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A Study Of Bullying in the Catholic Healthcare Workplace

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A STUDY OF BULLYING IN THE CATHOLIC HEALTHCARE WORKPLACE

BY

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DEDICATION

I dedicate this written project to my family and Catholic healthcare, for which I have worked most of my life. I am filled with gratitude for my loving husband, Michael, for being there for me throughout the entire doctoral program. My daughters, Honarae, Heidi, Suzanne, and MaryLu are all very special and gave me the strength to continue in my journey.

ABSTRACT

A STUDY OF BULLYING IN THE HEALTHCARE WORKPLACE

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This phenomenological qualitative study explored the impact and understanding of bullying in Catholic, mission-driven healthcare facilities, specifically how leaders respond to and manage bullying in their workplaces. The research is intended to make a positive contribution to Catholic healthcare communities by providing healthcare providers, educators, and policy makers information and tools to prevent and manage bullying in the workplace. The study employed Catholic social teaching and a Benedictine based theological reflection model to guide the two main areas of exploration: leaders' experiences of hearing complaints about bullying and tools available to them to stop bullying.

An anonymous survey was sent to 25 leaders in Roman Catholic, mission-driven healthcare organizations. The invited leaders represented executive leaders of mission, directors and managers, and spiritual leads/spiritual coordinators, all of whom have worked in one or more of the three Catholic healthcare systems and states (Minnesota, Nebraska, and Oregon) in which this researcher has worked. The survey, which was distributed through the Qualtrics online platform, asked the leaders four open-ended questions. Eleven participants (44%) responded to the survey.

The findings reflect themes that were culled from the researcher's deep reflection and analysis of the participants' responses. Three primary themes—anxiety, frustration,

and worry—emerged for two of the questions: one that asked leaders to describe their experiences of hearing complaints of bullying and another that asked them to share how individuals reporting the incidents described their experiences. The other two questions explored the tools available to and used by the participants; the findings from those questions imply that Catholic healthcare leaders minimally use Catholic social teaching when assisting individuals who report bullying.

The data received in this study illuminate the prevalence of bullying within Catholic healthcare organizations; they also suggest the need for greater engagement with and promotion of Catholic social teaching by leadership. This project presents practical solutions to address and prevent bullying in Catholic healthcare workplaces and offers recommendations for further research.

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CHAPTER 1

INTRODUCTION

Introduction

Ministering in a Catholic healthcare organization, I respond to questions and concerns related to ethics, policies, and care standards. One aspect of my work involves workplace bullying, a phenomenon that occurs in many work settings but is especially troubling in Catholic organizations because it violates the most basic Catholic and Christian principles. Workplace Bullying Institute (WBI) defines workplace bullying as "repeated mistreatment; abusive conduct that is: threatening, humiliating, or intimidating, work sabotage, or verbal abuse" (Namie et al., 2014, p. 3). Bullying occurs in Catholic hospitals among various constituencies: nurses to nurses, staff to staff, nurses to patients, doctors to nurses, and various other combinations. These scenarios contradict the following documents, which endorse the understanding that all people must be treated with dignity: Catholic social teaching; the documents of Vatican II; *Ethical and Religious Directives for Catholic Healthcare Services*, which is published and approved by the United States Conference of Catholic Bishops (USCCB); and papal encyclicals.

Catholic social teaching is "a body of doctrine developed by the church to help us apply the teachings of Jesus Christ to our communal, social life" (Evans, 2006, p. 1). Social justice refers to a claim to participate in the good of society and is reflected in Catholic social teaching's foundational principle that "every person is precious, that people are more important than things, and that the measure of every institution is whether it threatens or enhances the life and dignity of the human person" (USCCB, 2020, para. 2). The related concept of the common good maintains that we can never be

satisfied with a plan, policy, or situation that systematically overlooks the needs of some members of the community. Hence, concern for the common good requires us to strive to do what is good for the community as a whole and for the individuals within it. The Catholic healthcare community and all of the organizations that comprise it are bound to uphold the principles of Catholic social teaching and promote the common good. Bullying degrades the moral fiber of an individual or organization; this project seeks to explore the issue within Catholic healthcare organizations and provide tools for leaders to better manage and prevent situations of bullying.

Catholic healthcare employees who are bullied or witness bullying may seek support through several avenues: contacting the Employee Assistance Program (EAP), reporting the incident to a manager or the Human Resources department (HR), or reaching out to a spiritual caregiver or chaplain for support and counseling. In my work as a vice president of mission overseeing spiritual care and chaplaincy in the healthcare field, I have been involved with 16 bullying cases over the past five years. Based on my experience, I was compelled to explore how and why bullying exists in Catholic healthcare settings, particularly the experiences and responses of leaders when confronted with such incidents. My goal was to determine if and how Catholic social teaching can assist these organizations in managing bullying.

This research project identifies the problem and presents the research questions, context, purpose, and importance of the study. Definitions of bullying, including descriptions compiled from existing studies and a unique definition derived from research and personal experience, will be presented. Chapter two will discuss the theological frameworks, which include: a Benedictine based theological reflection model, which

incorporates Catholic social teaching; analysis of relevant scripture passages; and this researcher's personal experience. Chapter three will outline the qualitative phenomenological approach and methodology, sample population, and coding and analysis processes. Finally, chapters four and five will present the study's findings, conclusions, and recommendations for further research.

Statement of the Problem

Workplaces across the United States face issues of bullying. Current studies of healthcare settings show that bullying negatively affects the patient (Ariza-Montes et al., 2013; Gray, 2006; Omar et al., 2019). It also contributes to decreased productivity and increased medical expenses within a company (Fisher-Blando, 2008; Liberman, 2012; Wilson et al., 2011). Bullying also brings stress and burnout to staff members (The Joint Commission, 2016). Other problems include the potential for managers or HR representatives themselves to be instigators of bullying and for retaliation against those who report bullying to occur. Several victims who sought this researcher's support indicated that HR did not respond to their complaints and, in some cases, made the situation worse.

The researcher's experiences with workplace bullying revealed a disappointing irony when the principles of Catholic social teaching were considered against the high number of bullying cases she encountered in Catholic healthcare settings. While employees may not always intentionally bully, its existence and impact within Catholic healthcare must be made real in the eyes of leadership and management. Bullying not only affects the individuals who are targeted but the integrity of those around them.

A thorough review of the literature revealed many articles related to bullying but none that specifically address Catholic healthcare organizations. More research is needed to address this phenomenon in Catholic healthcare workplaces.

Context of the Study and Background of Researcher

The role of leaders in Catholic healthcare organizations is to work on behalf of the Catholic Church in Jesus's name. They are responsible for fostering the Catholic identity as a healing ministry of the church and integrating its identity in all aspects of operation. In cases of bullying, leaders are entrusted with the joint task of listening confidentially to peoples' stories and finding ways to respond with concrete action(s) to prevent further occurrences.

My current employer, Avera Health (Avera Health, personal communication, 2018) specifies and defines its "Standards for Service Excellence":

- "Communication": "We are committed to communicate effectively and compassionately in every interaction."
    - "Express empathy and compassion through verbal and non-verbal communication."
    - "Listen attentively."
- "Attitude": "We are committed to serve every person with hospitality and kindness."
    - "Treat everyone with dignity and respect."
    - "Manage Up by speaking positively about yourself, other employees, departments and providers."

    - "Display an empathetic approach in encounters by being sensitive to the needs of others."
- "Responsiveness": "We are committed to anticipate and to respond graciously to the needs of those we serve."
    - "Offer assistance to others without being asked."
- "Engagement": We are committed to a spirit of accountability and are responsible for every encounter."

Other standards across the industry may include teamwork, recognition, competency, appearance, and other criteria specific to each organization.

To become a board-certified chaplain, I completed a master's program and four units (1,600 hours) of Clinical Pastoral Education (CPE). The CPE hours included demonstrating in writing that I had addressed and met the certifying board's competencies, receiving written letters from the bishop and the priest to confirm my good standing in the Church, and receiving verification from employers of my 2,000 hours of work as a chaplain.

My responsibilities as a vice president of mission and board-certified chaplain include vigorously promoting the organization's mission, vision, and values by nurturing employees and creating and maintaining an environment that encourages open communication. I am expected to be available for patients, families, staff, care teams, and the community at all times, including during grief, trauma, and critical incidents. My role also includes supporting employees who have been bullied by colleagues.

Employees have come to me crying, shaking, and feeling sick and confused. They needed guidance and support from someone who would take the time to listen to their

concerns about the bullying they were experiencing in their department. Employees described how the negative treatment wore them down, caused their minds to be foggy, and led to sleepless nights. They also explained that it was difficult to come to work, and several shared instances of pulling off the road while driving to work because they needed to vomit. Some employees left their positions after only a few months on the job.

The individuals who came to me suffered mentally and physically from poor treatment. They felt like their work no longer mattered and they often gave up or quit their jobs. Many of the employees who experienced bullying told me they became sick more often than before and took more days off of work because of illness. The increased amount of time off snowballed into heightened mistreatment by their teammates and added pressure from HR regarding the growing number of missed workdays. These examples of the researcher's direct experience with bullying will inform aspects of this study and add to its depth.

Purpose of the Study

This qualitative, phenomenological study examined the impact and understanding of bullying in Catholic, mission-driven healthcare facilities, specifically how leaders respond to and manage bullying in their workplaces. Two main areas were explored: leaders' experiences of hearing complaints about bullying and tools available to them to stop bullying.

Although the negative effects of bullying are becoming clearer, existing research is limited. This study fills a gap in the research and broadens the current body of knowledge. The researcher intends for the project to make a positive contribution to

Catholic healthcare communities by providing healthcare providers, educators, and policy makers information and tools to prevent and manage bullying in the workplace.

Definitions of Bullying

Workplace bullying affects victims' physical health and psychological well-being (Allen et al., 2015; Ciby & Raya, 2014; Djurkovic et al., 2003; Giorgi et al., 2016). "Bullying has shown negative effects on the victim's mental and physical health, resulting in concentration problems, headaches, sleep disturbances, and altered eating habits" (Ciby & Raya, 2014, p. 75). Workplace Bullying Institute (2014) states:

> Being bullied at work most closely resembles the experience of being a battered spouse. The abuser inflicts pain when and where she or he chooses, keeping the target (victim) off balance knowing that violence can happen on a whim, but dangling the hope that safety is possible during a period of peace of unknown duration. (as cited in Ohio Department of Administration, Human Resources Division, p. 16)

Other definitions of bullying share common themes of aggression and repetition. "Bullying goes by many names: workplace aggression, indirect aggression, social or relational aggression, horizontal (lateral) violence, and workplace violence" (Gaffney et al., 2012, p. 2). Sercombe and Donnelly (2013) define bullying as aggressive behavior that is repeated toward another individual with the intent to hurt. Olweus (2001, p. 151) further defines it as "(1) intentional negative behavior that (2) typically occurs with some repetitiveness and is (3) directed against a person who has difficulty defending himself or herself." Idsoe et al. (2012) define bullying as "a subtype of aggressive behavior (Berkowitz, 1993) in which an individual or a group repeatedly and over time direct

negative actions against individuals who are not able to defend themselves, meaning there is an imbalance of power between perpetrators and victims" (p. 901).

This researcher defines bullying as an outright negative action or behavior, delivered verbally or physically, with the intent to intimidate, hurt, or belittle another person. Bullying actions may be condescending, threatening, or involve stepping into another person's space. The bully's intention is to establish control over another for the delight, satisfaction, or safety of making themself appear tough; their actions are often inflicted to compensate for poor self-perception.

Research Questions

This study investigated the experiences of leaders when confronted with complaints of bullying and the tools available to and used by them to assist employees. Four open-ended questions were explored:

1. What is your experience as a leader in hearing complaints about being bullied?
2. How do people talk about their experience of being bullied?
3. What tools are you using to assist people in handling their experience of being bullied?
4. What of Roman Catholic social justice teaching helps you respond to people coming to you impacted by bullying?

Importance of the Study

As an executive leader and chaplain who teaches others about the importance and value of living the Catholic mission and values, this researcher endeavored to contribute to the growing body of knowledge regarding workplace bullying. This project

specifically sought to inform the work of Catholic organizations that provide holistic care (body, mind, and spirit) to patients and clients and to assist leaders in cultivating similarly holistic work environments for their employees. Based on the researcher's review of current literature, this study provides the only research related specifically to the problem of bullying in Catholic healthcare systems.

Summary

This chapter introduced the problem of bullying in Catholic healthcare and the purpose of the study, which was to investigate the impact and understanding of bullying in Catholic, mission-driven healthcare facilities, specifically how leaders respond to and manage bullying in their workplaces. The context of the study, definitions of bullying, and the importance of the study were presented. Chapter one also outlined the four open-ended questions asked of the study's participants.

CHAPTER TWO

THEOLOGICAL REFLECTION

Introduction

Before initiating this project, the researcher presumed that bullying conflicted with the foundational value of the "Life and Dignity of the Human Person" (USCCB, 2020, para. 2) documented in Catholic social teaching. This section highlights the theological frameworks that shaped the study and guided the researcher in her investigation.

In 2003, Edward O. de Bary defined theological reflection as "*Vos pupuli vox dei*—The voice of the people is the voice of God, for God speaks through creation, and the human experience is our most direct contact with the divine voice" (de Bary, 2003, p. 5). Theological reflection for Christians, according to de Bary, is "a disciplined inquiry to respond, not to the gods, but to God who is revealed in Christ Jesus, the one, true, and living God who is revealed in the Old Testament" (de Bary, 2003, p. 25). This researcher employed a Benedictine based theological reflection model, which led with the practices of *Lectio Divina* and *Visio Divina*, to construct the study's theological scaffold.

Theological Frameworks

Lectio Divina is an ancient tradition of slow and thoughtful Scripture reading that entails listening deeply for God's message "with the ear of your heart," as St. Benedict (*The Rule of St. Benedict,* Prologue) encourages. The heart of theological reflection lies in hearing the spiritual meaning of the words on which one is reflecting and then

contemplating the wisdom they convey. “The fact is that in most moral matters we are guided by the heart….The word heart is understood here in the biblical sense as the deepest level of ourselves, where God’s Spirit joins our spirit” (Panicola et al., 2011, p. 64).

In his message to the church, Pope Benedict XVI (2010) describes Lectio Divina’s five steps, which combine prayer and scriptural reading: (1) read the Scripture passage, (2) meditate on the Scripture passage, (3) pray, (4) contemplate, and (5) act. Pope Francis today recommends Lectio Divina as a way of listening to God.

Visio Divina is a practice of seeing with the “eyes of your heart” (Klimosky, 2009, p. 7) by observing an image or illumination, such as an icon or work of art, while listening to a Scripture passage. This form of Christian prayer allows one’s heart and imagination to enter a sacred image, in silence, to perceive what God might be saying to them. Lectio and Visio Divina—hearing and seeing Christ in Scripture—allow God to speak to one’s heart; together, they undergirded the theological reflection of this project.

After engaging Lectio and Visio Divina to ponder the Scripture passages described in the next section, the researcher moved to her inherited Catholic tradition and specifically drew on Catholic social teaching. “Catholics believe that the word and grace of God in the person of Jesus Christ are revealed to us through Sacred Scripture and tradition” (O’Rourke & Boyle, 1999, p. 3). Catholic social teaching is rooted in Scripture, which is:

> a fundamental source of morality. The Judeo-Christian story and the personal witness of the women and men of the Bible are concrete symbols that shed light on who we ought to become and how we ought to act in relation to others….

> Scripture nonetheless gives us insight into, among other things, the values we should be promoting through our actions. (Panicola et al., 2011, p. 68)

The foundational principle of Catholic social teaching is respect for human dignity, which flows from creation in the image of God. The Catechism of the Catholic Church (Article 3, section II-1934) asserts: "Created in the image of the one God and equally endowed with rational souls, all…have the same nature and the same origin. Redeemed by the sacrifice of Christ, all are called to participate in the same divine beatitude: all therefore enjoy an equal dignity." As summarized by Kinast (1999), the Catholic Church's stance declares that "doctrinally every person is a human being, made in the image of God with dignity and rights who deserves respect, support, and acceptance" (p. 55). Embedded in Catholic social teaching's guiding principle of dignity are the following convictions about God and human beings:

- We are created in the image of God. Like God, human beings have the capacity to understand and reason, to desire and choose what is good, and to act out of love rather than self-centeredness.
- God created us to share God's goodness.
- God intends us to be friends to each other. We are supposed to care for one another.

The Benedictine model and Catholic social teaching principles described in this section moved the researcher to act from her heart and seek to understand the nature of bullying in Catholic healthcare workplaces. The following section describes this writer's theological reflection.

Scripture

The scriptural passages presented in this section underscore the belief that "sacred Scripture teaches that man was created 'to the image of God'" (O'Rourke & Boyle, 1999, p. 373). In today's culture, their messages are relevant to the issue of bullying in Catholic healthcare workplaces.

Passage One: *"What the Lord requires of you: Only to do justice and to love with kindness, and to walk humbly with your God" (Mic. 6:8 [The Catholic Study Bible: New American Bible Revised Edition, 2016]).*

Micah 6:8 asks every person to work against injustice and for social justice, which is embodied in Catholic social teaching's principle that "every person is precious, that people are more important than things, and that the measure of every institution is whether it threatens or enhances the life and dignity of the human person*"* (USCCB, 2020, para. 2). The passage urges all people to favor and model love and kindness and walk together in communion. The image conveys walking humbly. Examples of this message in action include advocating for social justice and striving to remove causes of oppression.

Passage two: *"When he saw the crowds, he had compassion for them, because they were harassed and helpless, like sheep without a shepherd" (Matt. 9:36).*

This passage illustrates Jesus's compassion for the helpless and underscores the concept of the common good. "The common good also suggests that the good of each person, the well-being of the human person, is connected to the good of others. That is, human beings only truly flourish in the context of a community" (Himes, 2001, p. 36). To have concern for the common good is to commit to fostering and sustaining a

community—whether it is a family, department, business, or healthcare system—so that it nurtures all of its members. The message is exemplified when we embrace and comfort individuals who are suffering or in need—including those who are bullied, marginalized, and vulnerable—and to always choose love and compassion over bullying. All people have a right and a duty to participate in society and contribute to the common good: "Catholic healthcare is realized when economic, political, and social conditions ensure protection for the fundamental rights of all individuals and enable all to fulfill their common purpose and reach their common goals" (USCCB, 2018, p. 8). The principles of respect for human dignity and concern for the common good work hand in hand; they are bedrocks of Catholic social teaching and should be guiding precepts within Catholic healthcare.

Passage three:

> *Listen! A sower went out to sow. And as he sowed, some seed fell on the path, and the birds came and ate it up. Other seed fell on rocky ground, where it did not have much soil, and it sprang up quickly, since it had no depth of soil. And when the sun rose, it was scorched; and since it had no root, it withered away. Other seed fell among thorns, and the thorns grew up and choked it, and it yielded no grain. Other seed fell into good soil and brought forth grain, growing up and increasing and yielding thirty and sixty and a hundredfold (Mark 4:3-9).*

This parable is relevant today in its reflection of human life and obstacles faced by all people. The first word, "listen," is also the first word in *The Rule of St. Benedict* (2001). It draws our attention to the importance of what is to come next and urges us to

listen with our heart ears. This parable is about us and reflects our past, present, and future. In the workplace, some days are good and other days are not. Sometimes we are particular about who we want to work alongside, sometimes we want to avoid certain people, and sometimes we fall on rough ground. These are the times when our vulnerability induces us to seek compassion or offer it to someone in need. Offering real compassion may involve discovering the larger and invisible burdens others are facing. Catholic healthcare employees are called to be sensitive to others' experiences, even when we may not know or relate to their stories. Through our compassion, we express our desire to recognize the universality of suffering and ease it for others. The value of compassion evokes the value of service, as Jesus exemplified, and the image of the sower gives us hope despite the difficulties we face in life.

Passages four and five:

"Then God said: Let us make human beings in our image, after our likeness" (Gen. 1:26).

"So God created humankind in his image, in the image of God he created them; male and female he created them" (Gen. 1:27).

Humans are created in God's image, which reflects intelligence and free will. As partners with God, we must respect and care for all human life. "Freedom is exercised in relationship between human beings. Every human person, created in the image of God, has the natural right to be recognized as a free and responsible being. All owe it to each other this duty of respect" (*Catechism of the Catholic Church*, 2016, Article 3, III-1738). All of humankind is made equal in dignity, value, and worth. We have the ability to communicate, reason, and relate, and these competencies—integrated with our capacity

to love and take responsibility for our actions—shape our worldview. Because every person is made in God's image, cruelty and violations of human rights are insults to both God and individuals.

Workplaces must embrace the dignity of every person by developing the abilities of one another. Catholic healthcare workplaces, especially, have a mandate in the form of Catholic social teaching to uphold this principle and honor the basic rights of workers. When we honor the dignity of every person, act with integrity, and communicate openly, we are living a moral life.

Passage six: *"And let us consider how to provoke one another to love and good deeds, not neglecting to meet together, as is the habit of some, but encouraging one another, and all the more as you see the day approaching" (Heb. 10:24-25).*

Hebrews 10:24-25 calls us to encourage one another, stimulate one another, perform acts of love, and help each other. We can apply these concepts in the workplace to transform behaviors, embrace diverse skills and talents, foster cooperation, and help employees realize their potential. This passage urges us to look beyond ourselves and stir each other to do good works, help those in need, and guide others. Love, above all, is a demonstration of deep compassion. We must reach out to those in need and offer comfort as Jesus did by nurturing the spiritual, emotional, and physical well-being of our colleagues and those we serve.

Catholic Social Teaching

Catholic social teaching is a tradition of teaching, thought, and practice rooted in scripture. "The Church's social teaching is a rich treasure of wisdom about building a just society and living lives of holiness amid the challenges of modern culture" (USCCB,

2020, para. 1). Built on seven themes, across which human dignity is a common thread, Catholic social teaching embodies a biblical call for justice, peace, and compassion; it is a central and essential element of faith, based on and inseparable from Roman Catholics' understanding of human life and dignity. Furthermore, it emphasizes commitment to the poor and vulnerable and calls us to reach out and build relationships of compassion and justice. The seven themes, as outlined by the USCCB (2020), are as follows:

1. "The Life and Dignity of the Human Person"
2. "The Call to Family, Community and Participation"
3. "Solidarity"
4. "The Dignity of Work"
5. "Rights and Responsibilities"
6. "Option for the Poor and Vulnerable"
7. "Care for God's Creation"

Catholic social teaching began in 1891 with Pope Leo XIII's encyclical promoting human dignity; the encyclical encourages individuals and organizations to preserve, develop, and care for all, and it emphasizes the obligation of workers to each other. Two of Catholic social teaching's central themes convey that human life is sacred and human life is fulfilled in community. Pope Francis (2013), writing more than 100 years after Pope Leo XIII, similarly asserts his reverence for all people: "Every person is worthy of our giving. Not for their physical appearance, their abilities, their language, their way of thinking, or for any satisfaction that we might receive, but rather because they are God's handiwork, his creation" (Chap. V, section I-274).

Reflections from the USCCB support this researcher's presumption that bullying conflicts with Catholic social teaching. The "Life and Dignity of the Human Person" theme "proclaims that human life is sacred and that the dignity of the human person is the foundation of a moral vision for society. This belief is the foundation of all the principles of our social teaching" (USCCB, 2020, para. 2). As Pope Paul VI declared at the Second Vatican Council in 1965, every human person is "created in the likeness of God" (section II-24) and "all violations of the integrity of the human person, such as mutilation, physical and mental torture, undue psychological pressures; all offenses against human dignity…poison civilization" (section II-27). Therefore, each person's life and dignity must be respected. Pope John Paul II (1991) similarly notes that the human person is made in the image and likeness of God, with an incomparable dignity and rights that flow from that dignity (section I-11). His words also promote peace: "Peace is not just the absence of war. It involves mutual respect and confidence between peoples and nations. It involves collaboration and binding agreements" (John Paul II, 1982, section 2, para. 3). People develop authentically when they are empowered to use the intelligence bestowed by God. Catholic healthcare fosters respectful and supportive environments that promote human flourishing and right relationship.

The USCCB's theme of "Solidarity" states, "We are one human family....We are brothers' and sisters' keepers, wherever they may be" (USCCB, 2020, para. 7). The theme is expanded on by the statement, "We are one human family whatever our national, racial, ethnic, economic, and ideological differences" (USCCB, 2020, para. 7).

Massaro (2000) describes solidarity as follows:

> a single word that captures a complex of meanings. It calls attention to the easily observable and indisputable fact that people are interdependent; they rely upon each other for almost all their biological and emotional needs. The complex fabric of social life, including human achievements such as language, art, culture, and education, testifies to the many ways in which people depend on shared efforts in all fields of human endeavor. To employ the term solidarity entails recognizing human interdependence not only as a necessary fact but also as a positive value in our lives. (p. 84)

Further statements by the USCCB are germane to this project's focus on workplace environments. The "Dignity of Work" theme declares, "Work is more than a way to make a living; it is a form of continuing participation in God's creation" (USCCB, 2020, para. 8). Additionally, the USCCB (2020, para. 3), asserts in its "Call to Family, Community, and Participation" theme, "The person is not only sacred but also social. How we organize our society—in economics and politics, in law and policy—directly affects human dignity and the capacity of individuals to grow in community" (USCCB, 2020, para. 3).

"Ear of the Heart" (*The Rule of St. Benedict,* Prologue)

Listening with the "ear of the heart" (*The Rule of St. Benedict,* Prologue) invites us to listen to our lives and take time to observe and reflect on what is happening in and around us. Listening with the "ear of the heart" (*The Rule of St. Benedict,* Prologue) calls us to be realistic, mindful, and welcoming. Right thinking leads to right practice; right practice leads to right thinking.

Catholic Healthcare's Responsibility

Applied to my professional roles, the Scripture passages noted above and Catholic social teaching support the principle that every person is precious and that every person has a fundamental right to be treated with dignity. This researcher is called to defend the dignity of life and support the common good.

Catholic healthcare is a response to the command of Jesus to "go and do likewise" (Luke 10:37). As a ministry of the Catholic church, Catholic healthcare embodies Christ's healing compassion in the world and empowers people to embrace their dignity and value. Compassion is the one word, by far, used by employees and leaders across health organizations in which this researcher has worked to describe their organization's identity and mission. "A Catholic healthcare facility aims to take on the character of a Christian community," (USCCB, 1981, p. 15) by striving to treat all people and families with profound respect.

A Catholic organization is not comprised of one human being, but a community of human beings who work together and whose relationships—with employees and those in their care—are bound by dignity and respect. Such an organization is distinguished by its desire to fulfill the purpose of life through service to others; thus, inclusion and dignity are paramount to this objective. As Pope John Paul II (1981) maintains, "Work is a good thing" (section II-9) because it expresses a person's dignity. Through work, the individual is transformed and becomes "more a human being" (section II-9). We must ask the question: Do we invest enough in our Catholic healthcare leaders and employees so that they may contribute to Christian life and thought through Catholic social teaching?

Summary

This chapter presented the project's theological framework, which engaged a Benedictine-based theological model. Using Lectio and Visio Divina, the researcher reflected on and analyzed selected Scripture passages, Catholic social teaching, and personal experience. Each component was explored in relation to the research topic of bullying in Catholic healthcare workplaces.

CHAPTER THREE

METHODOLOGY

Introduction

This qualitative, phenomenological study sought to examine the impact and understanding of bullying in Catholic, mission-driven healthcare facilities, specifically how leaders respond to and manage bullying in their workplaces. Twenty-five leaders representing various positions and locations were invited to answer four open-ended questions.

This chapter presents the study's methodology and design, including the sample population and research questions. Next, the data collection, coding, and analysis processes are discussed. Finally, the role of the researcher and considerations of validity, ethics, limitations, and delimitations are addressed.

Research Methods

This study used a qualitative, phenomenological approach to explore the issue of bullying in healthcare workplaces. This research method focuses on how people directly experiencing a single phenomenon of interest explore the context and make sense of the experience (Patton, 2002; Creswell, 2016). Qualitative research is "grounded in the social world of experience and seeks to make sense of lived experience" (Sensing, 2011, p. 57). Qualitative phenomenological research, as defined by Creswell (2016), "focuses on a single phenomenon to explore…by collecting data from individuals who have experienced the phenomenon" and examines "the context in which the individuals experience the phenomenon" (p. 262). The context (lived experience) is the heart of qualitative research, and the meaning is captured through the eyes of the researcher from

the data and the people. Qualitative research allows for themes to develop (Creswell, 1994).

This project relied on "exploratory research" (Creswell, 2016, p. 7) to investigate the particular phenomenon of bullying and its impact within the specific setting of Catholic healthcare workplaces. Thus, a qualitative approach was the most appropriate.

The sample size was small, so the survey's open-ended questions were designed to elicit rich responses from leaders about their experiences of bullying in Catholic healthcare. Those responses, in turn, enabled the researcher to conduct an in-depth analysis and produce the thick description of the phenomenon presented in chapter four.

Sample

The sample population consisted of Catholic healthcare leaders who are charged with supporting employees, some of whom may experience bullying and seek assistance. In cases of bullying, leaders are entrusted with the joint tasks of listening confidentially to peoples' stories and finding ways to respond to them with concrete action(s) to prevent further bullying.

The 25 leaders invited to participate in this study have worked in one or more of the three Catholic healthcare systems and states (Minnesota, Nebraska, and Oregon) in which this researcher has worked. The participants represented executive leaders of mission, directors and managers, and spiritual leaders/spiritual coordinators who work in Roman Catholic, mission-driven healthcare organizations. To preserve anonymity, specific demographic information was not collected; however, descriptions of Catholic healthcare leadership levels are provided in Appendix D.

Procedure

Upon approval from Seattle University's Institutional Review Board, the researcher sent one communication to the 25 leaders through the Qualtrics online survey platform. The communication included the Consent to Participate in Research form (Appendix B) and the project's online survey questionnaire (Appendix C). The consent form explained the purpose of the study, provided assurance of anonymity and confidentiality, and included contact details of the principle investigator and the Seattle University committee chairperson. It also explained that participation was voluntary and that participants were free to withdraw consent at any time, for any reason, without penalty. Recipients who wished to participate selected "yes" on the consent form page to indicate that they had read the details. They were then taken to the online questionnaire, completion of which served as consent to participate in the study. Those who did not consent to the study did not continue on to or complete the questionnaire.

The survey included four open-ended questions designed to elicit detailed descriptions of the leaders' experiences with bullying in their workplaces:

1. What is your experience as a leader in hearing complaints about being bullied?
2. How do people talk about their experience of being bullied?
3. What tools are you using to assist people in handling their experience of being bullied?
4. What of Roman Catholic social justice teaching helps you respond to people coming to you impacted by bullying?

A reminder email was sent two weeks later to the same 25 leaders to encourage those who had not yet responded to do so; the response rate increased as a result. The questionnaire remained open for six weeks in total and a final thank you email was sent to all 25 leaders when the time period ended.

When the survey process was complete, the researcher began the extensive work of coding and analyzing the data. These processes will be described later in this chapter and the findings will be presented in chapter four.

Role of the Researcher

The researcher in qualitative research serves as the "primary data collection instrument" (Creswell, 2003, p. 200). Accordingly, this researcher served as the sole investigator and performed the roles of data collector, data manager, and data analyzer. The researcher also protected the confidentiality of the subjects and the security of the gathered data (Creswell & Creswell, 2017). The researcher's experience working as a leader in Catholic healthcare provided a familiar context and understanding of the organizational structures of the participants' workplaces. That background, combined with an understanding of Catholic healthcare as a ministry of the Roman Catholic Church, lent credibility to the investigator.

Coding

"Coding is the process of analyzing qualitative text data by taking them apart to see what they yield before putting the data back together in a meaningful way. Through coding, the researcher develops diverse evidence for themes" (Creswell, 2016, p. 156). Upon receiving the completed surveys and over the course of two weeks, the researcher

began coding the survey responses by hand, heeding Patton's advice that "several readings of the data may be necessary before field notes or interviews can be completely indexed and coded" (Patton, 2002, p. 463). The researcher coded the data by reading through the transcripts many times and making notes about what the participants shared to gain a deeper understanding of the leaders' responses (Creswell, 2012).

The survey's open-ended questions were designed to encourage participants to describe their experience in detail. Once the researcher understood the data, *in vivo* coding was used to extract "the exact words of the participant or words heard" (Creswell, 2016, p. 160). Using an excel spreadsheet, the researcher assigned each leader a code consisting of the word "leader" followed by a number, 1 through 11, and inserted them into a column. She then transcribed, verbatim, the original text from the 11 participants' responses and placed them in a column adjacent to their identity code. Next, the researcher created brief in vivo summaries of the key words from each response and placed them in a third column. During this part of the analysis, initial themes emerged.

Through the researcher's deep reflection of the transcripts and creation of the in vivo summaries, commonalities in the leaders' responses emerged. As the researcher grew to understand the experience, she combined certain codes to form themes and documented certain themes as important. Each leader's response was linked to the themes in order to create groups. For example, if a response or experience stated by one leader resembled that of another, the response was placed under the corresponding theme. The themes were verified against the original responses to ensure that the meanings were sound. Through this intensive process of coding, the themes that emerged were identified and combined in such a way as to tell the "story" (Creswell, 2016, p. 153) of the

participants' experiences of addressing bullying in Catholic healthcare organizations. The process explained above was repeated for all four questions. Chapter four delineates the themes related to each question on the survey. The codes are presented in tables and organized by theme.

Validity

The survey yielded responses from two major sets of leaders (mission and spiritual care leaders) in healthcare organizations; therefore, the respondents themselves offered a triangulation of perspectives. "Triangulation refers to building evidence from different sources to establish the themes in a study" (Creswell, 2016, p. 191). Personal reflection related to the researcher's presumptions and the theological reflection described in chapter two provided further depth of understanding as required in phenomenological research: "The key to interpretation is not in the tools, or the reporting of the information guided by a set of techniques, but rather in how one makes sense of the experiences of everyday life" (Sensing, 2011, p. 72). Validity for this research was obtained through note taking, self-reflection, and checking for accuracy. To authenticate the researcher's interpretations, each leader received a summary of their responses to review and confirm.

Ethics

Protection of human participants is an ethical imperative for scholarly researchers (Creswell & Creswell, 2017). This study did not collect any direct or indirect identifiers of its participants. To facilitate greater confidentiality, the researcher did not retain a link to the individual responses, nor did the Qualtrics online survey save IP addresses or other identifying information. All participants were over 18 years of age.

The data collected in this research study is stored in confidential records and the computer used to store the data is protected with a password known only to the researcher. These provisions were implemented to prevent direct or indirect disclosure of any participant's identity in any publication or presentation of research data. No person's identity nor any healthcare organization's identity will be revealed in any compilation, study, report, or publication. Additionally, the research study was reviewed and approved by Seattle University's Institutional Review Board for adherence to the required protocols.

Limitations and Delimitations

The time required to complete the online survey represented one limitation of this project. The possibility that one or more of the participants may themselves have instigated bullying in their workplace was another limitation. This study was intentionally delimited to Catholic healthcare organizations.

Summary

This chapter described the research methodology used in this qualitative, phenomenological study of leaders in Catholic healthcare organizations. It outlined the methodology, sample population, instrumentation, procedure, coding, analysis, role of the researcher, validity, ethics, limitations and delimitations, and importance of the study. Chapter four will present the results of the data collection.

CHAPTER FOUR

FINDINGS

Introduction

This research study sought to explore the understanding and impact of bullying in Catholic healthcare workplaces and the use of Catholic social teaching to address and prevent it. This chapter outlines the research study's data collection results.

Twenty-five Catholic healthcare leaders were invited to participate and 11 completed the survey. The participants represented executive leaders of mission, directors and managers, and spiritual leads/spiritual coordinators who work in Roman Catholic, mission-driven healthcare organizations. Through the Qualtrics online survey platform, participants were asked four open-ended questions regarding their experiences of hearing complaints of bullying and the tools they engage when responding to complaints. The researcher particularly wanted to learn if and how Catholic social teaching principles had been applied and determine how they might be better utilized. The research questions as they appeared in the survey (Appendix C) are as follows:

1. What is your experience as a leader in hearing complaints about being bullied?
2. How do people talk about their experience of being bullied?
3. What tools are you using to assist people in handling their experience of being bullied?
4. What of Roman Catholic social justice teaching helps you respond to people coming to you impacted by bullying?

This chapter considers the findings and discusses the themes that emerged for each question. Accompanying tables further illustrate the themes and present the codes developed from the researcher's deep reflection and analysis of the transcripts.

Purpose of the Study

The purpose of this qualitative, phenomenological study was to investigate the impact and understanding of bullying in Catholic, mission-driven healthcare facilities in which this researcher has worked and learn about the tools used by leaders to respond to and manage bullying in their workplaces. Although the negative effects of bullying continue to become clearer, previous studies regarding bullying in Catholic healthcare do not exist. The researcher sought to fill this gap in the research and broaden the current body of knowledge regarding workplace bullying; hence, this study is the first in the United States to look at bullying within Catholic healthcare organizations. The researcher intends to make a positive contribution to Catholic healthcare by providing healthcare providers, educators, and policy makers information and tools to prevent and manage bullying in the workplace.

Results

The questionnaire presented to the participants was the only instrument used to collect data. Codes and themes emerged from the participants' responses and contributed to the data analysis. Ten of the 11 participants shared their experiences of hearing complaints of bullying, and one respondent indicated that they had not received any complaints. Since not every participant answered every question, the number of responses to each question is provided. This chapter considers each of the four research questions and the emergent themes in order.

Question One: What is Your Experience as a Leader in Hearing Complaints About Being Bullied?

Seven of the 11 survey participants answered this question directly; however, some participants who did not complete question one included relevant information in their answers to other questions. Although those responses are not included in the total response percentage, they were considered during the coding and analysis process. The majority (six out of seven) of the responses to question one conveyed that the leaders heard complaints of bullying directly from the individuals and sometimes from coworkers who themselves were not the targets. The following phrases provide a sampling of the leaders' feelings when hearing complaints from individuals about being bullied:

- "anxious and alone with no end in sight"
- "concerned and distressed like being between a rock and a hard place"
- "troubled not knowing which way to direct people" who sought their help.

Question Two: How Do People Talk About Their Experience of Being Bullied?

Seven participants answered this question directly; relevant information that appeared within answers to other questions was handled in the same manner as for question one. One of the leaders shared an employee's description of being bullied as stemming from "lack of respect." Another leader said the person being bullied became quiet during their conversation about the incident. Five leaders shared that people who talked to them about their experience of being bullied were frustrated, fearful, anxious, worried, or had difficulty speaking up about being bullied. The most common feeling resulting from being bullied was anxiety (71%); additionally, 57% of the leaders

responded that people who were bullied felt fearful, and 43% reported that bullied employees expressed worry and frustration. Additionally, 28% reported that the employees who sought their help had been bullied by a manager.

Some of the common traits of bullying as portrayed to the leaders included the following: demonstrating lack of respect for individuals by treating them coldly, leaving them out of conversations, giving them the silent treatment, talking negatively about them in front of others, and holding back important information needed to do their job. The following statements offer a sampling of the leaders' responses when describing how individuals talked about their experience of being bullied:

- "fearful when they were yelled at in private"
- "irritated when they were being left out of conversations"
- "worried they would lose their job"
- "felt sick, dizzy, confused whenever they were driving on their way to work"
- "worried about making mistakes from not knowing all the information…causing them to make mistakes"
- "discouraged for [*sic*] starting work in this area"
- "frustrated and discouraged that they were being left out of conversations"
- "bothered and anxious when they were not told information they needed to do their job correctly"

Themes for Questions One and Two

Questions one and two sought to understand what leaders in Catholic healthcare organizations hear, observe, and experience when approached with complaints about bullying. Themes for both questions emerged from the statements and phrases extracted

from the survey responses. After the researcher refined the initial themes that arose during the coding process, three dominant themes for both questions emerged: anxiety**,** worry**,** and frustration. Table 1 illustrates the emergent themes for questions one and two.

Table 1

Themes and Codes for Questions One and Two

Theme	Codes for leaders	Codes for employees
Anxiety	Concern, restlessness, anxious—like cannot sit or lie still, bothered, troubled, crying, feeling sick	Shook up, fearful, anxiety, misery, distressed, confused
Worry	Apprehensive, bothered, nervous, distressed, strain, uneasiness of mind, worried	Difficult to speak
Frustration	Dissatisfied, disheartened, frustrated, discouraged	Irritated

Question Three: What Tools Are You Using to Assist People in Handling Their Experience of Bullying?

This question strived to uncover the tools Catholic healthcare leaders rely on when supporting bullied employees and expose any commonality among the responses. Six of the 11 (55%) leaders responded to this question. Three (50%) participants indicated that they respond with active listening, compassion, and prayer, and two (33%) shared that they refer the bullied individuals to HR and the EAP. One leader (17%) mentioned Catholic social teaching, specifically the "dignity of life" principle and care for the vulnerable. Sample phrases and statements for question three include:

- "active listening, pray, compassion"
- "quiet presence, listen, compassion"

- "HR, HR assistance"
- "HR, EAP, education"
- "social teachings—always respecting another and caring for the vulnerable."

Table 2 illustrates the themes related to question three and the codes from which they were developed.

Table 2

Tools Used to Manage Complaints of Bullying

Tools (number of responses)	Codes
Compassion (3)	Compassion, prayer, active listening, quiet presence
Human Resources (2)	HR, HR assistance, EAP
Catholic Social Teaching (1)	Social teachings

Question Four: What of Roman Catholic Social Justice Teaching Helps You Respond to People?

Four of the 11 participants answered question four. Two (50%) of those four respondents engage the foundational "dignity of the human person" principle, which involves seeing an image of God in each person and caring for the vulnerable. One (25%) of the four leaders draws on the principle of "teaching on subsidiarity—handled by the smallest, lowest and least centralized competent to assist when needed authority." Another one (25%) of the four leaders invokes their organization's values and mission and listens with a non-judgmental approach. The dominant theme (50%), which centers on respect, dignity, and seeing an image of God in each person, indicates that people need

to feel valued, supported, heard, and respected. Table 3 illustrates the themes related to question four.

Table 3

Indications of Catholic Social Teaching Applied

Theme	Responses
Dignity of the human person	2
Teaching on subsidiarity	1
Values and mission	1

Summary

This chapter provided an overview of the study's findings. Twenty-five Catholic healthcare leaders were asked to consider four research questions regarding bullying in Catholic healthcare work settings. The leaders represented executive leaders of mission, directors and managers, and spiritual leads/spiritual coordinators who work in Catholic mission-driven healthcare organizations. Additionally, each of the invited leaders has worked in one or more of the three Catholic healthcare systems and states (Minnesota, Nebraska, and Oregon) in which this researcher has worked. Eleven leaders participated in the survey, although some participants did not respond to every question. The data were presented through tables, lists, and quotes from the survey responses.

Ten of the 11 leaders (91%) shared their experiences regarding complaints of bullying in their workplaces. Their responses to question one illuminated their feelings and reactions to hearing complaints, and their responses to question two described the feelings and reactions conveyed to them by the bullied individuals. Deep reflection and

analysis of the transcripts by the researcher, combined with in vivo coding, allowed three common themes for both questions to emerge: anxiety, worry, and frustration.

Seventeen percent of the respondents indicated that they engage Catholic social teaching to assist people who are bullied. Since Catholic healthcare is a ministry of the Catholic church, the researcher was surprised that more respondents did not mention Catholic social teaching principles as tools they use in cases of bullying. However, for those who did, the foundational principle most referred to (50%) was “dignity of the human person.”

Chapter five will further discuss the findings and conclusion of this research. Implications and suggestions for further study will also be discussed.

CHAPTER FIVE

IMPLICATIONS AND CONCLUSIONS

Introduction

The purpose of this qualitative, phenomenological research project was to investigate the impact and understanding of bullying in Catholic, mission-driven healthcare facilities, specifically how leaders respond to and manage bullying in their workplaces. The study had three major aims: (a) to learn about leaders' experiences when they hear complaints of bullying, (b) to learn how individuals describe their experiences of being bullied, and (c) to learn what, if any, Catholic social teaching principles leaders use as tools when responding to complaints of bullying. As evidenced by the anonymous Qualtrics survey, these aims were achieved.

All leaders serve as role models within organizations. In Catholic healthcare, leaders are expected to demonstrate behavioral management that promotes awareness and understanding of principles consistent with the mission, vision, and values of Catholic organizations. Their roles also demand confidentiality. The Catholic healthcare leaders who participated in this study represent executive leaders of mission, directors and managers, and spiritual leads/spiritual coordinators who have worked in one or more of the three Catholic healthcare systems and states (Minnesota, Nebraska, Oregon) in which this researcher has worked.

Four research questions propelled this study and were asked of each participant:

1. What is your experience as a leader in hearing complaints about being bullied?
2. How do people talk about their experience of being bullied?

3. What tools are you using to assist people in handling their experience of being bullied?
4. What of Roman Catholic social justice teaching helps you respond to people coming to you impacted by bullying?

Findings

Twenty-five leaders from three Catholic healthcare systems in three states were invited to participate in this study; 11 leaders responded and completed the survey. After careful coding and analysis by the researcher, emergent themes illuminated the experiences of leaders in hearing complaints about bullying and the experiences of the individuals who sought their help. Additionally, the responses revealed the Catholic social teaching principles engaged most by leaders and also the scant use of them in Catholic healthcare settings.

Ninety-one percent of the participants indicated that bullying occurred in their organizations. Their descriptions suggest that the leaders who hear complaints share similar feelings with those who directly experience the bullying. The researcher was struck by the parallel themes that emerged for both questions—anxiety, worry, and frustration—and the implication that a social justice issue such as bullying effects those on all sides in similar ways.

The tools that participants reported utilizing the most when responding to bullying complaints were compassion (50%), HR support (33%), and Catholic social teaching (17%). Despite the low response rate for Catholic social teaching, 50% of those respondents agreed that “dignity of the human person” was the principle they referred to

the most. Twenty-five percent responded that the principle of "solidarity" helped them respond to complaints of bullying. The remaining 25% of responses to question four did not refer to the principles of Catholic social teaching as relied upon tools; rather, the respondent highlighted the mission, values, and vision of their organization.

This study's high percentage (91%) of responses describing complaints of bullying reveals its prevalence within Catholic healthcare workplaces and signals the need to further develop education of Catholic social teaching principles. Although Catholic healthcare organizations should strive to embrace, utilize, and promote all seven principles outlined in chapter two, this project draws on four that challenge the essence of workplace bullying.

"Life and the Dignity of the Human Person" (USCCB, 2020, para. 2)

This foundational principle of Catholic social teaching calls us to defend the dignity of life and support the common good. All leaders in Catholic healthcare serve as role models and are expected to demonstrate and understand the principles consistent with the mission, vision, and values of Catholic organizations. Although only two participants referred to this principle when recounting their experiences in managing cases of bullying, it offers an overarching expectation for all workplace interactions.

"Call to Family, Community, and Participation" (USCCB, 2020, para. 3)

The USCCB (2020, para. 3) directly connects the way a society is organized to the ability of each member to thrive within it. A workplace is a community and, therefore, responsible for ensuring respectful and safe participation by all of its

employees. In the words of the United States Catholic Bishops (1986), “The ultimate injustice is for a person or group to be treated actively or abandoned passively as if they were non-members of the human race. To treat people in this way is effectively to say they simply do not count as human beings” (p. 18).

“The Dignity of Work and the Rights of Workers” (USCCB, 2020, para. 6)

Leaders in Catholic healthcare have a duty to respect the dignity of all employees and ensure that all employees respect the dignity of one another. Bullying attempts to diminish another person’s worth and conflicts with this guiding principle regarding work.

“Solidarity” (USCCB, 2020, para. 7)

One participant mentioned this theme when describing complaints of bullying; however, it is an essential principle for Catholic healthcare leaders to emphasize within workplace communities. **“**We cannot realize our full potential or appreciate the full meaning of our dignity unless we share our lives with others and cooperate on projects that hold the promise of mutual benefit” (Massaro, 2000, p. 84).

Contribution

This qualitative, phenomenological study fills a gap in the research about bullying by investigating the impact and understanding of it within Catholic, mission-driven healthcare facilities. The researcher sought to learn how leaders respond to and manage bullying in their workplaces and what, if any, Catholic social teaching principles they utilize to address and prevent it. This project serves to inform Catholic healthcare organizations of the need for increased teaching and application of these principles to combat workplace bullying.

The frameworks of this project included: (a) definitions of bullying, (b) information from the USCCB and the Catholic social teaching principles most relevant to bullying, and (c) Scripture passages that illustrate the concepts of social justice, community, and the common good, and which serve as examples for Catholic healthcare settings. The investigator was also familiar with the Catholic social teachings—ethical and religious—for Catholic healthcare services.

The data from this study illuminated the experiences of leaders when hearing complaints of bullying and the experiences of bullied individuals as conveyed to those leaders. The high percentage (91%) of responses indicating the existence of bullying in most of the participants' organizations confirmed the researcher's presumption that bullying is prevalent in Catholic healthcare workplaces. The data also indicated the tools the leaders accessed to assist people, including the Catholic social teaching principle(s) they employed. The low number of leaders who utilized Catholic social teaching implies a need for greater education and application of those principles.

Recommendations for Action

Based on the themes identified in this study and research regarding Catholic social teaching, the following conclusions could be expanded upon:

- the need for leaders to respond to bullying with the principles of Catholic social teaching, since Catholic healthcare is a ministry of the Catholic church
- the need for Catholic healthcare organizations to design policies and practices to eliminate bullying in their workplaces

Fewer than half the leaders who participated in the survey chose to respond to question four: What of Roman Catholic social justice teaching helps you respond to

people coming to you impacted by bullying? Those participants mentioned the dignity of the human person as germane to the issues associated with bullying but were mostly unable to cite other aspects of this complex and fundamental Catholic teaching. This researcher asserts that every Catholic institution, and most especially Catholic healthcare organizations, should embody these fundamental beliefs.

The researcher's experience with bullying cases revealed a perception among those reporting bullying that human resource departments, personnel, and policies were inadequate and often more harmful in ameliorating the issues. Thus, the researcher posits the need for substantial, ongoing, and universal education and formation in the Catholic social justice principals, with emphasis on how they should be implemented in Catholic healthcare organizations. The research further suggests that such curriculum should be required of all employees over the lifetime of their service within the organization. Each person's life and dignity must be respected; more voices are needed to spread and uphold this key principle of Catholic social teaching.

This study's findings also challenge the leaders who participated in the project, and all Catholic healthcare leaders, to develop policies regarding bullying. Consistency and a clear, unified message are crucial to establishing the expectations placed on all employees within an organization. Based on the researcher's review of the three systems in this study, no known policies regarding workplace bullying exist. However, the researcher recommends that an effective policy should include: (a) the purpose of the policy, (b) a statement that any form of bullying is unacceptable, (c) a clear definition of bullying that includes cyberbullying, (d) examples of bullying, (e) avenues available to

employees to report bullying, (f) consequences of bullying, and (g) training and education for all employees.

Suggestions for Future Research

As stated at the outset of this project, this is the first study of its kind related to Catholic healthcare institutions. The findings clearly point to the need for further research to address bullying in Catholic healthcare through the scope of Catholic social justice. Within that scope, the role of leadership in accessing and promoting Catholic social teaching is paramount. Future research studies would benefit from asking leaders how social justice teaching has proven to be a viable component of combatting bullying in their organizations.

Another extension to this study would refocus the questionnaire to target specific leaders in the workplace. For example, separate questionnaires could be created for each level of leadership: executive leaders, directors and managers, and coordinators and leads. This study was purposely limited to leaders working in Catholic healthcare; however, future research would benefit from surveying individuals working in HR and the EAP who talk with employees who are bullied in Catholic healthcare settings. Expanding the sample population would widen the lens of bullying in Catholic healthcare and further support the use of Catholic social teaching for education and prevention.

Conclusion

This study revealed that bullying persists in healthcare settings, particularly Catholic healthcare workplaces in at least three states and systems. More research is needed to broaden the scope of the research, including participants and locations, and to strengthen the use of Catholic social teaching by leaders. Committing to social justice

transformation and challenging the social realities of employees who are suffering is the Catholic way of healing and promoting positive behavior within Catholic healthcare settings. Catholic social teaching offers a powerful instrument to combat the pervasive and harmful effects of bullying. The researcher calls on Catholic healthcare organizations to confront this important social justice issue and remove the overwhelming obstacles that bullied individuals face regarding their physical and mental health and their ability to contribute safely and meaningfully in their workplaces.

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APPENDIX A

INSTITUTIONAL REVIEW BOARD APPROVAL

June 22, 2020

LuAnn Trutwin
School of Theology and Ministry
Seattle University

Dear LuAnn,

Thank you for your materials. After careful consideration, I have determined your project **A Study of Bullying in the Healthcare Workplace** exempt from IRB review in compliance with **45CFR46.104(d)**:

2) Research that includes only interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if (i) the investigator records information in such a manner that the identity of the human subjects cannot readily be ascertained (directly or through identifiers linked to the subjects); (ii) any disclosure of the data outside the research would not reasonably place subjects at risk of criminal or civil liability or damage the subjects' financial standing, employability, educational advancement, or reputation; or (iii) the investigator records information in such a manner that the participant's identity can readily be ascertained, and an IRB conducts a limited IRB review.

Note that a letter of exemption does **not** mean IRB "approval." *Do not include statements for publication or otherwise that the SU IRB has "reviewed and approved" this study*; rather, say the SU IRB has "determined the study to be exempt from IRB review in accordance with federal regulation criteria." Please retain this letter with your study files.

If your project alters in nature or scope, contact the IRB right away. If you have any questions, I'm happy to assist.

Best wishes,

Andrea McDowell, PhD
IRB Administrator

Email: irb@seattleu.edu
Phone: (206) 296-2585

cc: Dr. Sharon Callahan, Faculty Adviser

INSTITUTIONAL REVIEW BOARD
Administration 201 901 12th Avenue P.O. Box 222000 Seattle, WA 98122-1090

APPENDIX B

CONSENT TO PARTICIPATE IN RESEARCH

CONSENT TO PARTICIPATE IN RESEARCH

TITLE:	A Study of Bullying in the Catholic Healthcare Workplace
INVESTIGATOR:	LuAnn Mary Trutwin, Candidate for Doctorate of Ministry, Seattle University, 320-428-6116
ADVISOR: (if applicable)	[Sharon Callahan, Professor, Seattle University, 206-817-1019]
PURPOSE:	You are being asked to participate in a research project that seeks to investigate the impact and understanding of bullying in Catholic mission-driven healthcare facilities, specifically how leaders respond to and manage bullying in their workplaces. You will be asked to complete one online survey. This project is an online survey conducted by LuAnn Trutwin a VP of Mission and board-certified chaplain. I'll be the one reviewing and coding my review survey.
SOURCE OF SUPPORT:	This study is being performed as partial fulfillment of the requirements for the Doctoral degree in Ministry at Seattle University.
RISKS:	There are no known risks associated with this study. However, if you feel uncomfortable with a question skip it. If you desire more anonymity please consider using another computer other than a work computer.
BENEFITS:	The study will fill a gap in the research and broaden the current body of knowledge on the topic. It will also make a positive contribution to Catholic healthcare communities by providing healthcare providers, educators, and policy makers information and insight related to preventing and managing bullying in the workplace.
INCENTIVES:	You will receive no gifts/incentives for this study. Participation in the project will require no monetary cost to you.

CONFIDENTIALITY: Your name will never be used in any public dissemination of these data (publications, presentations, etc.). All research materials will be stored on a computer that will be protected with a password known only to this researcher. No person's identity or specific healthcare organization's identity will be revealed in any compilation, study, report, or publication. Human subjects research regulations require that data be kept for a minimum of three (3) years. When the research study ends, any identifying information will be removed from the data, or it will be destroyed. All of the information you provide will be kept confidential. The survey is anonymous and your IP address will not be retained.

RIGHT TO WITHDRAW: Your participation in this study is *voluntary*. You may withdraw your consent to participate at any time without penalty. Your withdrawal will not influence any other services to which you may be otherwise entitled.

SUMMARY OF RESULTS: A summary of the results of this research will be supplied to you, at no cost, upon request. The researcher LuAnn Trutwin can be contacted at the email address trutwinl@seattleu.edu.

VOLUNTARY CONSENT: I have read the above statements and understand what is being asked of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason, without penalty. Your completion of the survey is the consent to participate in the survey. On these terms, I certify that I am willing to participate in this research project.

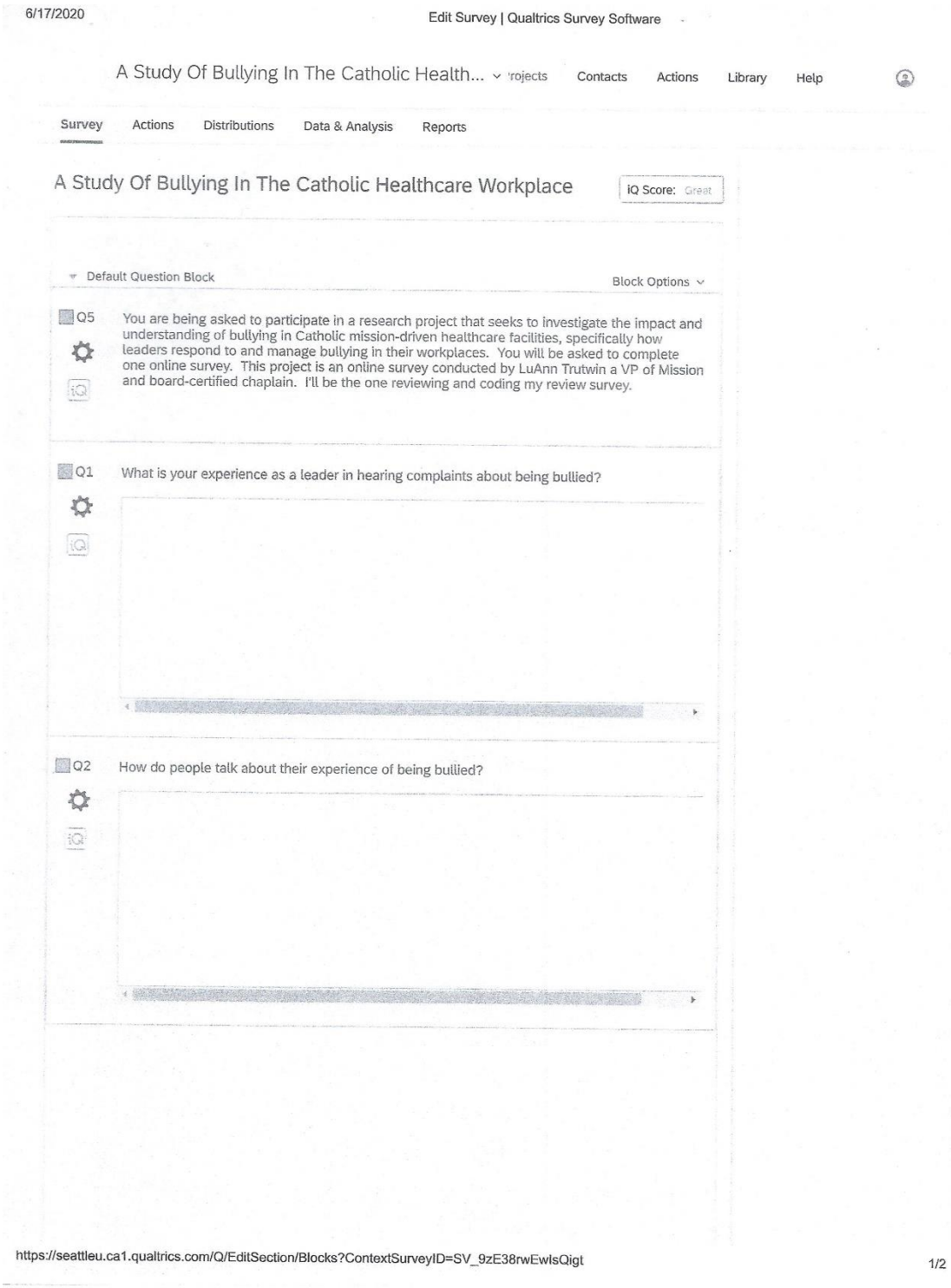
I understand that should I have any concerns about my participation in this study, I may email **[LuAnn Truwin]**, who is asking me to participate, at trutwinl@seattleu.edu. If I have any concerns that my rights are being violated, I may contact Dr. Michelle DuBois, Chair of the Seattle University Institutional Review Board at (206) 296-2585.

CONSENT TO USE IDENTIFYING INFORMATION:

The survey is anonymous so there will be no identifiers.

APPENDIX C

SURVEY



6/17/2020 Edit Survey | Qualtrics Survey Software

A Study Of Bullying In The Catholic Health... rojects Contacts Actions Library Help

Survey Actions Distributions Data & Analysis Reports

A Study Of Bullying In The Catholic Healthcare Workplace iQ Score: Great

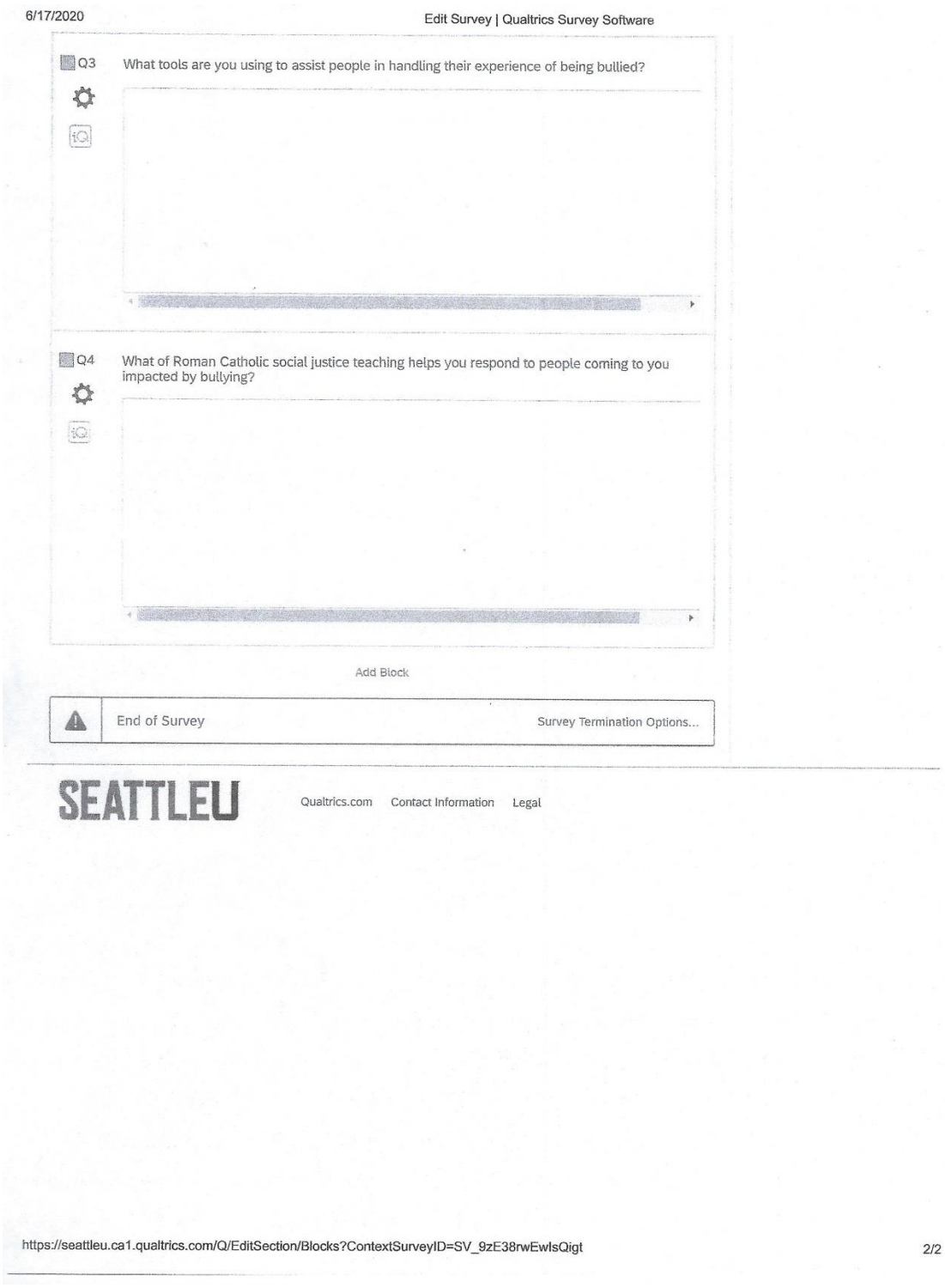
Default Question Block Block Options

Q5 You are being asked to participate in a research project that seeks to investigate the impact and understanding of bullying in Catholic mission-driven healthcare facilities, specifically how leaders respond to and manage bullying in their workplaces. You will be asked to complete one online survey. This project is an online survey conducted by LuAnn Trutwin a VP of Mission and board-certified chaplain. I'll be the one reviewing and coding my review survey.

Q1 What is your experience as a leader in hearing complaints about being bullied?

Q2 How do people talk about their experience of being bullied?

https://seattleu.ca1.qualtrics.com/Q/EditSection/Blocks?ContextSurveyID=SV_9zE38rwEwlsQigt 1/2


6/17/2020
Edit Survey | Qualtrics Survey Software
Q3
What tools are you using to assist people in handling their experience of being bullied?
Q4
What of Roman Catholic social justice teaching helps you respond to people coming to you impacted by bullying?
Add Block
End of Survey
Survey Termination Options...
SEATTLEU
Qualtrics.com
Contact Information
Legal
https://seattleu.ca1.qualtrics.com/Q/EditSection/Blocks?ContextSurveyID=SV_9zE38rwEwlsQigt
2/2

APPENDIX D

CATHOLIC HEALTHCARE LEADERSHIP LEVELS

Tiers of Leadership within Catholic Healthcare Organizations

Executive Leader (VP):

- Strategic thinker
- Ensures accountability
- Builds diverse and inclusive talent
- Innovative mindset
- Mission focused
- Ensures experiences of service and solidarity with those who are poor and vulnerable
- Demonstrates essential operational knowledge
- Brings to light leader tools

Director:

- Strategic execution
- Creates a work environment that appreciates and leverages diversity of thought & skills
- Integrates and balances long-term opportunities
- Is action-oriented
- Plans and prioritizes work to meet commitments aligned with organizational goals
- Is a role model of Catholic healthcare
- Ensures that services offered are consistent with the mission, values, and goals of the organization
- Consults with others on problems
- Develops and coaches others

Manager:

- Builds effective teams
- Fosters a learning environment within the team
- Assists people they lead to find meaning and purpose in their work
- Promotes effective working relationships and works effectively as part of a team
- Helps employees be more successful through coaching
- Provides others with opportunities for growth

Coordinator:

- Measures and documents performance
- Recruits, trains, and supervises chaplains
- Provides spiritual assessments
- Leadership qualities

Board Certified Chaplain/Chaplain:

- Professionally trained individual prepared to provide spiritual care
- Professional chaplains are personally rooted in a particular denomination, though are knowledgeable and respectful of different religions and cultural nuances
- Professional chaplains are committed to shaping the life, spirit, and ethical development of the organization.
- Helps individuals cope with illness, trauma, loss, fear, and life transitions
- Provides spiritual care to patients, families, and staff (provides ministry to all persons and draws upon each individual's belief systems and/or unique spiritual resources)
- Spiritual care is fundamental to the Catholic healthcare identity and a tangible expression of the organization's mission and values (spirituality is a key part of the catholic organization culture)
- Supports the organization's strategic direction
- Helps build a culture that supports spirituality-centered holistic care (Spiritual care is foundational to holistic care, which treats the whole person: body, mind, and spirit.)
- Works collaboratively with staff, volunteers, local clergy, and chaplains to ensure the spiritual needs of the organization are met