procedures that ensure those in charge of investigating and handling complaints of bullying have no personal interest in the outcome (Hutchinson et al., 2008). Since managers are commonly identified as perpetrators of bullying in the workplace (McKenna et al., 2003; Farrell, 2001), it may be ineffective, and provide little protection to targets, for them to take part in the reporting process (Hutchinson et al., 2008).

Seeking support from the organisation was mostly perceived by participants as unsatisfactory, which may explain why some nurses chose to ignore the bully, or avoid the situation by quitting their jobs. Zapf and Gross (2001) used a model developed by Withey and Cooper (1989) that consist of four reactions: exit, voice,

loyalty, or neglect, which can be explained by the two dimensions active vs. passive and constructive vs. destructive. Individuals who are unsatisfied may direct their interest to non-work matters by being passive and destructive: neglect. They may also try to solve the situation through voice, which is an active and constructive method. Another possibility is to quit their job (exit), active but destructive to the organisation.

Zapf and Gross (2001) in their study found that although targets initially chose active and constructive coping (voice), when their problem-solving efforts failed they switched to destructive ways such as quitting the job (exit), or low commitment (loyalty). This indicates that organisations play a major part in shaping targets' coping responses. Moreover, organisations engage in socialising, and reinforcement of norms of behaviour that signal their acceptability, so that when targets try to remedy their situation they are ignored, or their concerns are dismissed (Lewis, 2006).

# 6 Conclusion

This study set out to explore workplace bullying; it has identified the experiences and perceptions of nurses working in Saudi Arabian hospitals. Particularly, it described the nature and prevalence of bullying, common behaviours, characteristics of targets, antecedents, the impact of bullying, and responses to bullying. The study has also sought to determine whether these experiences and perceptions are in line with the majority of research conducted in Western countries. The general literature on this subject, specifically in the context of Arab countries and Saudi Arabia in particular, is lacking. The study sought to answer this question:

What are the experiences and perceptions of nurses working in Saudi Arabia in relation to workplace bullying?

## **The Study and its Findings**

The major finding of this study was that workplace bullying is prevalent in the nursing profession in Saudi Arabia. The nurses' interpretation of bullying mainly included power dominance, intimidation, and verbal or physical harassment. Although participants mentioned some elements of the definition of bullying, they made no direct reference to the persistence of negative behaviours. Many of the behaviours cited in this study are clearly forms of bullying, such as shouting, gossiping, excessive workloads, and reporting mistakes to the manager. All bullying behaviours reported were psychological in nature, except one physical act by a patient.

This study has also shown that there are some nurses who exhibit characteristics that seem to put them at greater risk of being bullied, such as new nurses, nurses from the

Philippines and India, and those who seem quiet and accepting. Health-care leaders should therefore, focus on protecting those who are more vulnerable to bullying.

Bullying was reported to have been triggered by a struggle for power, promotion or to maintain one's place in the hierarchy. Other triggers included discrimination, working conditions, and targets' silence. One finding that stood out in this study was the discrimination that motivated the bullying that many nurses reported. This illustrates how racism and discrimination can be identified as a form of bullying, and also how discrimination may create injustice in the workplace, which contributes to the development of bullying.

This study has also shown that bullying has produced different physiological and work-related outcomes for targets as perceived by study participants. One of the noteworthy finding that was reported by a number of nurses was bullying as a learned behaviour. This suggests that bullying becomes a habitual behaviour that goes unnoticed by the health-care organisation. This means special attention should be given to identifying any hostile behaviours that might be normalised in the workplace, and working towards eliminating them.

Responses to the issue of workplace bullying, as perceived by participants, were grouped into two categories: targets' coping strategies; and management responses. This study found that targets coping strategies were mostly passive, through either trying to ignore the bully or through avoidance. This could be attributed to nurses perceiving bullying as tolerable in their workplaces and that there is no benefit in seeking support from management, or filing a formal complaint. Nurses reported that targets had tried to cope with bullying by reporting it to Human Resources, a manager, or by making a formal complaint, and the majority received no or unsatisfactory response. Therefore there is no surprise that nurses resort to ignoring

the bullying or avoid it by leaving the workplace instead of seeking help through the proper channels.

This study also found that, although few hospitals had supportive leaders or workshops and policies, the majority of hospitals were either not focusing on this issue, or nurses were simply unaware of such initiatives.

## **Implications**

A number of implications can be deduced from the findings of this study. Drawing on the intervention research findings mentioned in the literature review chapter (Ferris, 2004; Hoffman, 2006; Altman, 2010; Fox & Stallworth, 2009; Duffy, 2009; Vartia & Leka, 2011), this study suggests that bullying acts can be prevented, or even potentially eliminated, if efforts are directed at two levels: the organisational; and the individual.

As a first step, health-care leaders should become aware of the possibility of bullying occurring in the workplace, and should work toward preventing it. It is the role of the organisation to eliminate bullying because the organisation has the power and control to change the workplace; all efforts should be directed at this goal.

Changing the attitudes of those who participate in discrimination and racist bullying, in particular, is mostly within the hands of leadership, especially clinical and executive managers (Allan, Cowie, & Smith, 2009). Laws and policies should be introduced affirming that bullying is not tolerated in the workplace, and outlining procedures as to how incidents of bullying will be handled (Lewis, 2006). Enacted laws concerning discrimination and racism should be put in place to protect workers in all industries from hostile acts in the workplace. Although laws alone cannot solve

this problem, they would at least provide targets with some legal support should they fail to solve the problem through other means.

Educational programmes for staff and management should be initiated, specifically raising their awareness about bullying, the nature of bullying, and how to deal with bullying, both as a target and as a witness (Lewis, 2006). These programmes should specifically target those who seem more vulnerable to workplace bullying, such as new nurses, Filipino and Indian nurses, and those working in stressful units.

Findings from this study suggest that bullying is triggered by the interplay of both organisational and individual factors. Therefore, organisations should take into consideration those factors that inadvertently contribute to bullying –unequal wages, high workloads, and general injustice in the workplace – and work to create better working environments.

### **Significance and Relevance of the Research Study**

This study is significant because it fills a gap in the existing literature where knowledge about workplace bullying in the Arab region, and particularly Saudi Arabia, is lacking. This study gave both targets and witnesses of bullying an opportunity to voice their concerns and thoughts. This qualitative study adds significantly to the current knowledge of workplace bullying, as it explored a new cultural setting, where leaders and managers may use the findings to help prevent and manage the problem.

Gaining an understanding of the impact of workplace bullying on nurses working in Saudi Arabia's hospitals may provide direction on how to protect them and ensure their rights are preserved. Taking into consideration the staff shortages that health-care organisations face, this study's findings may provide advice on areas of concern

that can impact the quality of the work environment and result in improvements, which may result in better nurse retention.

## **Limitations and Future Research**

Finally, a number of important limitations need to be considered. First, the generalisability of the findings of this study is limited due to methodological issues in this research. However generalisability of the findings was not the primary goal of the study; rather, the purpose was to conduct a preliminary investigation into the issue of workplace bullying in Saudi Arabia and to provide additional information that would help people to recognise it and prevent it from occurring. Groleau, Zelkowitz, and Cabral (2009), in an article that examined generalisability, argued that the main objective of qualitative studies is to inform the views and opinions of policy-makers whose actions influence individuals' health and welfare.

Particularly, although the sample size of this study is reasonably good, the representativeness of the population is questionable. This is because nurses who were recruited in this study worked in different hospitals, with differing work policies and working conditions. Future research could examine a single case study in relation to workplace bullying in a particular hospital setting, and explore whether the findings from this study can be replicated.

Another key limitation of this study is that, although the anonymity of participants was ensured, nurses might not have been forthcoming about all relevant issues due to the sensitive nature of this topic. Particularly having a Saudi interviewer might have created some hesitation among expatriate nurses to participate or openly share around culturally sensitive topics.

Since the bullying of nurses in health-care organisations was clearly underlined in this study, there is a need to investigate this experience and its prevalence more closely. Specifically, future research should examine group differences in the workplace and any experiences of hostility in nursing, and different professions, more closely. .

## **Conclusions**

It is time for nurses globally, and locally in Saudi Arabia, to demand a safe working environment for themselves and their patients. Based on empirical evidence, workplace bullying has been identified as a serious social problem that has damaging consequences for those being targeted, for the organisation, and for society in general (Einarsen et al., 2011). Findings from this study provide evidence for the existence of workplace bullying among nurses in Saudi hospitals. The majority of participants had both experienced and witnessed bullying as they sought to fit into challenging workplaces. Overlooking the triggers of bullying might put the recruitment and retention of nurses in Saudi hospitals at risk. It is hoped that management and policy-makers in Saudi hospitals might benefit from understanding workplace bullying and help by formulating and implementing prevention strategies. This study serves as a starting point for further research in Saudi Arabia and the Arab region in general.



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## Appendices

### Appendix A: Workplace Bullying Flyer



## Nurse Volunteers Needed!!

For Research interview on Workplace Behaviours

Hi,  
My name is Eman Alswaid.

This research study is part of my Master's degree at Massey University in Auckland, New Zealand.

I am interested in the views and experiences of all full-time nurses who are employed for at least six months on a number of different workplace behaviours -No 'special' knowledge is needed.

#### Description about the project:

- **HOW:**  
Face to face interviews on workplace behaviours. You will be asked some questions in a time and location of your convenience.
- **LENGTH:**  
Approximately 30 minutes interview, however there is no set time limit.
- **When**  
Interviews will be in participant's personal time
- **Where**  
Outside workplace to ensure confidentiality and anonymity.
- **Note:**  
Participation is volunteered and you are free to withdraw from the study at any time.
- **Interested?**  
To learn more about the study or participation, call, txt, or email me at:  
**0503931649**  
**eman.alswaid@gmail.com**

#### Supervisors contact email:

Dr. Bevan Cately  
B.E.Catley@massey.ac.nz

Dr. Darryl Forsyth  
d.forsyth@massey.ac.nz



This research is conducted under the supervision of Dr. Bevan Cately, and Dr. Darryl Forsyth, School of Management, Massey University, New Zealand, and has been reviewed and approved by Massey Human Ethics Committee

## Appendix B: Counselling Services

### Counselling service contact details:

#### Mutmaena Medical Center

Tel +966 12296669

#### Address:

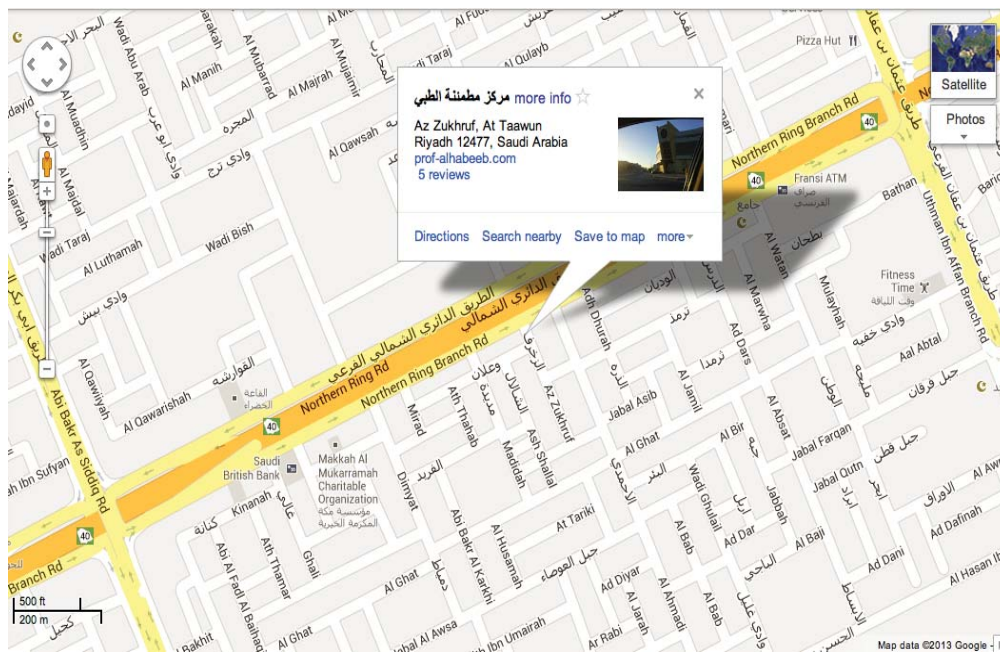
Az Zukhruf, At Taawun

Riyadh 12477, Saudi Arabia

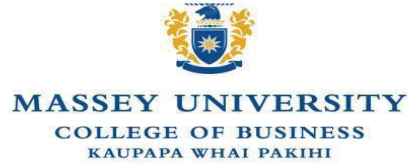
#### Direction notes:

Between exit six and seven on Northern Ring Rd

#### Map:



## Appendix C: Written Consent



School of Management  
Massey University  
Private Bag 102904  
Auckland 0745  
Aotearoa, New Zealand

### **Perceptions, experiences and understandings of workplace bullying among nurses in Saudi Arabia: An exploratory study.**

#### **PARTICIPANT CONSENT FORM - INDIVIDUAL**

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being sound recorded.

I agree to participate in this study under the conditions set out in the Information Sheet.

**Signature:**

**Date:**

.....

**Full Name - printed**

.....

## Appendix D: Massey University Ethics Approval



**MASSEY UNIVERSITY**  
ALBANY

**Eman Alswaid**  
**School of Management**  
Massey University  
Albany

11 June 2013

Dear Eman Alswaid

**HUMAN ETHICS APPROVAL APPLICATION – MUHECN 13/016**

**Perceptions, experiences and understandings of workplace bullying among nurses in Saudi Arabia: an exploratory study**

Thank you for your application. It has been fully considered, and approved by the Massey University Human Ethics Committee: Northern.

Approval is for three years. If this project has not been completed within three years from the date of this letter, a re-approval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Dr Ralph Bathurst  
Chair  
Human Ethics Committee: Northern

Te Kunenga  
ki Pūrehuroa

**Research Ethics Office**  
Private Bag 102 904, Auckland, 0745, New Zealand Telephone +64 9 414 0800 ex 43279 [humanethicsnorth@massey.ac.nz](mailto:humanethicsnorth@massey.ac.nz)

## Appendix E: Questions Guide



**MASSEY UNIVERSITY**  
COLLEGE OF BUSINESS  
KAUPAPA WHAI PAKIHI

1. How would you describe the relationships in work?
2. Have you ever heard of the term Workplace Bullying before and what does it mean to you? At this point participants will be provided with a written definition of workplace bullying and asked the following questions. The definition was:

### **Workplace bullying:**

A situation in which someone is exposed to hostile behavior on the part of one or more persons in the work environment which aim continually and repeatedly to offend, oppress, maltreat, or to exclude or isolate over a long period of time.

3. Do you think this happens around your workplace?
4. Why do you think it is happening/ or not happening?
5. To whom is it happening? And why?
6. Who do you think is responsible for the bullying? And why?
7. What effect does this have on people working in the hospital? (Targets and those who witness bullying)
8. What is currently done in relation to workplace bullying? What could they do to deal with it effectively?

## Appendix F: Information Sheet



School of Management  
Massey University  
Private Bag 102904  
Auckland 0745  
Aotearoa, New Zealand

# **Perceptions, experiences and understandings of workplace bullying among nurses in Saudi Arabia: An exploratory study**

## INFORMATION SHEET

### **Researcher Introduction**

My name is Eman Alswaid and I am currently doing an exploratory study on workplace bullying among nurses in Saudi Arabia. This is part of my Master's degree in Management at Massey University in Auckland, New Zealand. I really appreciate the time you are taking to consider participating in this study.

### **Project Description and Invitation**

This study aims to investigate different understandings, perceptions, and experiences of workplace bullying among both Saudi nurses and non-Saudi nurses in Saudi Arabia Health sector. It has been recognized that workplace bullying is a very serious issue that if not addressed will have negative consequences for the wellbeing of the worker and organisation. Studies have been conducted on workplace bullying in European countries and North America; however, little research has been done in Saudi Arabia and not in the nursing profession. Therefore, if you would like to discuss this issue I would like to formally invite you to participate in this important research.

### **Participant Identification and Recruitment**

I would like to speak to any full-time employed hospital nurse. Any nurse who wishes to discuss workplace bullying with me is welcome whether you know anything about this topic or not.

### **Project Procedures**



I am inviting you to participate in this study, which will involve semi-structured interviews about workplace bullying that will take about 30-50 minutes. Written consents will be signed after you read the information sheet and agree to take part in this study. If at any point in the interview process you feel any discomfort or emotional distress you may stop the interview immediately. Although there are no official counseling services available to nurses, contact details of external counseling services will be provided. Interviews will be conducted outside work place and in participant's personal time to ensure confidentiality of participant's identity.

#### **Data Management**

All data obtained in this study will only be used for this project and not given to anyone else for any other uses. Records will be kept confidential and no reference to any participants will be made.

#### **Participant's Rights**

You are under no obligation to accept this invitation. If you decide to participate, you have the right to: decline to answer any particular question; withdraw from the study (15<sup>th</sup> of July); ask any questions about the study at any time during your participation; provide information on the understanding that your name will not be used unless you give permission to the researcher; be given access to a summary of the project findings when it is concluded, and ask for the recorder to be turned off at any time during the interview.

#### **Project Contacts**

**Eman Alswaid**

[eman.alswaid@gmail.com](mailto:eman.alswaid@gmail.com)

+64 211621148

**Dr. Bevan Catley (Massey University supervisor)**

[B.E.Catley@massey.ac.nz](mailto:B.E.Catley@massey.ac.nz)

+64 9 414 0800 ext. 41491

**Dr. Darryl Forsyth (Massey University supervisor)**

[d.forsyth@massey.ac.nz](mailto:d.forsyth@massey.ac.nz)

+64 9 414 0800 ext. 43383

Please do not hesitate to contact either my supervisor or myself if you have any concerns or questions regarding this study.

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 13/016. If you have any concerns about the conduct of this research, please contact Dr Ralph Bathurst, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 43404, email [humanethicsnorth@massey.ac.nz](mailto:humanethicsnorth@massey.ac.nz).



## Appendix G: Sociodemographic Checklist

### Participants Demographics Sheet

Interview date \_\_\_\_\_

Location \_\_\_\_\_

Participant code \_\_\_\_\_

#### Participants Demographics

Gender:

male  female

Level of experience (years):

\_\_\_\_\_

Age group:

20-30  31-40

41-50  51-60

61 and over

Position:

Patient Care Assistant (PCA)

Staff Nurse 2 (SN2)

Staff Nurse 1 (SN1)

Charge Nurse (NC)

Clinical Nurse Coordinator (CNC)

Nurse Manger/Assistant Nurse Manager (NM/ANM)

Director of Nursing Care (CNC)

Other \_\_\_\_\_

Clinic/ Ward:

\_\_\_\_\_

Nationality:

\_\_\_\_\_

Number of years living in Saudi Arabia (for non-Saudis):

—

\_\_\_\_\_