9-2017

The Lived Experience of Feeling Disrespected

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THE LIVED EXPERIENCE OF FEELING DISRESPECTED

by

Nadine Donahue

A dissertation will be submitted to the Graduate Faculty in Nursing in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York.

2017
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Nadine Donahue

This manuscript has been read and accepted for the Graduate faculty in Nursing Science in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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ABSTRACT

The Lived Experience of Feeling Disrespected

by

Nadine Donahue

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The purpose of this study is to explore the lived experience of feeling disrespected. The participants were registered professional nurses, with at least two years of clinical experience. A phenomenological approach utilizing Giorgi’s method was used to analyze the data and interpret the findings for this study. New knowledge about feeling disrespected contributes to nursing science and may help nurses and organizations that employ them, provide a healthy work environment that supports and retain them. The experience of feeling disrespected was illuminated by the following themes; “Powerless, feeling like a “nobody,” treated like you are “stupid,” utter discouragement and broken connections. The themes that emerged will help nurses understand the importance of respecting those whom we care for and work with. Parse’s Theory of Humanbecoming was used to reflect on the findings in light of the humanbecoming, dignity and living quality that is affected when nurses feel disrespected. Feeling disrespected is utter discouragement, arising with speaking up-remaining silent, the visible-becoming invisible, disguised indifference creating broken connections.
Acknowledgements

I am deeply indebted to the following individuals for my successful completion of this project.

Dr. Keville Frederickson-Thank you for accepting me into the Graduate Center and believing in my ability. Your support and kindness gave me the courage to continue when I wanted to stop.

Dr. Donna Nickitas- I am deeply indebted to you for following in Dr. Frederickson’s footsteps and giving me hope, time and guidance when I needed it the most. Your dedication and kindness helped bring me to the finish line.

Dr. Bernadette Amicucci- For your support and friendship. I could not have done this without you. As my personal editor, you helped me reach proposal. Although we only worked together for a short time, you are forever in my heart and I will always consider you a cherished friend.

Dr Steve Baumann- Thank you for allowing me to think qualitatively and for steering me in the right direction. Thanks also for introducing me to Dr. Parse’s view on “living quality”.

Sr. Maria Pascuzzi- Thank you for taking the time to review my work with your busy schedule. Your guidance and support was invaluable.

Finally, thank you to Cohort 7 (Bridget, Suzanne, Meredith, Caroline, Alex, Randy, Eda and Annemarie) for welcoming into your group after “Sandy” and for sharing the experience with me.
Dedication

I would like to dedicate this work to my Dad, Thomas Carroll who epitomized respect by the way in which he lived his life. You were a great role model and we miss you every day.

To my Mom, Bernice Carroll who never stopped believing in me and pushing me to go on.

To my children, Courtney, Sarah, Daniel and Aidan. You are the four reasons for enjoying my journey through this world.

To my husband Danny, thank you for picking up the slack at home which allowed me to continue the journey.
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Chapter I

Vignette

Jennifer was blushing and sweating profusely. She felt like screaming and running from the room, but could not. Her mind was trying to register how at 35 years of age, she could to made to feel like crying by a woman she considered a colleague. Jennifer was a veteran of 12-years of nursing practice who has an earned doctorate, now is a hospital staff educator. But this experience left her, at a loss for words.

Her day started like many other days, making rounds on all the units in the hospital. At lunchtime, an emergency cardiac arrest was called in the cafeteria. Jennifer responded to the emergency and ran to the closest unit to retrieve the emergency code cart. The closest unit was the emergency triage unit, where Jennifer had her office. She told the staff she was taking the emergency cart to respond to the cardiac arrest in the cafeteria. She ran with the emergency cart to the cafeteria and returned with a new cart after the incident. Once she returned to the triage nursing station, she reported the situation to the nurses and informing them that she replaced the emergency cart. Meanwhile, the nurse manager walked over to her and proceeded to scold Jennifer for taking the emergency cart. The nurse manager yelled, “You had no right to take my code cart off the unit. Who do you think you are?” As the yelling continued, though Jennifer could barely process the negative comments that she was being bombarded with. Jennifer felt her face flushing and her hands shaking. She wanted to run away. Present during this interaction were four family members, three attending physicians and several staff nurses. No one came to her defense.

After this interaction, Jennifer realized that it was time to leave her job. She felt unappreciated and disrespected. Jennifer explained to me that this was the culmination of 2
years of disrespect from a colleague with whom she had daily interactions. Jennifer reported feeling loss and sadness combined with loneliness when not one of her colleagues came to her defense.

In this vignette, Jennifer described an experience that was similar to numerous incidents that had occurred throughout the years and made her feel disrespected. These experiences resulted in her decision to leave her position rather than remain in an environment where being disrespected was an acceptable part of the workplace.

Introduction

Reports show that individuals choose the nursing profession because they desire a career that allows them to care for those in need and practice compassion, respect and integrity (Middleton, 2011; Lachman, 2014; Twiss, 2015). These three characteristics are consistent with The Code of Ethics for Nurses (hereafter referred to as The Code) with Interpretative Statements (2015). The Code serves as the foundation for clinical practice and decision-making for all nurses and the organizations that employ them (ANA, 2015). Nurses are required to show respect to all individuals with whom they come in contact (ANA, 2015). In short, nurses are held to high professional and ethical standards. These standards are, to be sure, at least partly why nurses are repeatedly rated among the nation’s most trusted professionals (Gallup, 2015).

When professional values are not upheld, negative behaviors present themselves and the care for patients is often affected (Joint Commission, 2009). The Code identifies respect as “a fundamental principle that underlies all nursing practice for the inherent dignity, worth, unique attributes, and human rights of all individuals” (ANA, 2015, Provision 1, p.1). The Code has nine provisions that outline the professional responsibilities nurses should adhere to in order to
provide respectful, competent care to patients, families, groups and communities. Of these provisions, respect for self and others is an essential attribute for the human experience of caring. Respect is defined as showing esteem for, or a sense of worth or excellence of, a person, while disrespect is defined as speech or behavior that shows you do not think of someone or something as valuable, important, etc., a lack of respect (Merriam-Webster, 2015). When respect is not present negative behaviors and ineffective communication among nurses arise. Research has shown that these behaviors, that may lead to poor patient outcomes and increased costs, and higher likelihood that qualified professionals to seek other positions or leave the profession entirely (Joint Commission, 2008; Kaplan, Mestel & Feldman, 2010; Gaffney, Demarco, Hofmeyer, Vessey & Budin, 2012; Ulrich, Lavandero, Woods & Early, 2104; Townsend, 2012). The literature on negative behaviors, highlights terms such as “incivility”, “bullying”, “lateral violence”, “horizontal violence” and “disruptive behavior” (See Appendix A). These negative behaviors are barriers that impede a nurses’ ability to effectively live out their vocation. Despite clear guidelines on professional respectful behavior in the nursing setting, disrespectful behavior remains widespread and often goes unreported (Smith, 2010). When these negative behaviors occur, they undermine patient safety, affect morale, and cause some nurses to leave their positions (Joint Commission, 2009).

According to Townsend (2012), sixty percent of new graduate nurses leave their positions within the first year because of mistreatment from fellow colleagues. The problem was highlighted in 2004, and continues to be a cause for concern (Griffin, 2004; Townsend, 2012; Blevins, 2015). A study by the Joint Commission in 2009 that linked negative behaviors to adverse outcomes, such as medical errors and poor patient outcomes, led the Joint Commission to identify negative behaviors among staff members as a “sentinel event alert” (Joint
Commission, 2009). A sentinel event is an unexpected occurrence that causes patient safety to be at risk (Lachman, 2014).

Negative behaviors in the healthcare setting are often offensive and malicious, which affect nurses’ ability to effectively perform their role in providing care to patients. Disrespect in the workplace is widespread. Even so, there has been little research to address this particular concern. Notably absent are studies which focus on the effects of feeling disrespected on nurses and the possible consequences on patient care making disrespect a phenomenon worth studying. Being rude or discourteous in society today may be interpreted as a lack of respect. Nursing researchers have identified the implications of disrespect in nursing educational settings, finding that disrespect in these early stages may provide the foundation for continued disrespect in professional health care settings. Parse (2010) reports: “The changing patterns of civility worldwide, in nursing education classrooms and health care settings raise questions about the implications that the disrespect has on the health and well-being, not only of nurses, but also the recipients of healthcare and of all those involved in teaching-learning situations” (p. 193).

Effective nurse communication and collegial support are essential elements of high quality patient care (Blevins, 2015). Nevertheless, the nursing workplace is rife with examples that suggest the absence of such behaviors. Many nurses do not support each other but, instead, behave in ways that can be classified as disrespectful. When this occurs, nurses’ idealism and professionalism may be undermined (Lachman, 2014, Stratton, 2016), the result of which is poor health outcomes for patients and the nurses who care for them (Gaffney et al., 2012; Christie & Jones, 2013; Sanner-Stiehr & Smith, 2013; Buerhaus, Donelan, Ulrich, Norman, DesRoches & Dittus, 2007). Professional nurses have an obligation to maintain respectful relationships with patients and the colleagues with whom they interact, yet this is not often observed in clinical
practice. More knowledge is needed in order to better design practice environments that do not exhibit disrespect among nurses.

Aim of Study

The aim of this study was to explore the meaning of feeling disrespected as described by full-time registered nurses working in clinical nursing practice. The phenomenological method was used to uncover the meaning of feeling disrespected. An understanding of feeling disrespected is important to comprehend how disrespect impacts nurses’ communication and their provision of patient care. It may also reveal how nursing organizations respond to negative behaviors in the workplace. Phenomenology involves deep listening to the experiences of those who experience the phenomenon. Participants in this study were encouraged to describe their experience of feeling disrespected in their professional nursing roles. The research question was: What is your experience of feeling disrespected? Participants were also asked: What is feeling disrespected like for you? This illumination provides insight into the personal meaning of feeling disrespected, and how these feelings may affect nurses, their ability to perform their professional health care responsibilities.

Phenomenon in Context

This study used Parse’s theory (Parse, 2010) as a guiding paradigm to identify and expose how nurses in clinical practice described their experience of feeling disrespected. Parse’s view highlights the complexity of human relations, requiring an honest exploration of the possibility that close relationships may include paradoxes, such as love-hate and joy-sorrow. Parse’s perspective on feeling disrespected is that it is one half of a paradox: feeling disrespected-feeling respected (Parse, 2010). Hawkins expands on Parse’s perspective, linking
Parse’s subjective notion to the active consequences of feeling disrespected. Hawkins writes “It is in feeling respected or disrespected that people make decisions about how they feel about themselves, others, and the world in which they live” (Hawkins, 2015 p. 8). Hawkins argument may be extended to the nursing workplace. Indeed, the meaning of an experience to an individual—such as feeling disrespected—may affect his or her decision to continue working at an organization.

This study identified and exposed how nurses in clinical practice describe their experience of feeling disrespected using Parse’s Theory as a guiding paradigm for living quality. “Living quality is what the individual is living at the moment; it is the becoming visible-invisible becoming of the emerging now. It is the now moment and that is all there is” (Parse, 2014, p. 28). This living quality changes as the person changes, what is experienced today is different when you talk about it tomorrow or experience new things. Parse’s Theory provides a unique way of looking at the human experience of feeling disrespected.
Theoretical Framework

The conceptual framework for the study of feeling disrespected is Parse’s (2014) humanbecoming paradigm. This framework specifies that humanuniverse is indivisible, unpredictable, everchanging; it is characterized by postulates: illimitability, paradox, freedom, and mystery. In Parse’s paradigm, illimitability is defined as unbounded knowing extending to infinity, an “all-at-once remembering-prospecting with the becoming visible-invisible becoming of the emerging now” (Parse, 2014, p. 31). Feeling disrespected is an experience that affects living quality. Paradox is defined as coexisting apparent opposites. Feeling disrespected suggests the paradox speaking—being silent. Voicing an opinion is stifling. It is not being listened to and ignored and not knowing what is next. The second postulate posits “the paradox
illuminates humanuniverse diversity with the visible- invisible becoming of the emerging now” (Parse, 2014 p. 32). Describing disrespect is the manifestation of the rhythm feeling respect-disrespect. Freedom is defined … “Freedom which contextually construes liberation” (Parse, 2014 p32). The fourth postulate is mystery. “Mystery is the unexplainable, that which cannot be completely known unequivocally” (Parse, 2014, p. 33). The mystery reveals itself in each description as each experience is different. The postulates underpin the three principles which all exist at once.

The first principle is “structuring meaning is the imaging and valuing of languaging” (Parse, 2014, p. 37). It is elaborated when an individual uses language to describe their experience. The value that that individual gives to an experience may then be interpreted. Every individual has their own reality or perspective on an experience. A second principle of humanbecoming specifies that humanuniverse is configuring rhythmical patterns in the revealing-concealing and enabling-limiting of connecting-separating. (Parse, 2014, p. 36). This specifies the concept of disrespect as paradoxes that are in rhythm with each other. This means that individuals disclose meanings but simultaneously hide them. It is a way in which one lives with their reality and suggests a pattern. For example, a person who experiences respect, usually knows disrespect; someone who feels connected, understands separation. The third principle of humanbecoming posits that humanuniverse involves “cotranscending with possibles as the powering and originating of transforming (Parse, 2014, p. 35). This principle speaks to how individuals move forward which are paradoxes that one would like to happen such as powering, originating and transforming. “Humans move beyond the moment as the unfamiliar becomes familiar in the presence of a new light and the familiar is visited anew through shifting perspectives” (Parse, 2015, p. 56). Feeling disrespected can diminish peacefulness and ability to
express preferred ways of being. Frustration may occur in the context of experience of disregard as it changes purpose as one lives out values in new and unfamiliar ways.

Feeling disrespected has ethical ramifications. To disrespect another individual through words or actions is to deny presence and individuality. The ethos of humanbecoming is dignity. When one has dignity, it allows one to show and give respect to others. Respect for self involves having dignity. Parse (2010) described human dignity as an ethical phenomenon and detailed four tenets of human dignity. “The four tenets are: 1. Reverence is solemn regard for human presence. 2. Awe is beholding the unexplainable of human existence. 3. Betrayal is violation of human trust. 4. Shame is humiliation with dishonoring human worth” (Parse, 2010, p. 258).

Disrespect is not showing reverence or appreciation for another through words or actions that may negatively change an individual’s understanding of the world. “Reverence involves commitment to core values found in a discipline such as the importance as truth telling, respect for human dignity, and awe for the existence for human creation and the mystery of human life” (Milton, 2017 p21). Disrespect can cause unpleasant feelings that create confusion about a nurse’s commitment to the profession. It is not respecting the individuality of others causing mistrust. Betrayal by another can cause one’s trust to be broken. Truth is necessary for one’s well-being. The ethos of human dignity described by Parse is something that many individuals should expect in a professional environment from those they communicate with and care for.

Justification of Study

The Code of Ethics for Nurses (2015) asserts that it is the duty of all nurses to “practice with compassion and respect for the inherent dignity, worth, and unique attributes of every person” (ANA, 2015, Provision 1, p. 1). The nine provisions of The Code collectively state that nurses have the responsibility in all roles and settings to adhere to nursing values that
demonstrate integrity for the profession. Understanding the experience of feeling disrespected is essential for nurses and nursing leaders if health care systems are to foster professional communication and promote quality care and patient safety. Sustaining a culture of safety is a priority in today’s healthcare environments (Joint Commission, 2009; Agency for Healthcare Research & Quality, 2012). Promoting a culture of safety is a major priority for health care services and systems to improve quality care and reduce costs. Several changes have been made on the basis of scientific evidence to improve the safety of patients across the United States. The commitment to providing quality care encompasses the need to empower nurses and others to act for the good of the patient and healthcare organization (Bullock, 2011; Guglielmi, Graling, Paige, Cammarata, Lopez, & Groah, 2013).

Respectful communication must be a moral imperative of care delivery to achieve a culture of safety (Bullock, 2011). The way in which one communicates with another has the potential to cause an individual to feel respected or disrespected depending on the character of the communication (Norgaard, Ammentorp, Kyvik, & Kofoed, 2012). If nurses anticipate that communication regarding a patient’s status will be met with resentment or irritation, they may become fearful in communicating important status updates (McNamara, 2012). Disrespectful communication may lead to psychological or physiological distress or both (Roberts, 1983; Farrell, 1999; Griffin, 2004; Longo & Sherman, 2007; Enbree & White, 2010; Gaffney, Demarco et al., 2012; Lachman, 2014; Blevins, 2015). On the contrary, respectful communication fosters civil, open and transparent interpersonal exchanges, improving nurses; confidences, morale, teamwork and the quality of patient care. (Kaplan et al., 2010; Raake, 2015).
Assumptions and Biases

The behavior of registered nurses is subject to high professional standards. Behaviors that adversely affect the patient-nurse relationship are considered unacceptable and may negatively impact patient care. Inappropriate individual nurse behavior, if left unchallenged, may spread to the work climate of the unit. Professional registered nurses are expected to continually exhibit respectful and civil behaviors in workplace encounters, with both colleagues and patients. The Code directs nurses to treat colleagues, students, other health care professionals and patients with dignity and respect. Nurses must refrain from harassment, disrespect or threatening action (ANA, 2015). Nurses should role model good moral character at all times and adhere to our core nursing values. This includes holding ourselves accountable for our interactions with all healthcare personnel.

My assumptions and biases arise from the assumption that there exists variation in backgrounds, cultures and life experiences that contribute to disrespect in the healthcare setting. Despite such differences, nurses must provide safe, quality care while communicating effectively with co-workers. When negative behaviors by individuals or by members of a workgroup impact the overall functioning of the group, it may create silos and an overall inability to internally communicate information amongst members on patient needs and overall care. It is my firm belief that regardless of how one feels when at work, exhibiting respectful qualities is the only way to behave if quality patient care is the outcome. Nurses must collaborate with each other and communicate effectively in order to provide excellent care. I have witnessed collegiality and respect which show a commitment to fostering ethical behavior that promotes a healthy work environment. Unfortunately, I have also witnessed negative interactions where many times, I stood by and did not intervene, not sure if it was appropriate. Not knowing how to interpret
these experiences, precluded my seeing the meaning in certain situations. When I ultimately experienced disrespectful behavior, I began to realize how detrimental it could be. Following this experience, I wanted to understand and to give voice to nurses’ experience of disrespect.

At present, there are many individuals transitioning into the nursing profession. Though desire to help others is important to them, many come for other motivations, including the possibility of economic stability. In any case, it is imperative for healthcare institutions to ensure that in addition to knowledge, and skills, nurses should have the insight and characteristics to effectively care for patients at their most vulnerable effectively. The qualities of compassion and empathy are a necessary component of this care.

Methodology

A phenomenological approach was applied to reveal professional nurses’ lived experience of feeling disrespected. The participants were registered professional nurses with at least 2 years of full-time clinical practice experience as registered nurses. Each nurse shared his or her experience with the researcher in a single face-to-face interview that lasted between 30 to 45 minutes. Transcripts were generated from audiotaped dialogues with each participant. Each transcript was read and re-read to uncover how the experience affected each participant. Within these stories, the researcher looked for common themes. These themes were identified and became the core concepts of the structure of the lived experience of feeling disrespected.

Giorgi’s (1975, 1985, 2012) phenomenological method was used to uncover the themes and create the structure of the meaning of the experience of feeling disrespected, as described by nurses. Giorgi’s (1975, 1985, 2012) method involves four essential steps that are performed in order to get to the essence of the participant’s experience (Giorgi, 2012).
As all researchers must do, I too had to assume the correct psychological attitude while listening to the description and again when reading the transcripts. This allows the researcher to view the objects of consciousness with focusing on the experience and meaning of each participant. First, the transcripts were read over many times in order to gain a holistic sense of the experience (Giorgi, 2009). An IRB approved transcriptionist transcribed the digitally recorded tapes. After transcription, the researcher read the transcripts first individually then all together to gain a sense of the whole. Next, reduction occurred when after reading the data over and over to capture a sense of the whole, meaning units began to emerge. Individual meaning units were assigned to each transcript. Codes were assigned to the shifts in meaning to help categorize the data and interpret it. The meaning units allowed the researcher to further develop themes into essences. Bracketing was used to remain attentive to the description of the experience for each participant. The essences were then transformed, to the structure of the meaning of feeling disrespected. These essences helped synthesize the description of the lived experience of feeling disrespected.

Relevance to Nursing

The continued nursing shortage should motivate organizations around the country to explore this phenomenon of disrespect in nursing to increase the numbers of future nurses. The Bureau of Labor Statistics projects a need for 525,000 replacement nurses in the workforce by 2022 and estimates that the shortage of registered nurses will by that time exceed 1 million (Bureau of Labor Statistics, 2013). Understanding the phenomenon of feeling disrespected as described by nurses who have experienced it, sheds light on why it must not be tolerated in the workplace. Raso (2015) suggests that healthy workplaces lead to better health outcomes at lower costs.
Chapter 1 described the why this study is so important in view of the widespread experience of disrespect and the limited research devoted to this topic. The findings uncovered four themes which provided the researcher with a means to synthesize the experience nurses have of feeling disrespected. The gaps in the literature on nurses’ experience of feeling disrespected were described. Chapter II will describe the evolution of the study and identifies the historical, theoretical and experiential context.
Chapter II

Evolution of Study

A review of the literature reveals that negative behaviors are closely identified with disrespectful behavior in nursing, and affect both nursing retention and patient safety. (Lavandero, Woods & Early, 2014; Becher & Visovsky, 2012; Joint Commission, 2009; Cleary, Hunt, Walter & Robertson, 2009; Coursey, Rodriguez, Diechmann & Austen, 2013). For example, incivility, bullying has been linked to poor outcomes and errors in care (JCAHO, 2009). The underlying phenomenon for all negative behaviors is disrespect. The experience of feeling disrespected is demoralizing, dehumanizing and harmful.

Conceptual Context

This study was undertaken to describe the concept of feeling disrespected as described by registered professional nurses who work in the clinical setting. The concept of negative behaviors is described extensively in the literature. Nevertheless, a qualitative look at the phenomenon from the perspective of those who have experienced it will broaden the literature of how nurses describe feeling this way. A qualitative phenomenological study was undertaken by Rosemarie Parse (2006) in order to ascertain the experience of feeling respected. The responses were examined using Parse’s (2014) humanbecoming theory. In Parse’s study, disrespect was examined using her humanbecoming theory. Her ten participants were professionals who held such occupations as hairstylist and librarian. Parse’s method involved extraction-synthesis, in which the story told by the participant is synthesized and a language is used to describe the essence of what was said in order to capture the core of each participants’ dialogue. The participants reported that feeling respected is important to the quality of life and health of the
individual. Feeling respected was described by the participants as “feeling confident, being trusted, appreciated, and experiencing self-worth, experiencing joy.” In addition, the participants described, “uneasiness with others’ expectations, the possibility of being judged and seeking an understanding even with disagreements was described” (p. 54). Parse found that feeling respected is a paradoxical rhythm with “Feeling not respected”.

Bournes and Milton (2009) investigated the lived experience of nurses as it relates to feeling respected–not respected with Parse’s (2014) humanbecoming theory guiding their qualitative study. Bournes and Milton (2009) sample consisted of 37 nurses from a large teaching hospital in Canada. Participants expressed their feelings of feeling respect–not respect. The findings revealed that respect was found to produce feelings of affirmation and confidence. Emotions that emerged when participants were respected included happiness, appreciation, safety and comfort. By comparison, feeling not respected resulted in feelings of anger or frustration, disappointment, insecurity and discomfort. The researchers were able to ascertain that feeling respected was important, especially as it relates to quality of life at work. In many instances, those who reported feeling respected felt a sense of belonging to the group, which, in turn, gave them more self-confidence. Those reporting feeling not respected also reported not wanting to come to work. Most participants described that feeling respected–not respected was a two-way street and had to be earned. This research supports further exploring feeling disrespected in hopes of encouraging nurses to enter into the profession and prevent those already in place from leaving.
Negative Behaviors

Negative behaviors that can make a person feel disrespected exist in the field of nursing. In fact, the Joint Commission, acknowledging the associated risk for patient safety, established a sentinel event alert classification for organizations to set behavioral standards to address disruptive behaviors in the workplace (JCAHO, 2008). The nursing literature uses terminology such as incivility, bullying, disruptive behavior and horizontal and lateral violence. Unfortunately, these terms are all used interchangeably and overlap, making it difficult to separate them (Lachman, 2014). In any case for this study, it is important to consider that such negative behaviors are capable of producing feelings of disrespect.

Olender-Russo (2009) studied reasons why nurses leave their positions, citing unhealthy relationships with their colleagues, which she identifies as bullying behaviors. Statistics show that more than 50% of nurses reported being a victim of abuse at work, and more than 90% report witnessing abusive behavior (Lipley, 2006). Abusive behaviors can fit within the concept of disrespect.

Olender-Russo (2009) provides evidence that organizations can use formulas such as Felgen’s 12E2 to ensure colleagues treat each other well. Four elements are included in the formula: inspiration, infrastructure, education and evidence. Felgen’s formula can be applied in healthcare settings to increase collegial respect. Examples such as recognizing individual accomplishments and rewarding individuals may even empower nurses. Articulation of an organizations strategic plan may also promote respectful behavior. The strategic plan should be introduced to all new hires’ orientation, and be rearticulated throughout their career. Olender-Russo also suggests utilizing of role-playing to foster the proper professional behavior within the organization. The key appears to be stopping negative behaviors before the employee has a
chance to consistently incorporate them. Olender–Russo insists that we should envision a workplace where everyone is treated with respect. Such a workplace can only improve and enhance outcomes for that organization. One positive outcome may also include financial gains, since better work environments can reduce absenteeism and yield better clinical outcomes when the organizations take into account reduced absenteeism and better clinical outcomes (Olender-Russo, 2009).

Singleton (2010) explored perceptions of disrespect among medical surgical nurses, writing that “the concept of respect embraces being taken seriously by another. Feelings of disrespect were identified when the person perceives he/she is being ignored, disregarded, dismissed, insulted, and treated rudely or discourteously” (p. 262). Nurses associated disrespect with being ignored, disregarded, dismissed, insulted and treated rudely or discourteously” (p. 262). Singleton moreover reported that professionals who provide patient care desire and expect respect. Medical-Surgical nurses care for patients with a broad range of diagnoses, juggling acute and chronic situations all at once. Behaving ethically and with integrity requires honesty, respect and responsibility and is a prerequisite for all nurses to maintain professionalism. The impact on patient care where nurses who feel disrespected has not been studied; however, the researcher can assume that those who work in respectful environments may feel more self-confident and that confidence in turn may be found in better patient outcomes.

Sheridan-Leos (2008) studied lateral violence in the form of coworker directed disrespect, within the oppressed group model (Roberts, 1983; Freshwater, 2000), which characterizes the oppressed and powerless group as the profession remains predominately a female profession. The oppressed group model (Roberts, 1983), tells us that nurses are oppressed and lack self-esteem, so loss of control and frustration cause them to turn on each other. Nurse
are considered an oppressed and powerless group, as nursing remains disproportionately female. The role of gender, combined with oppression, causes nurses to express their frustration laterally at each other and at new graduates. The cost of lateral violence to the individual nurse, patient, staff and organization is great as the profession is in the midst of a nursing shortage and is concerned about patient safety issues. Lateral violence includes verbal abuse and other disrespectful behaviors that can leave one feeling disrespected (Woelfle & McCaffrey, 2007).

King-Jones (2011) explored horizontal violence research and the socialization of new nurses using Michael Foucault’s (1968, 1980) theory as a framework of understanding. Foucault’s theory involves the balance of power between individuals. King-Jones recommends that experiences nurses examine the appropriateness of their behavior toward new entrants. She moreover suggests that academia has a responsibility to change its culture toward horizontal violence, as nurses are socialized into the culture of horizontal violence in their college years.

Nurses eating their young (Roberts, 1983) is an often-quoted phrase coined by Roberts relating to the tradition of older nurses mistreating or disregarding the less experienced nurses and not demonstrating respect. Nurses who leave the profession often state their decision was influenced by stress and decreased satisfaction linked to horizontal violence between nurses. Horizontal violence is a clear example of disrespect. Nursing growth is expected to be faster than any other profession in the period 2008 and 2022 in the United States. By 2022 the nursing shortage will grow to more than 1,000,000 (www.bls.gov). King-Jones posits that Foucault’s work tells us that “power is not held or controlled by any one group but exercised within relationships” (p. 83). Nursing researchers and educators can apply Foucault’s theory when assessing how the power structure can be changed in order to socialize new nurses and create healthy work environments.
Disrespect Seen as Injustice

Applying a Rawlsian distributive justice perspective (Rawls, 1971), Miller (2001) explored the association between perceived disrespect—an entitlement in Rawls model—and both anger and perceived injustice. Miller documents such examples as participants feeling indignation when their salaries were lower than expected, which threatened personal value. In the Rawlsian model, the perception of fairness has less to do with outcome (e.g. income) than with the symbolic status placed on the injustice. The most common reported experience of everyday injustice takes place in the form of disrespect (Lupfer, Weeks, Doan, & Houston, 2000; Messick, Bloom, Boldizar, & Samuelson, 1985; Mikula, 1986; Mikula, Petri, & Tanzer, 1990). A study by Mikula (1986) noted that among college students; the three most unjust events experienced in everyday life were unjustified accusation and blaming, lack of recognition for effort, and violations of promises or agreements. Less frequently mentioned were failure to admit error, using an inappropriate tone when giving orders, and illegal use of one’s power. Violations of interpersonal codes of conduct provoke a feeling of injustice in organizations (Miller, 2001).

The relationship between disrespect and anger appears related to existing personal anger level and other individual attributes. For example, individuals with high levels of anger appear to have a low threshold for disrespect from others (Dodge, Price, Bachorowski, & Newman, 1990). Equally interesting, individuals with low levels of self-worth tend to have more moderate anger responses than those with higher levels (Donnerstein & Walster, 1982). The notions of entitlement and broader group values also seem relevant. Disrespectful behaviors deprive individuals of their perceived entitlements (Bourdieu, 1965) and provokes moralistic anger (Durkheim, 1964) when applied to categories of individuals. This depends on the degree of harm depend so n the level of disrespect inherent in the offending act. In conclusion, the concept of
justice varies across cultures, but the feelings of disrespect and injustice are similar in many
groups of people.

A particular application of disrespect as injustice was investigated by Hawkins (2017) qualitative phenomenological study of obese women. Hawkins used Parse’s (2014) humanbecoming perspective to explore how women who embody largeness reported feeling disrespected. Ten obese women were interviewed to elucidate disrespect from the perspective of women whose body size is widely stigmatized in the United States. The results were reported from the perspective of quality of life for these women in relation to the patient-provider relationship. Her research described the structure of feeling disrespected by women who embody largeness as “mortifying disheartenment arising with disquieting irreverence, as distancing affiliations surface while enduring hardship” (Hawkins, 2017, p. 158).

Experiential Context

As a registered professional nurse for more than 30 years, 12 of which were spent as a nurse educator, made me realize that the moral and ethical behavior of professional nursing goes back to one’s childhood experiences and the lessons learned in those early developmental years. The need to respect others and their feelings are applicable in all of one’s frequent daily life, interactions with others in all various settings one is exposed. Additionally, understanding respectful behavior means that, even when the most difficult and perhaps stressful situations arise, nurses are required, and expected, to be respectful. Developing and maintaining positive relationships with others whether in a personal, social or workplace setting requires an ability to be aware of how others interpretation of our words and/or actions. The effects of an individual’s disrespectful words and actions can be a reason a nursing unit is ineffective and in turn adversely impact patient care. Behavioral traits acquired during childhood have translated into both my
personal and professional lives. Patients and colleagues are always given the utmost respect. I have a vivid memory of starting my first nursing position at a well-known Cancer hospital in New York City. There were 25 new nurses in the orientation. I became friendly with some nurses in my group and we would meet for lunch every day. We would all trade stories of how our day was going on our respective units. I will never forget how one girl, with whom I had become friendly, kept telling the group that the nurses on her unit were not treating her nicely or as she had expected. She would report how her colleagues would embarrass her in front of the physicians and family members instead of correcting her mistakes in private. She also told the group that there was no one in her unit she felt comfortable with or trusted to confide in. Although we were not working in her unit we would all offer her support and encouragement. We tried to assure her that at the end of her orientation things would change and she would be happier and that she would be accepted as part of the team. After three months, we were all on our own, assigned to our units and planned to meet for a celebratory dinner. She arrived at the dinner and informed us that she had resigned as a result of the daily treatment she was continually subjected. She saw no light at the end of the tunnel and no support system or supervisor to confide in. Here was someone that could have been an asset to the institution, well spoken, graduate of Georgetown University with her BSN. By all accounts she represented an asset that most institutions would be seeking out to hire rather than allowing them to get discouraged and resign. I lost touch with her and often wonder how bad things must have been for her to quit her job. Unfortunately, that scenario has played out many times since. I have experienced the feeling of disrespect from colleagues many times in my professional life. Thankfully, my situations always eventually changed for the better. However, the feeling of disrespect is one that I would not wish on another. I can find no good excuse for treating anyone
with disrespect, even if they treat me that way. I am interested in the fact that nurses working in clinical settings also feel disrespected. Disrespect should not be tolerated in any professional organization. My belief is that all workplaces where nurses interact should be healthy and respectful.

Chapter 2 reviewed the literature regarding the experimental dimensions of disrespect in nursing and other disciplines. While the literature on disrespect is limited in nursing, much has been written about the effects of incivility and negative behaviors in other settings. Experts in the fields of psychology and sociology have attempted to discuss disrespect as it relates to justice and anger. In this study, I hoped to highlight the experiential context, which has largely been neglected in nursing. Chapter 3 will describe the phenomenological method that will be used to explore feeling disrespected.
Chapter III

Methodology

This research study used an existential phenomenological approach to uncover the lived experience of feeling disrespected. The study is qualitative because of the need to have a better understanding of the experience of being disrespected as revealed by nurses who are familiar with it. Giorgi’s (1975, 1985, 2009) descriptive phenomenological method was used to guide this process and analyze the narratives generated by dialogue with participants.

Giorgi’s method involves the search for meaning, interpretation and the creation of new knowledge as discovered by the researcher from the human experience. The method begins by assuming the phenomenological attitude and then listening to the description of the phenomenon. The researcher listens to audio-recorded interviews and reads the transcripts of each interview in order to get a sense of the whole picture. “Once a sense of the whole has been grasped, the researcher goes back to the beginning and rereads through with the specific aim of discriminating meaning units” (Giorgi, 1985, p. 10). Meaning units will reveal the commonalities associated with the description of feeling disrespected from each participant. These meaning units are shifts in meaning or “facts” identified by the participants that the researcher finds when rereading the transcripts. “Since one cannot analyze a whole text simultaneously, one has to break it down into manageable units” (Giorgi, 1985, p. 11). This reveals psychological insight into the participants’ descriptions, which will allow the researcher to transform the data or meaning units. Again, this involves sometimes putting the data down, taking a break and returning for another look to ensure that nothing is missed. The method allows the researcher to uncover the “context of discovery” rather than “context of verification” (Giorgi, 1985, p. 14). The last step is to transform the data and interpret the structure of the experience of feeling disrespected. The
ontological interpretation that Giorgi asserts comes from a combination of the work of Husserl, Heidegger, Merleau-Ponty and Gadamer on the essence of the human experience. The findings may be used to improve the profession of nursing.

Phenomenology

Phenomenology, the focus on the lived experiences of individuals, has roots in the philosophy of Husserl and Heidegger. Both Husserl and Heidegger believed that the essence of the description of an experience can only be related by the individual experiencing the phenomenon. Our individual perceptions of the events that we experience. The description of the phenomena are the essences of our consciousness. Phenomenology examines first person experiences and interprets these experiences to give meaning to our experiences. This method guided the researcher to explore the essence of the phenomenon of feeling disrespected.

Husserl

Edmund Husserl (1859-1938) developed phenomenology to study the structure of consciousness in human existence and experience. According to Husserl (Husserl, trans. 1931), “Sciences of experience are sciences of fact” (p. 10). Husserl describes a reciprocal relationship between the science of facts and science of essence to seek the absolute truth and significance needed on the meaning of human experience. The essence of the experience, and meaning that experience has to each human, is the phenomena of the structure of consciousness. This essence can only be described by the individual experiencing it. “The connection which holds between individual object and essence … is to each individual object a state of being belongs as its essence, just as conversely to each essence there corresponds a series of possible individuals” (Husserl, trans. 1931, p. 18). Husserl further tells us “the pure essence can be exemplified intuitively in the data of experience, data of perceptions, memory, and so forth (Husserl, trans.
1931, p. 14). He believed in looking at objects with intentionality in order for them to be
transferred into our consciousness. Husserl believed that the guiding theme of phenomenology is
to go “back to the things themselves” (Giorgi, 1985, p. 252). This can be interpreted as going to
where the experience is in order to allow the experience of the participant to be heard and reveal
itself in consciousness. Husserl expanded upon the description of phenomena through
“bracketing” or “epoche” of assumptions, in order to find where the “relevant spheres of being
and knowledge lie.” Bracketing is placing the researcher’s assumptions aside in order to
interpret the experience as that individual perceives it. For the researcher, this means that biases,
personal beliefs or preconceived ideas must be bracketed or set aside in order to properly reflect
on what is being described (Husserl, trans. 1913/1972). Husserl’s belief in the descriptive
method provided the foundation for many other phenomenological methods used today.

Heidegger

Martin Heidegger (1889-1976) was another philosopher who influenced phenomenology.
He believed that interpretation of truth and logic could be achieved in uncovering the human
experience. Heidegger’s vision was to discover the meaning of “being” or Dasein, or
consciousness in the world. His mission to understand “Being” as consciousness led him on a
journey. According to Heidegger (trans, 1962), “An understanding of being is already included
in conceiving anything which one apprehends” (p. 20). He attempted to deconstruct the history
of ontology and interpret it through language by changing everyday words in order to explain his
position. For example, when he talked about being with objects in the world, he used Dasein to
explain how objects represent themselves. According to Heidegger, existence encompasses the
past, present and future and these are inseparable (Spiegelberg, 1982; Dreyfus, 1991). Heidegger
eventually came to adapt Husserl’s phenomenological method of transcendental reduction when
he purported that logic needed to be abandoned in order to explore questions that have no clear answers and that exploring objects of thought can be perceived through one’s consciousness and considered reality (Giorgi, 2005). Most importantly, he believed that the lived experience of being needed to be authentic. Heidegger’s interpretative view was also embraced by philosophers such as Merleau-Ponty and Hans-Georg Gadamer.

Merleau-Ponty

Maurice Merleau-Ponty (1908-1061) also believed that phenomenology is the study of essences and the meaning of these essences is discovered when we find meaning in our life. Merleau-Ponty (trans, 1945) tells us that “The world is not what I think but what I live through” (p. 23). We must reflect on our own experiences, which are perceived by ourselves in order to understand the structure of consciousness or what we perceive from our experiences. He is similar to Heidegger in that he used language to describe perception and sensations, telling us that “experiences are interconnected and reveal to us real properties of the thing itself, which is … as it appears and not hidden substance that lies beneath our experience of its appearance.” (Merleau-Ponty, trans, 1948, p. 17).

Gadamer

Hans-Georg Gadamer (1900-2002) is considered the creator of hermeneutics as a method of interpretation, started by Heidegger. He used linguistics similar to Martin Heidegger and believed that experiences would be understood more deeply by engaging in dialogue with the individual person about personal experiences so that answers could be interpreted from reflecting on the description given. Gadamer believed that meaning is an ongoing process shaped by understanding. One’s past experience affects one’s future experiences. He also posited that the understanding that one seeks, to fully understand an experience, is not always achievable.
(Gadamer, trans. 1976). Meaning and understanding lie in the summation of all human experiences according to Gadamer, and meaning is derived from not only the answer but also the way in which a meaningful question is asked (Vessey, 2014).

Chapter 3 described the methodology that was used to interpret the meaning of the planned research study. The history of phenomenology and the philosophers who helped influence the thinking and method utilized by Giorgi were reviewed. Chapter 4 will describe how the Giorgi method was applied for this research study.
Chapter IV

Methodology Applied

Giorgi’s (1975, 1985, 2009) descriptive phenomenological method was used to uncover the themes and structure of the meaning of the experience of feeling disrespected as related by registered nurses working in clinical practice. This method (1975, 1985, 2009) involves four essential levels of data analysis. The researcher first assumes the phenomenological attitude when reading the entire description to obtain an appreciation of the whole when listening to the description of the experiences that were digitally recorded. Descriptions emerge when the participant answers the question and then describes their experience to the researcher. In this study, the researcher performed the interviews, (thereby listening first), and later after transcription, reread the interviews. An initial reading of the data was accomplished to gain an overall sense of the experience as described by the participants (Giorgi, 2009). Initially, common themes were identified, listed and coded.

After the initial reading, the researcher seeks to reduce the data again, to capture the whole sense of the meaning. From these shifts in meaning, meaning units emerge. I assigned color codes to help categorize the data and interpret it. Meaning units were coded by colored pens in order to break the different themes into sections. These meaning units allow the researcher to determine distinctions among the participants’ descriptions. Rereading the transcripts many times is necessary so that meaning units identified depend on what the participant described. Bracketing was used to remain attentive and alert to the meaning of the data throughout the process. “The phenomenological approach is holistic and so no further steps can be taken until the researcher has an understanding of what the data is like” (Giorgi, 2014, p. 1). Giorgi (1985) describes this phase in which the researcher must be the most open to identify
the central theme for each unit. Once the meaning units have been established, the researcher’s fourth step is to examine all the meaning units to reveal the true meaning of the phenomenon.

The final step of data analysis is to create the structure of the experience as told by the participants. This systematic analysis allowed me to look at the meaning units again and transform the data into the structure of feeling disrespected. This involves taking the meaning units and transformed meaning and putting them in a consistent statement while asking the question: What does this tell me about feeling disrespected? A fully developed structural statement revealed the meaning of the experience from the words of the participants (Giorgi, 1985). According to Giorgi (2009), communicating the meaning of the data is best described when using ordinary words that will provide psychological clarity to the structure of the meaning of the experience. The meaning must be seen exactly as presented in consciousness according to Giorgi. “Whatever presents itself to consciousness should be taken precisely with the meaning with which it presents itself, and one should refrain from affirming that it is what it presents to be” (Giorgi, 1984, p. 47).

The researcher reviewed the revealed meaning units with a counterpart throughout the process to confirm the data analysis process in order to ensure participants’ descriptions are interpreted accurately. (Giorgi, 1984, p. 47). “To be true to phenomenology, the researcher must follow the thing itself, wherever and whenever it appears, while being attentive, conscious and alert to its appearance and concealment” (Munhall 2012, p. 119). By giving a voice to the study participants, and documenting their experiences, transparency is revealed in context. Rigor is maintained by adhering to Giorgi’s recommendations of reading and rereading to discover the sense of the whole allowing the researcher to intimately know the participants’ experience.
Protection of Human Subjects

Permission to conduct research was submitted to the Hunter College, CUNY Institutional Review Board and approved before beginning the research. A consent form was given to each participant and signed before beginning the interviews. Strict confidentiality was maintained throughout the process. A demographic sheet was filled out with age, years in nursing, degree attained, clinical experience and type of hospital small, research etc. Once consent was obtained, the audiotape was turned on and the participant was asked the question, “Can you tell me what feeling disrespected is like for you? Audiotapes and transcripts of interviews are secured in a safe place where only I have access. Real names of the participants are not used; rather pseudonyms were assigned to each transcript before analysis and review. All taped interviews were locked in the researcher’s home in a secure safe and will remain there for 3 years after completion of the study and then destroyed. Additionally, notes made during the interview process and reflected on the interviews afterwards are secured in a safe place.

Sample

Those invited to participate were registered nurses with at least 2 years of full-time clinical experience and who self-identified with feeling disrespected. All participants worked full time in acute care inpatient settings. Nurse participants were invited to participate through snowball sampling technique. This involved selecting a few individuals who I knew would be able to identify others who might want to participate in the study. “This approach is most useful when a study is carried on in a setting in which possible participants are scattered” (Lunenburg & Irby, 2008, p. 176). Participants were interviewed until saturation was reached. It is estimated that between 1 and 20 participants will be needed to achieve saturation. (Lunenburg & Irby, 2008). Saturation was reached at six participants, however seven were interviewed in total. It
was at this time that the themes of feeling disrespected were repeating themselves. Giorgi’s (1985) major tenet holds that quality of data rather than quantity is preferred. Informed consent was obtained prior to the interview, and the participants were informed that they could decline to continue and stop the interview at any time.

Data Collection

I used the open-ended interview question: “Can you describe what feeling disrespected is like for you?” Participants were encouraged to say more about the phenomenon of interest with the use of non-leading follow-up questions. All dialogue with participants was digitally recorded and sent to an IRB-approved transcriptionist. A gift card in the amount of $5.00 was provided for each participant after the interview to thank them for participating. I transcribed documents and read and reread the documents in order to become familiar with the content. Giorgi’s method (1975, 1985, 2009) was be used to interpret the data to analyze and find meaning in the lived experience of feeling disrespected.

Rigor

In qualitative research, studies are evaluated for merit and rigor (Munhall, 2012). “Rigor is valued because the findings of rigorous studies are seen as being more credible and of greater worth” (Burns & Grove, 2011, p. 75). In order for the study to be rigorous, the researcher must demonstrate that the methodological process for performing a phenomenological study has been achieved. As all researchers, I tried to maintain an open, trustworthy relationship with the participants and faculty chair. Proof of rigor was demonstrated both by the following of Giorgi’s method and by the process by which themes were developed. Bracketing biases are shown through journaling and self-reflection. Data is carefully kept and notes are accurate. Committee
members must be in agreement that the researcher has “captured, at least partially, the meaning of the experience to the participants “(Munhall, 2012, p. 522). Demonstrating the ability to analyze the data according to a clear theoretical approach is important. Feedback was asked throughout the process and on the analysis and interpretation of the data from the committee chair and faculty experts in qualitative research. The ultimate goal of the researcher is to achieve a thoughtful, sensitive description of the experience of the participants in order to add understanding to the phenomenon of feeling disrespected.

In conducting this research, the goal of gaining an understanding of the lived experience of feeling disrespected from the perspective of nurses who have experienced disrespect was achieved. The use of Giorgi’s method of analysis (1975, 1985, 2009) helped gain deeper understanding of the description and essence of the nurses’ experience.
Chapter 5

Findings

The purpose of this chapter is to present the findings of this investigation into the lived experience of feeling disrespected. The themes that emerged from the narratives are described. The philosophical method used is Giorgi’s (1975, 1985, 2009) phenomenological method was used for this investigation. This chapter will describe a comprehensive analysis and discussion of the participants lived experience.

Research Setting and Participants

In the preceding chapters, I outlined the significance of the study, reviewed the relevant literature and discussed the methodology. For this study, all the participants interviewed were female. I met the participants at various locations in order for them to feel comfortable. These locations included participants’ apartments (n=3), restaurants (n=2), and my home (n=2). Participants educational levels ranged from Baccalaureate in Nursing (n = 7), Accelerated BSN (n = 4), and Master’s (n = 1). Nursing was a second career for four of the seven participants. All participants had worked as staff nurses, and two were senior staff nurses, which is equivalent to an assistant nurse manager. The participants worked in clinical settings spanning medical surgical, telemetry, surgical stepdown, intensive care, staff education and neurology. As stated before, a purposive snowball sampling was utilized for this study. Some participants were referred to me by friends who informed them about my study of potential participants whom they believed would be interested in my study. All chosen participants met the criteria of full- time work in the clinical area for at least 2 years. During the sampling and interview process, I kept a
journal in order to organize my thoughts and the participants’ descriptions. According to Giorgi (1985), re-interviewing may alter the participant’s perception of the experience so each participant was only interviewed once. Common themes in each interview were identified, listed, and coded. Individual meaning units were reviewed and described in order to reduce them into the essence of the structure of the experience.

Participants’ Experiences

Sophia

Sophia was referred to this research by a friend. The interview took place in her apartment which was about 15 minutes from my home in a largely Russian enclave in Brooklyn New York. Sophia said that she and her family emigrated from Russia fifteen years ago; she spoke no English when she arrived in the United States. Sophia explained that her mother was a Dentist and her brother was an Engineer. Sophia said, there are many times when I felt disrespected. Sophia said that one time she felt so disrespected, that she could not speak with her supervisor. This led to her feeling more ignored and that her comments were being discounted by her supervisor. She stated that one day she spoke to her supervisor. It was a day when staffing was very poor and she was very frustrated, she told her supervisor that “she (her supervisor) needed to advocate for the nurses so we could have proper staffing.”

After the incident, Sophia apologized for her abrupt tone telling her supervisor that she had been frustrated and that it was hard to accomplish all the work that needed to be done and provide appropriate care for patients at the same time. Sophia reported that the supervisor said “I don’t work for you I work for the VA”. Sophia said, “I studied hard to achieve this degree and what this person said was that I am basically worth nothing. It cuts to your core. She must mean that the patients also count for nothing, because their care is at risk”. After this incident, Sophia
reported that things were never the same. The supervisor seemed to pick at everything Sophia did and making Sophia think that her supervisors was looking to retaliate against her. Two months later, Sophia reports that she was written up for what she saw as “retaliation.” “Now I have to deal with this and the union, I went home and cried like I was in grade school as I knew now that the bully was after me”. Sophia went further to tell me that the supervisor placed her in the same group as those who do not care. “I was being placed in the same pile as nurses who do nothing” which she said caused her great distress.

Sophia described that each day when I arrived at work I had “a dreaded feeling as if I am being strangled and I can’t stop the strangler, I have no control”. Sophia said she was strong and she knew she would be able to get through this, but she feels angry that she is in this position. “I went into nursing to help people because I am compassionate. When you are unable to do your job effectively and you are disrespected over nonsense it makes you wonder if you made the right choice.” Sophia went on to say, “There needs to be proper communication, you just can’t think that you are going to change a unit by demanding everything and giving nothing. If we are professional, then people need to behave that way. Where do you go when those who are supposed to support you don’t care”? As soon as I am done with school, I will look for another job. I’ve worked too hard for my degree to be bullied at work.” The interview lasted about 25 minutes, Sophia got very emotional when talking about being written up by her supervisor. She started our meeting proudly showing me her apartment and telling me how her desire to become a nurse was so strong in order to help others. I still believe that she has this desire and that she will find her niche. When we said good-bye, I walked to my car and jotted down my notes about our meeting. I reread my notes again after receiving her transcribed interview and added them to the interview document.
Caroline

Caroline was referred to this research by a fellow colleague and after speaking on the phone we agreed to meet in my home which was a 45 minute drive from her house. Caroline said prior to entering nursing school at the age of 28 she had worked for a large advertising firm for four years in New York City but could not see it as a career she wanted to continue.

Caroline said that she worked as a senior staff nurse on a neurological intensive care unit at a large teaching hospital in New York City. Caroline started to describe a story about how she was approached by two managers in her unit who told her she should apply for a senior staff position. They encouraged her to apply and that their recommendation to senior management carried a lot of influence as to who obtained the promotion. Caroline said to them, “I feel so honored that you both sought me out for this position. It makes me feel as if my hard work did not go unnoticed. I can assure you I will not disappoint you”. Caroline said she spent hours preparing for the interview and “set my mind to the fact that if for some outside chance I didn’t get the position I at least had gotten interview experience”. Caroline said she had undergone two interviews which she felt went quite fine. This was also confirmed by the managers who had recommended her. She said they then told her that the position was hers and that Human Resources would be notifying her shortly. She said she was nervous until one of them said, “We like your leadership skills and the way in which you are always willing to help other staff in the unit and that we see you as a true team player”. Caroline said she was asked not to say anything until they made the announcement at the next staff meeting, which Caroline said, “seemed appropriate so I happily waited for the announcement.” A few weeks went by before a staff meeting was scheduled. Caroline described the shock she felt when an announcement was made at the meeting that another nurse was promoted to senior staff not her. She said, “So the job that
they said was mine was given to someone else with no prior explanation no briefing prior to the announcement.” Caroline said she was in total disbelief and felt betrayed and disrespected by not having been told prior to the meeting.

When the meeting ended, Caroline said she was called into her manager’s office for a meeting. She said, I felt flushed, hurt and angry and I immediately asked her, “How could I be told I had been given the position and then have it taken back by me without you or anyone else having the courtesy of letting me know prior to the staff meeting? Caroline continued to describe how in the meeting with her manager, she felt the manager totally dismissed her feelings of disappointment and made light of it saying, “In the scheme of things this was absolutely nothing and it is being merely a bump in the road and you really do not know what real disappointment is”. Caroline said the manager then went on to tell her how for the last three years she was trying to conceive and that in her words, “that is a real disappointment”. Caroline said I told her, “If I had never been told I received the position, then I would have accepted it, but to be told I got it and then have it taken away I felt like I was betrayed by you and others. I didn’t understand how no one felt the need to tell me exactly what happened. Not only didn’t I get the position, but the people I trusted turned to me and told me it had been a misunderstanding.” Caroline continued, when I challenged the managers’ who told me I got the position they admitted to me that they were overruled by someone higher than them.” Caroline said the meeting ended with the manager saying there was nothing she could do.

Caroline went on to say that she spent a few weeks agonizing over what to do and finally scheduled a meeting with the Union and Human Resources. She said “I am not a fighter but my hurt and disappointment, which I believed were justified, gave me some sort of strength. I just felt it was all so unprofessional. We work in a small unit and now things were strained through
no fault of mine, it made going to work painful.” Caroline went on to say that as a result of her complaint she was no longer praised by the two managers who once were so complimentary. She said, “All of a sudden, I was made out to be disrespectful because I was standing up for myself in a professional manner. I was taken off the wound care team, where I had previously been praised by the hospitalist for my good work. The manager then would put individuals in charge that had never been in charge before, passing me over continually. I ignored it all, but still it hurt deeply. Caroline said the mistreatment from defending herself never ended. She continued to say, “When someone questions your judgment without thinking it through…they are jumping to conclusions without asking your opinion.” Caroline said that this had caused her continued stress when you now believe that people really don’t have your back. She said she continually made efforts to transfer out to another unit when all of a sudden money was found and a second position was authorized. She then said, ”Unfortunately, the damage was already done and both sides could not shake the hurt feelings and the sense of mistrust.” Caroline said the only reason the monies were allocated for the second position was purely a result of union intervention. “Even so, it left a bitter taste in my mouth, the betrayal of these two assistant managers who did not speak up for me created a deep wound. Even though I went in each day, behaved professionally, smiled etc. it seemed like nothing was ever going to be the same.” Caroline then said that as a result of that incident her relationship with one of the managers continually deteriorated and she would call her out in front of the staff and try to embarrass her. She said, “It makes you feel little and powerless. As a nurse, you really have to play it cool. You get yelled at for a lot of things that are really out of your power. This can make you feel inadequate.” Our interview ended with Caroline describing the inconsistency of emotions where she went from feeling part of a team to feeling like an outsider for speaking up where she saw injustice. She felt
that the two assistant managers should had stood up to their boss and but they allowed the
to turn each of them against each other and against her causing a major rift in the unit.
Caroline equated the negative interactions with colleagues’ as “causing needless stress in an
already stressful environment.”

Maggy

Maggy was referred to this study by a neighbor and after a brief conversation she agreed
to meet with me the next day at my house which happened to be around the corner from hers.
Maggy started the conversation by telling me that after working as a high school science teacher
for fifteen years, she decided at the age of forty to follow her childhood dream of one day
becoming a nurse. This was a career move that she said was delayed for a number of years, as
she was too busy raising her three children.

Maggy told me that she had worked at an inner city public hospital adding, “It really
makes you wonder whether or not you chose the right field. You go into nursing hoping to help
people, being told that you will work as a team and you then assume that in every situation that
is how it’s going to be. In the clinical setting, I continually found that many colleagues found
pleasure in making you feel as though your skills are not up to par. In my hospital, I was in the
minority and I was made to feel uncomfortable almost on a daily basis. There was one particular
group that had worked there for some time that made me feel like an outsider. I felt like I was
back at middle school or high school, where you had to impress the cool kids to get accepted or
you would not have many friends. My skills, my abilities and most everything was under constant
scrutiny and questioned by not only other nurses but by the other staff whether it was in or
outside my unit. Everybody aligned themselves with little groups and you start to really doubt
yourself and your skills. You begin to wonder: Is this the profession for you? Is this just not the
right fit? Did you do something wrong? You continually start doubting yourself, doubting your skills, doubting wanting to be there.” Maggy went on tell me a story where these behaviors of ignoring her by her colleagues not only affected her but had affected a patient’s care. She said, “Assuming that I was in a professional organization, I reported the inappropriate behavior to my nurse manager and outlined specific instances where I felt patient care was affected because of the treatment I had received. It did not matter to my manager; in fact, she told me that it appeared to her that I had trouble getting along with others. I was not whining; I was describing a specific instance where a patient didn’t receive adequate care because someone never reported to me that the patient had asked for assistance to go to the toilet.” Maggy went on to say how the patient had climbed over the bed rails and fell, luckily not breaking a hip. Maggy went on to say that she asked the patient, “Why didn’t you call me”? The patient replied, “I told the other nurse you are working with that I had to go to the bathroom.” Maggy said she had asked the aides on duty if the other nurse on duty with her had informed them and they both said they were never made aware. Maggy said the fall required an incident report and “I wrote exactly what the patient said on the sheet.” Maggy went on to say how her nurse manager wanted her to change her statement but she refused. She then said, “From that point forward, I was also labelled a troublemaker. I worked as a team collaboratively with other teachers and administrators in the Board of Education, I know how to work as a team, and there was no teamwork in this hospital. I blame the administration. The administration sets the tone. If those nurses were written up and told their behavior would not to be tolerated these situations would be few and far between.” Maggy said the stress of the job started to affect her health and it was then that she made the decision to leave the hospital. She stated that she is now a school nurse at a city public school but still feels like she has failed as a nurse at times because she could not make it work. “My dreams
went down in flames, it’s very disappointing when you have worked so hard for something especially when you know coming into nursing as a second career, and something that I always wanted to do...you feel so defeated.” We sat a little while longer and I thanked Maggy for speaking with me.

Nicole

Nicole was referred to this study after seeing my flyer at an alumni get-together at her alma mater, Molloy College in Long Island, NY. We briefly talked on the phone and agreed to meet the following week at her apartment in Astoria, N.Y.

The conversation began with Nicole telling me that she worked at a privately-owned hospital in Brooklyn, N.Y for the last seven years. This hospital was currently being merged with other facilities. She began describing various incidences where she felt disrespected by doctors, administrators and senior staff nurses who she said continually reported made her feel as if she was incompetent. I was trying to get Nicole focused on the subject matter as she drifted from story to story. I then repeated the research question, “Can you describe a time when you felt disrespected? She then said, “It’s the nurses that are more senior to you and the managers that really get me the most. Sometimes colleagues make you feel small when you ask a question. I can take sarcasm from an obnoxious physician but when people who you work beside day after day and are supposed to have your back, and don’t, or they make you feel stupid or incompetent for no particular reason, it wounds you. It is expected that physicians try to throw nurses under the bus in certain instances; but when nurses do it to each other, you die a little each time it happens. You think to yourself, when am I going to good enough for them to stop questioning my judgment? Why doesn’t anyone say anything positive? Aren’t we supposed to care for each other too? It’s at these times when I question what I am doing in this field. The highs are high like
when you save a patient or pick up a problem quickly and the lows are low when you are questioned about nonsense when you know you did the right thing but someone assumes you screwed up because no one wants to take the blame.” Nicole went on further to describe an incident where she was managing a patient with tachycardia all night. She stated that she had notified everyone including cardiology that she would be monitoring the patient closely for any changes. If there were any, she would notify them immediately. The next morning immediately after giving report, her manager started to verbally scream at her in the middle of the unit right after she had finished giving report. Nicole went on to say that, “My manager stormed over to me yelling that my patient had sustained tachycardia and asked why I did nothing about it all night. She never looked at my note. The whole world had been notified and was aware of it. I had documented it all, an EKG had been done, and cardiology had seen the patient. I told her that I had the situation under control by she felt I had missed something. I had just finished telling the whole story to the day nurse and now I had to defend myself to my manager. It really makes you look and feel stupid.” Nicole went on to tell me that it took her a becoming more senior and experienced to realize that “No one should be spoken to that way in a professional setting, not even new nurses. It’s not right, it makes you feel like almost as if you got hit”. Nicole stopped a few seconds and finished by adding “Nurses should never take for granted how much experience you have. When a new nurse comes along and they ask you a question, you should never dismiss them, where is the trust?” As the conversation came to a close I thanked Nicole for participating in my study.

Alexa

Alexa was referred to me from Nicole. They worked together at the same privately-owned hospital in Brooklyn. NY and in the same clinical unit. After speaking briefly on the
phone, we agreed to meet the following week at an eatery location close to her workplace. The conversation started with Alexa saying, “After speaking about it with Nicole she was compelled to want to be a part of my study.” She also felt that it was appropriate to tell me that she was soon to marry a surgeon who happened to work at the same hospital.

Alexa immediately began describing a recent experience at work where she felt disrespected and not trusted, she said, “All I can tell you there is a complete lack of trust in nursing, the good nurses have no power. When you perform your job professionally and a perceived lack of communication gets you written up. Let me explain, I am always sweet and nice to everyone. In fact, everyone knows that because I have been working here for several years. There are also a fair number of nurses who barely do their job. They never answer the phone nicely and hardly interact with their patients. Does anyone ever call them out on their unprofessional behavior? NEVER. Well, last week, was the final straw for me. I was having a very busy day with patients going bad left and right. A group of administrators’ and managers walked through my unit because we are joining a larger network. I didn’t have time to answer a lot of questions and a senior manager didn’t like my tone. I was later spoken to by my manager who informed me that she was going to write me up.” Alexa went on to describe how frustrated this made her feel and how the cattiness is what she is unhappiest about most. “It does not matter to the hospital whether or not you behave professionally and are a team player because we have lots of staff that never professional and are never nice. That’s fine with the hospital; mediocre nurses are just fine here.” Alexa went on to describe “Managers are afraid to go after one nurse who is beyond rude to everyone giving one-word answers to almost every question and rolling her eyes at everyone. I feel sorry for her patients they suffer. On the other hand, good nurses are a target. I have a busy day and someone does not like my tone of voice and I get
written up because I appeared uncooperative. You can see why it’s not just.” Alexa talked about how everyone in the unit including the physicians seem to avoid the nurses whom they know to be lazy or incompetent. Alexa described how her relationship with the physicians is much better than with nursing management. Alexa concluded the interview by saying, “Well I’ve had enough I’m leaving the hospital to work at a surgery center where the patients are easy and I don’t have to deal with this anymore.” I thanked her for her time and for her being part of my study. It was sad to see such a dedicated, young, spirited nurse want to leave a unit where patients most likely benefitted from her care because she felt powerless as she described.

Dena

Dena was referred to me through a colleague from the Graduate Center who thought she might be a good candidate for my study. Dena and I spoke on the phone and we decided to meet at her apartment in Manhattan.

Our conversation started with Dena telling me that she worked for the last five years as an Assistant Nurse Manager at a large metropolitan hospital in New York. Dena began describing an incident when she was covering for a manager who was on maternity leave and was asked to pick preceptors prior to JCAHO orientation. Dena said that, “I was basically doing two jobs at the same time but spent many hours picking my best nurses for this position. Someone who was not picked got very upset and wrote a letter to human resources reporting me for favoritism. I was doing the best I could with one set of hands. I was told that a complaint letter was written. Then I had to defend my position to HR and the VP of Nursing.” Dena went on “Thankfully I had plenty of documentation that this nurse wasn’t as skilled as the other nurses, who helped, but it was very hard. I felt like I did all this hard work only to be judged.” Dena described how she cried at the frustration of being judged and not supported by her manager.
when she returned from maternity leave. Dena went further to describe how she felt helpless and hurt when the staff nurse was listened to and she was dismissed. “It’s like getting stabbed in the back, I treat all my nurses the same and I felt betrayed, it changes relationships.” Instead of coming to me, this individual went behind my back. I was overhearing whispering about the issue. Nurses would stop talking when I entered the break room. I no longer felt part of a team.”

When we finished the interview, I thanked her for participating in my study. As I drove home I could not help but notice the similarities in the reports of the nurses I had interviewed. They all reported they had gone into the nursing profession, not for monetary reasons but because they really wanted to make a difference in people’s lives. They all were negatively affected by instances that appeared to be beyond their control.

Jane

Jane was referred to me by another friend who had told her about my study. She spoke briefly on the phone and agreed to meet at a restaurant in Merrick, NY which was halfway between our homes.

The conversation began by Jane telling me that she had worked for the last four years at a small Catholic Hospital in Long Island, New York and is currently attending Stony Brook University for her Nurse Practitioner Certificate. Jane then said, “Nurses are always thought of as most trusted profession, the highest ethical profession, and yet behind the scenes it is not always as it seems.” She described working on a Telemetry unit when she was a new nurse and working the overnight shift so she and her husband could take care of their children. She then said, “So I started on telemetry, nights and I was nervous to work nights. My preceptor is a well-known nurse on the unit. She had been there fifteen years, everyone knew her. I remember that she did not want to precept me. I felt intimidated to ask her a question. Every time I asked her a
question it seemed to bother her. Everything I did in fact, seemed to bother her. It made me feel uneasy. I was always stressed because I felt I was not part of the clique. Every chance I had, I tried to do things by myself. She spoke down to me and gave me inquisitive looks. I remember thinking she is fine with other nurses what did I do to her.” Jane continued “When I spoke to my manager about it one day the manager just laughed and said “Oh that’s Maggie and laughed.” The manager just chalked it up to the fact that Maggie was not a people person. Well she was a people person with everyone except me.” Jane went to tell me how she basically taught herself all she needed to know and created alliances with some of the physicians so she would know all about cardiac issues. Then she asked me, “What kind of example does this set for new nurses? I was able to handle it but like you don’t exist wears you down, especially when nurses need to react to patient situations. You need to know that someone has your back.” I sat quietly and did not answer, but reflected on her question. “Are we supposed to accept this behavior that we all know exists? Why were my questions not important? Now that I have experience and I am more confident I remember how it felt. There are still seasoned nurses who are not nice to each other, I was not looking for friends, just professional relationships, I have plenty of friends. A lot still needs to be done to improve our nursing culture, we still eat our young.” Jane finished the interview by telling me “what I find so inappropriate and disrespectful is the immature, mean spirited behavior from professionals just like me that most would not expect in the workplace. I guess I was looking for too much.” I thanked Jane for her time and for participating in my study. We said goodbye, and I headed home. I could not help but reflect as I drove about Jane’s story. As soon as I reached home I wrote in my journal and made notes about our interview.

This study was conducted to understand the lived experience of feeling disrespected as described by nurses who feel that way. The participant nurses interviewed had between 2 and 10
years’ experience. Each participant’s account of feeling disrespected was accompanied by vivid memories of episodes of painful encounters with colleagues. I coded the meaning units after rereading each interview after transcription took place (Table 1). I also made notes after each interview that I added to my notebook. The audit trail (Figure 1) shows the process of refining the meaning units from the participants’ description in order to form the structure of the meaning of feeling disrespected. Initially fifty-one meaning units were uncovered to help transform the meaning of feeling disrespected. To further interpret the experience of feeling disrespected, the researcher synthesized the meaning units into deeper more abstract meaning, reflecting a newly transformed meaning about their experience. This became the basis of the general structure of the experience. The participant experience is represented in (Figure 1), as not being listened to and belittled, tossed aside while experiencing disappointment, anger and wounded; and doubting nursing as their career choice. The structure of the lived experience of feeling disrespected as uncovered in this study is; utter discouragement arising with speaking up-remaining silent, the visible becoming invisible, disguised indifference creating broken connections.

Table 1. Participant Meaning Units

- It’s difficult when you can’t speak to your supervisor
- No one advocates for nurses
- Tosses in a pile like I was worth nothing”
- Retaliated against for speaking up
- Frustration, cried like I was in grade school and the bully was after me”
- I have a dreaded feeling when I go to work
- I have no control
- I wonder if I made the right choice?
- Demanding everything and giving nothing
- There is a need to behave professionally
- Where do you go when those who are supposed to support you don’t care?
- I have worked too hard to be bullied
- A job that was given to me was given to someone else with no explanation
• The manager totally dismissed my feelings
• I was told “You don’t know what disappointment is”
• Downplaying all the hard work to obtain the position
• I was betrayed by the people I trusted
• Now I was suddenly an outsider
• Managers didn’t speak for me
• Jumping to conclusions without thinking it through
• Scrutinizing every decision
• Now things were strained, it made going to work difficult
• All of a sudden, I was disrespectful when I used to be praised
• I was passed over continually
• I was judged without thinking it through
• I couldn’t shake the hurt feeling and mistrust
• The damage was done
• It left a bitter taste in my mouth
• It seemed like nothing was ever going to be the same
• It makes you feel little and powerless
• They acted like I didn’t exist
• You doubt why you became a nurse
• They found pleasure in making you think your skills were not up to par
• Made me feel like an outsider, that I needed to try to get accepted
• Everyone aligned themselves with little groups
• You continually start doubting yourself
• It made me physically sick
• You feel so defeated
• They make you feel small for asking a question
• When nurses make you feel stupid or incompetent it wounds
• When am I going to be good enough?
• Having to defend myself over and over
• There is no trust
• Disgusted by unprofessional treatment
• Lack of communication
• I was treated differently
• Having to defend my position and being judged
• Feeling betrayed by others changes relationships
• I no longer felt part of the team.
• Behind the scenes it is not as it seems
• Treated differently and no one cared
Not listened to, belittled, tossed in a pile, strangled, disappointment, angry, treated like an outsider, dismissed, little, weak, outside the loop, ignored, feeling judged, self-doubt, frustrated, stressed, small, incompetent, defensive, wounded, mistrust, treated different, angry, out of the clique, dismissed, ignored, feeling disappointed

**Figure 2 Synthesized Meaning Units**
Essential Themes

Powerless, I felt like a nobody?

All of the participants described that these experiences left them with the impression that they were treated like “nobodies.” Sophia felt she was grouped into the same pile of nurses who did not work hard. She began to question if she was doing the right thing. She reported not feeling as if she counted to her manager. Sophia reported that she felt disrespected when she was not listened to by her manager who is part of administration. She stated “So, she told me she doesn’t work for us; she works for the VA. I told her that she doesn’t stand up for us and I feel dismissed.” Caroline, a registered nurse in a busy surgical unit, reported that in her experience “feeling disrespected” is being constantly questioned by administration: “At work, when someone questions your judgment without thinking it through ... they are jumping to conclusions without asking your opinion.” Nicole reported feeling frustrated when her manager arrived in the middle of her shift and “begins scrutinizing every decision,” you become frustrated—She must decide, she told me, between explaining herself and just doing her job. Caroline felt that her experience was belittled by administration when one administrator compared her failure to get promoted with the administrator’s own inability to conceive: “This is just a little bump in the road and you really do not know what disappointment is.” Maggy stated that her complaints to her manager about disrespectful colleagues fell on deaf ears. Nicole said her power struggle came when she felt she was being thrown under the bus by her nursing manager, whom she felt never backed the nurses up. She described feeling that she didn’t have a voice. Alex’s struggle with administration occurred when she was written up after a busy day of caring for some very sick patients for answering a question in a tone of voice that administration deemed uncivil. “I
didn’t have time to answer a lot of questions ‘she stated’ and a senior manager didn’t like my tone. I was later spoken to by my manager who informed me that she was going to write me up.’’

Alex felt she was held to a standard that wasn’t applied to other nurses. Because she is often kind and calm, management was quicker to discipline her for what they saw as incivility, despite the fact, she said that many of her co-workers are often rude. Her frustration was described as she compared her behavior in one instance with individuals who are consistently rude and never spoken to about their manner. “It’s almost a double standard; if you’re professional and nice, God forbid you have a bad moment. If you are nasty by nature, that’s just fine because it is your personality, unprofessional as it is.” Alex describes not having enough people to turn to in difficult situations. She described how physicians are sometimes better to nurses than the nurse’s own management. “It’s almost as if nursing management likes to come down on nursing staff and exhibit their power over them, she said. Dena described her power struggle, which made her feel like a nobody was when someone accused her of favoritism, then began to talk behind her back and ignore her when they weren’t happy with the outcome. “Knowing how much time I put into my decision, only to be accused and challenged to defend it made me feel as if I had no power.” The impact of these various experiences caused the participants to question their vocation. Many described not wanting to get up and return to work. A career in of which they had dreamed about was suddenly making them feel sick. The experience of feeling disrespected seemed to zap their passion for a career that they willingly chose. It affected their abilities to perform their duties without ridicule or mistrust. The reality of their situation made them feel like they didn’t count as part of a collaborative team. In a profession where growth is vital, the poor communication and judgmental treatment appeared to impede their growth.
Treated as if you are just stupid

Caroline described negative interactions with colleagues that made her feel stupid and powerless. “As a nurse, you really have to play it cool.’ She told me.” You get yelled at for a lot of things that are really out of your power. This can make you feel inadequate.” Maggy agreed: “You question everything you do, and you feel so defeated when you are trying to do the right thing. When you are there for the patients and trying your best.” Nicole reported times when colleagues would try to make her feel incompetent because she had asked a question. “They say it in a way that they’re demeaning or that you’re not worth their time.” Dena was questioned by the VP of Nursing regarding a decision she had made. She had to defend her choice regarding the best nurses for a certain job. She reports that she had “done all this hard work just to be judged.” Jane reported that she had a preceptor who did not want to precept her. “She spoke down to me and gave me inquisitive looks. I remember thinking it was weird that she was friendly with the older nurses but not nice or friendly to me, very unwarranted.” All of the participants expressed frustration with their work relationships, which did not match up to those they had envisioned when they entered the nursing career. Criticism they received was not constructive; it was mean. They felt their opportunities and opinions were restricted by individuals who did not wish them well or want to see them succeed.

They also appeared to mistrust those who they believed they were stupid which furthered the divide.

Utter Discouragement

Sophia reported that her manager continued to threaten to write up her and her coworkers up. She stated “there is mistrust there, a lot of belittling going on now. I feel let down by the
person who is supposed to support me.” Caroline’s perceived annoyance in her role is described when she was disparaged by her manager for speaking up on behalf of the staff. She felt that this was within the guidelines of her position. “Downplaying all the hard work I put into getting a position makes you think, ‘is this worth it? Did I do enough or am I in the wrong place?’” Maggy reported that she had serious doubts about her decision to make a career change into nursing. After returning to school to become a nurse, she found herself with self-doubt asking herself why she had made the change only to be constantly belittled and treated like she was nonexistent by the very colleagues she interacted with daily and to find administration did not care to intervene. “It’s disappointing when you have worked so hard for something. You feel so defeated.” After falling ill from the stress that she experienced, she made another decision to leave her position and find a different job. Nicole similarly had her decision-making abilities questioned by a nursing manager in front of other staff. “I had control of the situation, but she didn’t bother to ask what I had done for the patient. I had advocated for my patient. To have administration come in and escalate the situation without asking me what interventions I had initiated.” Dena reported her decisions in regard to staff were continuously overridden by others in the unit that had no power. For instance, picking preceptors and promoting staff were included as part of her job title. If a staff member complained to a manager or higher up, he or she was listened to but Dena wasn’t. “There is no chain of command, so basically why have me in that position? I had no power, if every decision I made could be changed on a whim.” Jane felt deepening mistrust after her colleagues acted in an unprofessional manner toward her. It made her question her competency and role as a nurse. She described feeling “intimidated to ask her preceptor a question,” because when she spoke up, she was shut down and have her observations discounted by her manager.
This discouragement led each of the nurses to question their vocation and why they were still in this situation. I could see the frustration on their faces when they retold their experiences. Some shed tears, as though they were ashamed to tell their story. They reported not wanting to get out of bed and go into work, for fear of experiencing additional trauma. These negative interactions caused them stress, which they felt was unhealthy and unnecessary.

Broken Connections

In many instances, the participants described that there was a breakdown in relations with colleagues. These breakdowns led to deeper interpersonal rifts between nurses that were often quite painful. Sophia described one broken connection that followed from an instance when she was written up, in what she described as an act of “retaliation,” she reported that her ability to communicate with her supervisor was changed forever. The “incident” that caused this broken connection was something that neither Sophia nor her supervisor was able to fix. Caroline’s broken connection came after speaking up for herself and challenging a decision she believed was unfair. Things changed for her when she began to be treated differently than she had been treated before. “All of a sudden, I was made out to be disrespectful because I was standing up for myself in a professional manner. I was taken off the wound care team, where I had previously been praised by the hospitalist for my good work.” She talked about being part of a team at first. But suddenly, “feeling like an outsider.” Maggy also reported experiencing broken connections when she reported an inappropriate incident, in which a patient’s safety was risked, her supervisor did not approve of the way she wrote up the incident, apparently looking to keep another nurse out of trouble and not having the patient’s best interest at heart. Following Maggy’s report, her supervisor displayed disapproval. “From that point forward, I was also labelled a troublemaker.” Nicole’s broken connections were related to an incident in which her
manager jumped to conclusions before allowing time to see how a situation played out. She described a situation where both her colleagues and the manager didn’t trust her judgment, which made her feel disconnected from the unit. Alexa’s connections were broken when her hard work seemed to go unnoticed in light of procedural issues. Alexa described the “loss of personal interaction that she believed was lost when she described that she and some other nurses were treated differently because management could get away with it”. Dena’s described feeling betrayed by both fellow colleagues and administration as follows, “I felt betrayed; it changes relationships when you follow protocol and believe that you are doing the right thing only to be challenged on all sides.” All of the participants reported that they believed their opportunities for advancement were inhibited by these interactions, making it impossible to fit into the culture.

This chapter discussed the findings of the seven participants. The participants’ descriptions include several quotations that represented each participant experience of what feeling disrespected is like for them. Meaning units were identified after reading the transcripts, and four essential themes were identified. The participants’ words were used to support these essential themes in order to provide rigor to the study. These themes were discussed with my chair and with another faculty with whom I work. I assessed the meaning units by reviewing the transcripts over again to make sure that I had compared each participant shift in meaning (Table 1).
Reflection on the Findings

Nursing Perspective

The perspective that guided this study was Parse’s (2014) humanbecoming paradigm. This perspective postulates that the humanuniverse is indivisible, unpredictable, everchanging; it is characterized by the following postulates: illimitability, paradox, freedom and mystery. Illimitability is defined as unbounded knowing extending to infinity, an “all-at-once remembering-prospecting with the becoming visible-invisible becoming of the emerging now” (Parse, 2014, p. 31). Parse’s (2014) humanbecoming theory was used to analyze the experiences described by the participants of this study, in order to uncover the meaning of “feeling disrespected as an emergent, in-the-moment experience or sensation. Feeling disrespected for these participants aligns with the paradox speaking—remaining silent. The participants often reported that when they spoke up in the workplace to voice their concerns about a particular situation, they were silenced and dismissed. For example, Sophia description that “I was written up after speaking up to my supervisor as pure retaliation. She said I was basically worth nothing,” “You really do not know what disappointment is” said a supervisor to Caroline when she spoke up about not getting promoted; “My manager would pass me over and put individuals who were never in charge in charge” reported Caroline after she spoke up for her staff nurses; “My skills, my abilities and most everything was under constant scrutiny and questioned,” reported Maggy after refusing to change a statement. She continued, “From that point forward, I was labelled a troublemaker.” After reporting to a staff nurse that she had a patient’s status under control, Nicole was approached by a manager and yelled at “And now I had to defend myself to my manager. It really makes you look and feel stupid.” Even though the participants
thought their speaking up would bring forth positive changes, they soon discovered it was no so. Many times, they felt more belittled than ever before.

In contrast to Parse’s (2006) study on feeling respected where the core concepts are “experienced fortifying assuredness amid potential disregard, fulfilling delight and prized alliances” (p. 53). This study reported a loss of situational control or “powerlessness” among its participants. It must be noted that in Parse’s (2006) study on feeling respected, she did not use nurses for her study. Rather, she studied individuals with different careers such as managers and hair dressers. The participants in this study reported that the loss of control caused them to feel weak and small as if they were incompetent. Voicing their opinion caused them to be silenced, which in turn made them feel intimidated and at times belittled. The loss of trust caused further insecurity, leading to further self-doubt and intimidation. The meaning of feeling disrespected as uncovered in this study is not the antonym of respect, the antonym of respect is contempt, the meaning of feeling disrespected as uncovered in this study, is the absence of the expected feeling of respect that nurses should, if they took seriously their own stated code of ethics, show to not only each of their patients, but to each other.

A second principle of humanbecoming school of thought specifies that humanuniverse involves “configuring rhythmical patterns in the revealing-concealing and enabling-limiting of connecting-separating” (Parse, 2014, p. 36). The paradox of enabling-limiting may potentiate a nurse’s self-esteem or limit his or her sense of power and autonomy. When nurses were restricted, they experienced a separation from those with whom they worked. They experienced disregard of their self-worth and their sense of assuredness was broken. They felt dismissed and disguised; “like a nobody.” When they felt that they couldn’t trust those they worked with, they felt like outsiders. Connecting-separating was made visible as the professional and social bonds
were broken. These disrupted bonds were evident as participants described "feeling like I was stabbed in the back" and "having your dreams go down in flames" or "now I was an outsider, I was no longer part of the team" and "From that point on, I was labeled a troublemaker." Such sentiments revealed how devastating these broken relationships were. The total loss of human dignity and respect between professional colleagues went against the ethical conduct and the Code of Ethics.

The ethical dilemmas experienced by the participants resulted from of behavioral or communication patterns, from those whom they didn’t expect. It was not patients who disrespected these participants; it was nurses. Nurses are nominally professional, expected to uphold the Code of Ethics and exhibit good moral character, compassion, respectfulness and trustworthiness. In this study, negative behavior was displayed as irreverent or disrespectful within the practice. Clearly, many of the participants felt betrayed by their colleagues. The participants received negative treatment from individuals who whom they needed to collaborate with to improve patient outcomes. The ANA (2015) Code of Ethics for Nurses states that “the establishment of positive, respectful, relationships is crucial to preventing incivility, bullying, and workplace violence as a part of culture of respect” (ANA 2015). Respect is essential in nursing in order to achieve the values and ethics of the profession. Mutual trust, collaboration, and accountability must be continually emphasized, both personally and organizationally. The covenant between the profession and society is made explicit in the code” (ANA, 2015, provision 9). It makes clear that human dignity and respect extends to all colleagues and society. Respect is to be taught in schools of nursing and speaks to the moral character of individuals.

The third principle of human becoming posits that human universe involves cotranscending with the possibles as “the powering and originating of transforming” (Parse,
Feeling disrespect in the nursing workplace was experienced by the study participants as constraining. Constraint was not a static experience, but as Parse’s explains when individuals experience constraint, they continue to change or adapt with their fellow coworkers, patients, and/or families. The participants reported that constraint diminishes their peacefulness and ability to express their preferred ways of being in the workplace. As a result, frustration grows in the context of their experience of disregard. The finding include reference to living new ways of speaking and keeping quiet. This constraint, changes their direction and purpose as they live out their values in new and unfamiliar ways. The direction is changed but what will be is not yet; participants may one day look back at this disrespect and realize that it caused them to travel a different path but a path they will be satisfied with. Many of the participants revealed that they did not want others to be treated the way they themselves were treated. The situations in some ways changed all of the participants’ paths and purpose. Many envisioned a successful and productive career for themselves, one in which they would continue to survive and create new pathways in order to prevent further disrespect. The constraint was intended to diminish their peace but not their professionalism.

Hawkins (2017) described four core concepts of the experiences of feeling disrespected by women living with embodied largeness as experiencing “mortifying disheartenment, disquieting irreverence, distancing affiliations and enduring hardship” (p. 156). The results of the nurses in this study were compared, and similarities were found among two groups of participants. The disrespect described by the participants in Hawkins’ (2017) study of feeling disrespected was brought on by a stigmatizing presence that the participants lived with which was morbid obesity. Nurses, a group in society that is held in high esteem, did not appear to describe enduring hardship that was described by Hawkins’ group. The essences in the nurse
participants were situational and did not appear to be long standing. Because nursing is a respected profession, the interviewees in this study, did not expect to find such levels of disrespect within the profession, much less to be targets of disrespectful, unprofessional behavior. The participants in Hawkins’ study had all lived for years with their situation seemingly unable to change it. Similarities included the description by Hawkins’s (2017) of disquieting irreverence experienced by the enlarged women. In my study, the nurse participants described powerlessness and feeling like a “nobody which is relatable to irreverence. Hawkins’s (2017) described mortifying disheartenment; the nurse participants described utter discouragement which is similar but appears temporary to their situation. Hawkins (2017) described distancing affiliations as a concept her subjects described when feeling disrespected; the participant nurses described broken connections. These are more or less, descriptions of analogous situations. Looking at the two studies, the similarities are glaring yet the circumstances are not. Nurses are not supposed to be made to feel powerless at their workplace. Nurses take care of the vulnerable and are needed to support and empathize with patients who are frightened and sick. In the clinical setting, teamwork is imperative for a unit to run well. There is no place for disrespect among professionals.

The literature on disrespectful behaviors such as incivility, bullying and lateral or horizontal violence show that these behaviors all have negative consequences, including poor patient care, errors in care, financial loss to the institution. Knowing this, the motivations for change are clear. The participants’ descriptions are the personal consequences of feeling disrespected related to negative behaviors.

Four essences were developed: feeling powerless, “feeling like a nobody”; being treated like you are “stupid”; utter discouragement; and broken connections. These essences provided
the structure of feeling disrespected. Feeling disrespected is a universal living experience of “health and living quality” (Hawkins, 2017, p. 152.). Feeling powerless, like a “nobody,” occurred when the participants felt treated as if they were invisible, with no possibility of changing their situation. All participants wished to be part of a team of professional nurses. It appeared that the participants expected that they would be treated fairly and were disappointed when that did not happen. Colleagues and administrators, participants reported used language and treatment that made participants feel like they were “stupid”. The broken connections resulted from feelings of betrayal that could not be set aside- cast out of the team or circle. I sensed that the participants believed they had no power when their situation could not be resolved. The utter discouragement described in the interviews and sensed by the participants when they believed they were being judged incorrectly.

Limitations of the study

The limitation of all phenomenological study is that the findings are not generalizable. The phenomenon, feeling disrespected, changes over time, even for the participants, who were generous with their time and personal experiences, this study provides only a snap shot. The use of having a single researcher to uncover the meaning units and explore the universe essences in the participant’s narratives is a limitation that was partially overcome by the dissertation committees’ assistance.

Implications for Nursing Science

Understanding the lived experience of feeling disrespected described by nurses can provide insight into nursing relationships. Increased awareness of how disrespectful behaviors negatively impact nursing relations, can lead to changed behaviors that will improve how nurses communicate and increase the quality of the experience in the workplace. The culture in many
healthcare organizations can be changed for the better. The literature suggests that teaching effective communications skills can improve nurses’ confidence, morale, teamwork, and the quality of patient care (Kaplan et al., 2010; Raake, 2015). Nurses who feel disrespected may experience psychological or physiological distress or both. (Roberts, 1983; Farrell, 1999; Griffin, 2004; Longo & Sherman, 2007; Enbree & White, 2010; Gaffney, Demarco et al., 2012; Lachman, 2014; Blevins, 2015).

Research also indicates that communication skills training can improve inter-collegial and patient communication and increase self-efficacy in health care workers (Bonczek, Quinlan-Colwell, Tran & Wines, 2016; Griffin, 2004; Norgaard, Ammentorp, Kyvik & Kofoed, 2012; Griffin & Clark, 2014). Professional communication skills have been shown to increase retention in new graduates (Griffin, 2004; Clark and Griffin, 2014). Some recommendations to create environments that are professional and respectful include providing extensive professional communication combined with simulation in all leadership classes before nursing students graduate and enter the work environment. By defining professional behaviors and role playing, students are allowed to play out scenarios and learn from debriefing. Another recommendation is for health care organizations actually question nurse turnover. Leadership should refocus to create positive work cultures that retain nurses. The participants in my study all reiterated how breakdowns in communication occurred, which caused tension and in turn caused professional relationships to be changed and many times broken. Conflict resolution should be part of nursing staff meetings to find causes and solutions to mitigate conflicts. As nursing moves forward, keeping pace with the changing healthcare requirement, now more than ever nurses must recognize that respectful professional interactions lead to competent patient care and safe work environments for all.
In conclusion, a number of recommendations can be suggested that will help ameliorate the problems associated with disrespect in the nursing profession. First, making sure all nurses are educated to recognize the negative effects one feels when disrespected. Second, making sure that nurses understand that disrespect among colleagues will not be tolerated by healthcare institutions. Third, having healthcare institutions make sure that the policies and procedures in place to prevent this treatment are followed and fully embraced. Finally, remembering that as professional nurses, we have an obligation to create respectful professional environments where we work for the sake of the profession.
Appendix A: Definition of Terms

*Incivility:* a term used to describe rude treatment and behaviors directed toward another. If allowed to continue, the recipients of this behavior may suffer psychological or physical ailments possibly causing employees to take sick time and miss work (Clark, 2013).

*Bullying:* persistent, negative behavior from one or more persons over a prolonged period of time (Olender-Russo, 2009).

*Lateral Violence:* unacceptable, disruptive and inappropriate behavior involving nurses either overtly or covertly aiming their dissatisfaction with work to others who are in an equal or lesser position (Coursey et al., 2013).

*Horizontal Violence:* psychological harassment that creates hostility in the workplace between two nurses or a nurse and another health care professional (ANA, 2006).

*Disruptive behavior:* a combination of all of the terms and can include horizontal or lateral violence, bullying, gossiping, undue criticism, bickering and blaming, undermining and scapegoating (Joint Commission, 2008).
Appendix B: Participant Consent Form
THE CITY UNIVERSITY OF NEW YORK
Hunter College
Hunter-Bellevue School of Nursing

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Title of Research Study: The lived experience of feeling disrespected
Principal Investigator: Nadine Donahue MS, RN-BC, CNE
Doctoral Student
CUNY Graduate Center
365 5th Ave.
New York, NY 10016
Chair Person
Dr. Steven Baumann
Professor Hunter College/CUNY Graduate Center
425 East 25th Street, NY, NY, 10010
212-481-4457

You are being asked to participate in a research study because you are a nurse who identifies with feeling disrespected.

Purpose:
The purpose of this research study is to understand what the structure of the experience of feeling disrespected is like for nurses who feel they have been disrespected. These nurses will have at least two years’ full time clinical experience. The knowledge gained from this phenomenological study may help nurses and organizations who employ nurses to improve communication among and within their organizations. This may prompt other organizations to develop programs where nurses are in serviced in proper professional communication and the need for respectful interactions with their colleagues.

Procedures:
After obtaining Institutional Review Board (IRB) approval, the researcher will seek to recruit Registered Nurses who have worked for at least two years and feel they have been disrespected. Inclusion will be limited to nurses who have worked full time in the clinical area for at least two years. If you volunteer to participate in this research study, you agree to sign the informed consent and will be interviewed in a private place such as a coffee shop or meeting room. Each participant will also be asked to complete a demographic sheet to avoid coercion or bias. The registered nurse participants will be told that they can stop the interview anytime they wish and although there is little chance of emotional distress, participants will be referred to their employee assistance department if required. Every effort will be made to keep the comments of the participants confidential and unrelated to their role as a nurse. Participants will be numbered in the order of their participation, and the sheet linking their number and name will be kept in a locked file cabinet in the researcher’s office for 3 years and then destroyed. Their real names will not be used in any subsequent publication. Every effort will be made to reduce the anxiety the participants may have, related to a breach of confidentiality or concern of what they might say. Participants will be informed that they may withdraw from the study at any time with no consequences.
Time Commitment:
Data will be collected by semi-structured, open-ended interviews lasting approximately 30 minutes to 1 hour. The participants will choose the place, time, and date for the interview.

Potential Risks or Discomforts:
There are no potential risks to the participant. Every effort will be made to reduce the anxiety the participants may have, related to a breach of confidentiality or concern of what they might say will affect their academic progress or graduation.

Potential Benefits:
There are no direct benefits to participating in this study; however, your participation may increase knowledge of what disrespect feels like for those who have been disrespected.

Costs:
Participation in this study will involve no cost to the participant except possibly the cost of transportation to the meeting place.

Payment for Participation: You will not receive any payment for participating in this research study; however, each participant will receive a $5.00 coffee card as a Honorius.

Confidentiality:
This researcher will make the best effort to maintain confidentiality of any information that is collected during this research study, and that can identify you. We will disclose this information only with your permission or as required by law.

Participants will be numbered in the order of their participation and the sheet linking their number and name will be kept in a locked file cabinet in the researcher’s office for 3 years and then destroyed. Their real names will not be used in any subsequent publication. The research team, authorized CUNY staff, and government agencies that oversee this type of research may have access to research data and records in order to monitor the research. Research records provided to authorized, non-CUNY individuals will not contain identifiable information about you. Publications and/or presentations that result from this study will not identify you by name.

Participants’ Rights:

- Your participation in this research study is entirely voluntary. If you decide not to participate, there will be no penalty to you, and you will not lose any benefits to which you are otherwise entitled.

- You can decide to withdraw your consent and stop participating in the research at any time, without any penalty.

Questions, Comments or Concerns:
If you have any questions, comments or concerns about the research, you can talk to one of the following researchers: Nadine Donahue MS, RN-BC, CNE 917 273 -XXXX. If you have questions about your rights as a research participant, or you have comments or concerns that you would like to discuss with someone other than the researchers, please call the CUNY Research Compliance Administrator at 646-664-8918. Alternately, you can write to:

CUNY Office of the Vice Chancellor for Research
Attn: Research Compliance Administrator
205 East 42nd Street
New York, NY 10017

Signature of Participant:
If you agree to participate in this research study, please sign and date below. You will be given a copy of this consent form to keep.

_____________________________________________________
Printed Name of Participant

_____________________________________________________
Signature of Participant Date

Signature of Individual Obtaining Consent

_____________________________________________________
Printed Name of Individual Obtaining Consent

_____________________________________________________
Signature of Individual Obtaining Consent Date
Appendix C: Notice

Attention Nurses:

Have you experienced disrespect?

Would you like to talk about feeling disrespected and your experience?

I am a Ph.D. student looking for registered nurses who are working full time in the clinical setting and have at least two years of full-time experience.

If you are interested in participating in this study, contact me at NDonahue@york.cuny.edu

Or

917 273-XXXX

I will meet you at a meeting place of your choice near your home or a library in a private room. The conversation will take approximately 30 minutes to 1 hour.

Table 1:
Participant Meaning Units

- It’s difficult when you can’t speak to your supervisor
- No one advocates for nurses
- Tosses in a pile like I was worth nothing”
- Retaliated against for speaking up
- Frustration, cried like I was in grade school and the bully was after me”
- I have a dreaded feeling when I go to work
- I have no control
- I wonder if I made the right choice?
- Demanding everything and giving nothing
- There is a need to behave professionally
- Where do you go when those who are supposed to support you don’t care?
- I have worked too hard to be bullied
- A job that was given to me was given to someone else with no explanation
- The manager totally dismissed my feelings
- I was told “You don’t know what disappointment is”
- Downplaying all the hard work to obtain the position
- I was betrayed by the people I trusted
- Now I was suddenly an outsider
- Managers didn’t speak for me
- Jumping to conclusions without thinking it through
- Scrutinizing every decision
- Now things were strained, it made going to work difficult
- All of a sudden, I was disrespectful when I used to be praised
- I was passed over continually
- I was judged without thinking it through
- I couldn’t shake the hurt feeling and mistrust
- The damage was done
- It left a bitter taste in my mouth
- It seemed like nothing was ever going to be the same
- It makes you feel little and powerless
- They acted like I didn’t exist
- You doubt why you became a nurse
- They found pleasure in making you think your skills were not up to par
- Made me feel like an outsider, that I needed to try to get accepted
- Everyone aligned themselves with little groups
- You continually start doubting yourself
- It made me physically sick
- You feel so defeated
- They make you feel small for asking a question
- When nurses make you feel stupid or incompetent it wounds
- When am I going to be good enough?
• Having to defend myself over and over
• There is no trust
• Disgusted by unprofessional treatment
• Lack of communication

• I was treated differently
• Having to defend my position and being judged
• Feeling betrayed by others changes relationships

• I no longer felt part of the team.
• Behind the scenes it is not as it seems
• Treated differently and no one cared
Not listened to, belittled, tossed in a pile, strangled, disappointment, angry, treated like an outsider, dismissed, little, weak, outside the loop, ignored, feeling judged, self-doubt, frustrated, stressed, small, incompetent, defensive, wounded, mistrust, treated different, angry, out of the clique, dismissed, ignored, feeling disappointed.

**Figure 2 Synthesized Meaning Units**
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