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Resonant Leadership and Workplace Empowerment: The Value of Positive Organizational Cultures in Reducing Workplace Incivility

EXECUTIVE SUMMARY

- ▶ Nursing leaders are indispensable in creating positive nursing work environments that retain an empowered and satisfied nursing workforce.
- ▶ Positive and supportive leadership styles can lower patient mortality and improve nurses' health, job satisfaction, organizational commitment, emotional exhaustion, and intent to stay in their position.
- ▶ The results of this study support the role of positive leadership approaches that empower nurses and discourage workplace incivility and burnout in nursing work environments.
- ▶ The findings also provide empirical support for the notion of resonant leadership, a relatively new theory of relationship-focused leadership approaches.
- ▶ This research adds to the growing body of knowledge documenting the key role of positive leadership practices in creating healthy work environments that promote retention of nurses in a time of a severe nursing shortage.

“WORKPLACE INCIVILITY MAY BE subtle, but its effects are not” (Cortina & Magley, 2009, p. 272). Uncivil behaviors in the workplace can negatively influence employee health, job satisfaction, productivity, commitment, and turnover (Andersson & Pearson, 1999; Lim & Cortina, 2005; Porath & Erez, 2007). In nursing workplaces, incivility has been linked to a variety of negative organizational outcomes, including increased burnout and turnover intentions and decreased job satisfaction and commitment (Laschinger, Leiter, Day, & Gilin, 2009; Smith, Andrusyszyn, & Laschinger, 2010). Furthermore, workplace incivility creates a heavy financial burden for health care organizations, estimated at \$23.8 billion annually in the United States to cover direct and indirect costs associated with uncivil and violent workplace behaviors, such as absenteeism, turnover, lost productivity, and legal action (Sheehan, McCarthy, Barker, & Henderson, 2001). Lewis and Malecha (2011) estimated the yearly cost of lost productivity due to workplace incivility to be \$11,581 per nurse. Clearly, the

high personal and organizational cost of workplace incivility must be addressed to promote nurse retention and to sustain effective health care organizations.

Nursing leaders are indispensable in creating positive nursing work environments that retain an empowered and satisfied nursing workforce (Duffield, Roche, O'Brien-Pallas, Catling-Paull, & King, 2009; VanOyen Force, 2005; Weberg, 2010). The style of leadership that nursing managers develop influences important staff, patient, and organizational outcomes (Cummings, Hayduk, & Estabrooks, 2005; Leka, Jain, Zwetsloot, & Cox, 2010). Positive and supportive leadership styles can lower patient mortality (Cummings, Midodzi, Wong, & Estabrooks, 2010), improve nurses' health (Boumans & Landeweerd, 1993, 1994), job satisfaction (Larrabee et al., 2003; Laschinger & Leiter, 2006), organizational commitment (Avolio, Zhu, Koh, & Bhatia, 2004; Laschinger & Leiter, 2006), emotional exhaustion (Cummings et al., 2005), and intent to stay in their position (Cowden, Cummings, & Profetto-McGrath, 2011; Duffield et al., 2009).

Hutton (2006) suggests the need for a preventative rather than reactionary approach to work-

NOTE: Authors' biographical information and sources of funding can be found on the following page.

place incivility, stressing the importance of early diagnosis and intervention in mitigating organizational costs associated with toxic work environments. Nurse leaders play a critical role in establishing the quality of the work environment by setting acceptable standards of behavior and ensuring employees have access to what they need to function effectively.

Purpose of the Study

The purpose of this study was to test a model linking a positive leadership approach and workplace empowerment to workplace incivility, burnout, and subsequently job satisfaction.

Theoretical Framework

The theoretical framework for this study integrates concepts from Boyatzis and McKee’s (2005) resonant leadership theory, Kanter’s (1977, 1993) theory of organizational empowerment, Andersson and Pearson’s (1999) workplace incivility theory, and Maslach and Leiter’s (1997) burnout theory. Kanter (1977, 1993) describes empowering organizational structures that must be in place for employees to be effective in their work, and previous research has demonstrated the importance of positive leadership styles in ensuring access to these structures (Laschinger, Purdy, & Almost, 2007; Laschinger, Wong, McMahon,

& Kaufmann, 1999; Morrison, Jones, & Fuller, 1997). We reasoned that the disempowering work environments create conditions for incivility as nurses respond negatively to a lack of necessary support and resources to accomplish their work in meaningful ways (Laschinger, Leiter et al., 2009; Smith et al., 2010). The stress associated with ongoing workplace incivility over time results in emotional exhaustion and job dissatisfaction (Laschinger, Leiter et al., 2009; Smith et al., 2010). We argue that leaders who employ positive leadership styles are less likely to create work environments that foster incivility and subsequent burnout and job dissatisfaction.

Workplace Incivility

Workplace incivility is defined as “low intensity deviant behaviour with ambiguous intent to harm the target, in violation of workplace norms for mutual respect” (Andersson & Pearson, 1999, p. 457). Some examples of incivility in the workplace include dismissing an employee’s ideas or opinions, making derogatory or demeaning remarks about individuals at work, and excluding people from unit-based social activities (Andersson & Pearson, 1999; Hutton, 2006). Although uncivil behaviors may appear relatively harmless, their potential for escalation to workplace violence rep-

resents a threat to healthy work environments. Andersson and Pearson (1999) introduced the notion of incivility spirals, where thoughtless acts are interpreted by targets as uncivil, which over time leads to cognitive and affective appraisals that cause them to reciprocate these uncivil behaviors. This reoccurring sequence of incivility followed by a desire for reciprocation ultimately leads to a tipping point, at which time the intent to harm changes from ambiguous to overt, and may escalate to violence. Workplace incivility differs from more overt forms of workplace aggression in that it is not necessarily intentional, is less persistent than bullying, and may or may not entail a power imbalance (Hershcovis, 2011). However, according to Porath and Erez (2007), when workplace incivility is unchecked, it can escalate to more aggressive forms of workplace violence.

The prevalence of incivility in the workplace varies markedly among studies, with rates as low as 13%-19% (Cole, Grubb, Sauter, Swanson, & Lawless, 1997) and as high as 71%-75% reported (Cortina, Magley, Williams, & Langhout, 2001; Einarsen & Raknes, 1997). However, one consistent finding is that when incivility is present it has destructive consequences for nurses, patients, and the organization. Workplace incivility has been linked to decreased mental health (depression, anxiety) (Hansen et al., 2006; Tepper, 2000), patient safety (Felblinger, 2008), organizational commitment and turnover intentions (Leiter, Laschinger, Day, & Gilin Oore, 2011), increased job stress (Agervold & Mikkelsen, 2004), somatic symptoms (LeBlanc & Kelloway, 2002), and emotional exhaustion (Grandey, Kern, & Frone, 2007).

Most explanations of workplace mistreatment subscribe to Leymann’s (1990) “environmental hypothesis” as the underlying mechanism behind this phenomenon. Leymann’s hypothesis states

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that stressful workplace conditions result in worker fatigue which may manifest in counterproductive work behaviors, such as incivility. Leymann (1996) further substantiated this notion in a thorough review of approximately 800 case studies of negative work environments. He found employees reporting counterproductive work behaviors described their work environments as poorly organized with a helpless or uninterested management team. There is considerable additional empirical support for this proposition (Einarsen, Raknes, & Matthiesen, 1994; Zapf, Knorz, & Kull, 1996). Laschinger, Leiter, and colleagues (2009) found structural empowerment was significantly related to both supervisor and co-worker incivility in a large study with Canadian health care workers, a finding later replicated by Smith and associates (2010). These results suggest structurally empowering work environments may be able to create conditions on the unit that reduce the likelihood of stressful situations that result in uncivil behaviors.

Workplace Empowerment

Kanter's (1977, 1993) theory of structural empowerment is based on the notion of *power*, as measured by one's ability to get things done. Power is created and transferred within an organization through formal and informal systems. Formal power is created when positions are visible, flexible, and central to the organization, and informal power is created through connections inside and outside the organization, such as relationships with sponsors, peers, and other co-workers. Formal and informal power facilitate access to four empowerment structures: (a) access to opportunities to learn and grow, (b) access to information, (c) access to support, and (d) access to resources required for the job. Access to *opportunity* provides individuals with challenges, rewards, and

occasions for professional development. Access to *information* refers to the provision of both technical knowledge related to the core role of the employee, and information concerning the larger organization, such as its goals, policies, and decisions. Access to *resources* refers to the ability to obtain the necessary materials, money, and time to accomplish job demands. Finally, access to *support* provides employees with feedback, guidance, and emotional support from superiors, peers, and subordinates that functions in a way to maximize effectiveness. Kanter suggests management is essential in ensuring employees have access to these structures, thus creating structurally empowering conditions in their workplaces.

Empowering nursing work environments correlate with numerous positive nurse outcomes, such as increased job satisfaction, organizational commitment, and reduced burnout and incivility (Greco, Laschinger, & Wong, 2006; Laschinger, Leiter et al., 2009; Smith et al., 2010). Laschinger, Finegan, and Wilk (2009, 2011) demonstrated that strong nursing leadership predicted staff nurses' perceptions of structural empowerment on their units. Structural empowerment has also been related to several other forms of positive leadership styles, including Thomas and Velthouse's (1990) leader empowering behaviors (Conger & Kanungo, 1988; Greco et al., 2006; Laschinger et al., 1999), emotionally intelligent leadership (Lucas, Laschinger, & Wong, 2008; Young-Ritchie, Laschinger, & Wong, 2009), and authentic leadership (Laschinger, Wong, & Grau, 2012; Wong & Laschinger, 2012). Thus, there appears to be empirical support for the positive influence of leadership on structural empowerment in the workplace. However, resonant leadership, a relationally focused leadership style, has remained largely unexplored

in connection with structurally empowering work environments and resulting nursing outcomes.

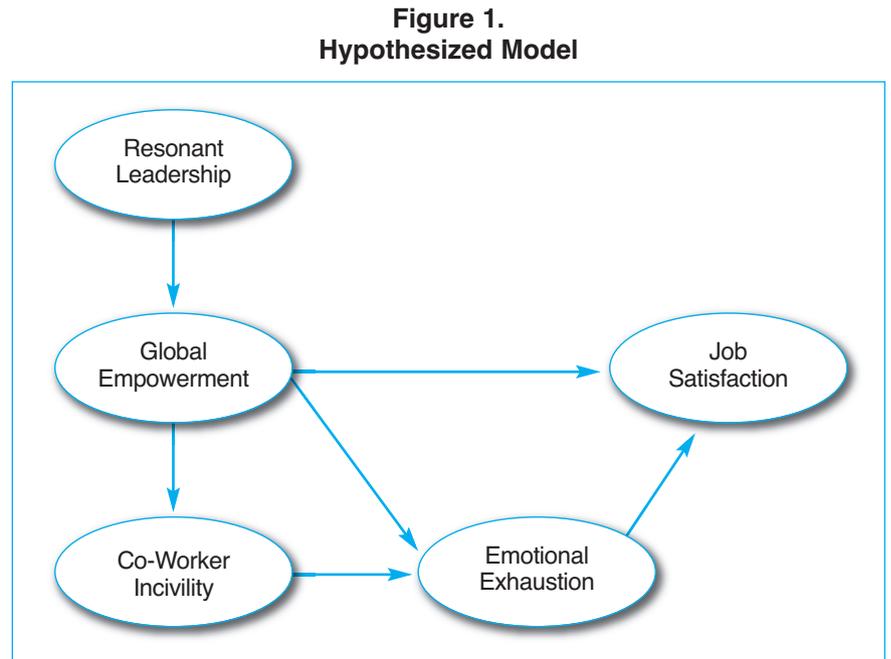
Resonant Leadership

Relationally focused leadership styles are associated with positive work environments that promote employee engagement and result in greater work satisfaction and productivity (Uhl-Bien, 2006). Resonant leadership (Boyatzis & McKee, 2005; Cummings, 2004) is one example of a relationally focused leadership style. Resonant leadership is distinguished from other theories of leadership by its foundation on emotional intelligence (Goleman, Boyatzis, & McKee, 2002). Four domains compose the emotional intelligence framework: emotional self-awareness, self-management, socio-political awareness, and effective management of relationships with others (Goleman et al., 2002). Goleman and colleagues (2002) describe six leadership styles used in leading teams in organizations, four of which are labeled resonant leadership, along with two dissonant styles. According to these authors, leaders can develop emotional intelligence competencies and learn when and how to use each style depending on the situation at hand. Resonant leadership styles include visionary, coaching, affiliative, and democratic approaches, whereas dissonant styles include pace setting and commanding. According to Goleman and associates (2002), dissonant leadership styles are often misapplied, but can be useful in particular situations. However, they emphasize the need for leaders to focus on developing the more positive resonant styles to build resonance among team members. Resonant leaders are in tune with their surroundings, which results in the synchronization of the thoughts and emotions of people working around them. Resonant leaders are able to control not only their own emotions but those of the people they lead, while concurrently building

strong and trusting relationships (Boyatzis & McKee, 2005). Resonant leaders are empathetic, passionate, committed, and have the ability to read people and groups accurately. They provide hope and courage in moving toward a new and exciting future, enabling those around them to be the best they can be (Boyatzis, 2008). While they make exceptional colleagues and are able to achieve results, resonant leaders are able to transfer their expertise and knowledge, empowering those around them.

A systematic review found leadership styles that were conceptually consistent with the notion of resonant leadership were positively correlated with several components of nursing professional practice environments, including effective nursing leadership, use of nursing models of care, and nurse-physician collaboration. These styles of leadership were also associated with improved conflict management, job security, staff nurse health and job satisfaction, as well as lower levels of anxiety, emotional exhaustion, and stress (Cowden et al., 2011).

A recent study by Squires, Tourangeau, Laschinger, and Doran (2010) examined the influence of resonant leadership on organizational justice, quality of nursing work environments, and nurse and patient outcomes in a study of acute care nurses. Squires and associates (2010) used a newly developed measure of resonant leadership (Estabrooks, Squires, Cummings, Birdsell, & Norton, 2009; Estabrooks, Squires, Hayduk, Cummings, & Norton, 2011) based on Goleman and co-authors (2002) and Boyatzis and McKee's (2005) model. Squires and colleagues (2010) found resonant leadership was significantly related to higher-quality leader-nurse relationships, improved safety climates, and supportive professional practice environments, as well as lower-emotional



exhaustion and job turnover intentions among nurses. This study is one of the first to demonstrate acceptable reliability and validity of the resonant leadership scale. In another recent study, Estabrooks and colleagues (2011) found resonant leadership explained a significant amount of variation in emotional exhaustion, job satisfaction, and support for innovative ideas, adding empirical support for the relevance of this notion of leadership in nursing settings.

Hypothesized Model

We integrated the concepts from the theories and research described previously into a hypothesized model to examine the influence of resonant leadership and empowerment on nurses' experiences of workplace incivility and burnout and ultimately job satisfaction in acute care nursing settings (see Figure 1). First we hypothesized that nurses' perceptions of their immediate supervisors' resonant leadership behaviors would be positively related to the extent to which they considered their work environments to be structurally empowering. These

positive working conditions were then hypothesized to be associated with lower co-worker incivility and subsequently lower burnout (emotional exhaustion), and ultimately lower job satisfaction. We reasoned resonant leaders are fundamental to creating work environments that foster positive working relationships and discourage uncivil behaviors among co-workers and therefore protect nurses from the negative effects of incivility, such as burnout and job dissatisfaction.

Methods

Study sample. The analysis reported here is part of a larger national study of nurses' worklives. In the larger study, provincial regulatory bodies' registry lists from nine participating provinces in Canada were used to generate samples of nurses working in direct patient care positions. Participants received a survey at their home mailing addresses using the Dillman Total Design Methodology (Dillman, 2007) to increase return rates. From a total sample of 3,600 nurses (400 per province), 1,241 usable questionnaires were

returned (35% return rate). Data were collected from September 2010 to January 2011.

Instrumentation. *Resonant leadership* behaviors of the current supervisor were measured using the 10-item Resonant Leadership Scale (Cummings, 2006), a subscale of the Alberta Context Tool (Estabrooks et al., 2009, 2011). Using a 5-point Likert-type scale (1=strongly disagree, 5=strongly agree), participants indicated the extent to which they felt their immediate supervisor displayed these types of leadership behaviors (e.g., acts on values even if it is at a personal cost). This tool has previously demonstrated strong internal consistency ($\alpha=0.95$) and validity (Estabrooks et al., 2009, 2011).

Workplace empowerment was measured using the two-item Global Empowerment Scale (Laschinger, 1996). Using a 5-point Likert-type scale (1=strongly disagree, 5=strongly agree), participants indicated the extent to which they felt their workplace was empowering (e.g., overall, I consider my workplace to be an empowering environment). This scale has demonstrated reliability ($\alpha=0.84-0.88$) and validity in numerous nursing studies (Cho, Laschinger, & Wong, 2006; Sarmiento, Laschinger, & Iwasiw, 2004).

Employees' self-reported exposure to co-worker incivility in the past month was measured using the Workplace Incivility Scale (e.g., paid little attention to your statement or showed little interest in your opinion [Cortina et al., 2001]). Participants rated these items using a 7-point Likert-type scale (0=never, 6=daily). This scale has previously demonstrated adequate reliability ($\alpha=0.89$) and validity (Cortina et al., 2001).

The Maslach Burnout Inventory-General Survey (Schaufeli, Leiter, Maslach, & Jackson, 1996) was used to measure the core component of burnout, *emotional exhaustion* (e.g., I feel emotionally drained from my work). A total of

five items were rated on a 7-point Likert scale (0=never, 6=daily). Scores greater than three were interpreted to mean the respondent is experiencing burnout (Leiter & Maslach, 2004). Acceptable reliability ($\alpha=0.82-0.94$) and validity for this tool have been demonstrated across several studies (Laschinger, Grau, Finegan, & Wilk, 2010; Schaufeli & Janczur, 1994; Schutte, Toppinen, Kalimo, & Schaufeli, 2000).

A four-item global measure of work satisfaction previously used in nursing populations was used to measure *job satisfaction* (Laschinger, Finegan, Shamian, & Wilk, 2001). Items are rated on a five-point Likert scale (1=strongly disagree, 5=strongly agree; e.g., I feel very satisfied with my job). Construct validity for a one-factor model was established by Laschinger and colleagues (2001) and acceptable reliability ($\alpha=0.78-0.84$) has been demonstrated (Laschinger, Finegan, Shamian, & Wilk, 2004).

Data analysis. Descriptive, inferential, and reliability analyses of the demographic and major study variables were conducted using the Statistical Package for the Social Sciences (SPSS) version 20.0 (IBM, 2011a) statistical software program. Structural equation modeling (SEM) with maximum likelihood estimation was conducted to test the hypothesized model using the Analysis of Moment Structures (AMOS) version 20.0 (IBM, 2011b) statistical software program. A missing values analysis suggested minor missing data (3%) that was missing completely at random, and when the amount of missing data is small (less than 5%) the amount of bias is very likely trivial (Graham & Hofer, 2000). Given the low percentage of data missing completely at random, we used a simple mean imputation for missing values based on the recommendations of Little and Rubin (1987). Kline (2005) suggests a sample size of 200 or more constitutes an adequate sample size for SEM, thus our sample size of 1,241 was sufficient.

Although discrepancies exist regarding the best index of overall fit for evaluating models, we followed Hoyle and Panter's (1995) recommendation that the following criteria be used to evaluate the model fit: omnibus fit indices such as the chi-square (χ^2) and the chi-square/degrees of freedom ratio (χ^2/df) (Jöreskog & Sörbom, 1989), the incremental fit indices Comparative Fit Index (CFI) (Bentler & Bonett, 1980), and the Incremental Fit Index (IFI) (Bollen, 1989). Additionally, the Root Mean Square Error of Approximation (RMSEA) was calculated as advocated by Browne and Cudeck (1989). The difference between the hypothesized model and the recently identified version of the model is measured by the χ^2 . Low nonstatistically significant values of χ^2 are desired; however, it is very sensitive to sample size, so with a model using a larger sample size, the null hypothesis is likely to be rejected the majority of the time (Kline, 2005). Due to this limitation, the χ^2 was used only to evaluate the potential differences in fit among competing models. Incremental fit indices indicate the proportion of improvement of the hypothesized model relative to a null model, typically assuming no correlation among observed variables. The commonly agreed upon critical value for the CFI and IFI is 0.90 or higher (Kline, 2005). The RMSEA is the standardized summary of the average co-variance residuals, and is a resulting measure of the lack of fit between the data and the model (Kline, 2005). Low values (between 0 and 0.06) are indicative of a good-fitting model (Hu & Bentler, 1999).

Results

Participants. The demographic profile of the sample is presented in Table 1. The majority of nurses were female (93.6%), averaged 41.52 years of age, and had 16.80 years of nursing experience (11.99 years in their current organization and 7.56 years on their

current unit). Almost half of the nurses in our sample were diploma prepared (48.2%), while the remaining participants were baccalaureate prepared (51.85), which is slightly higher than the national average (40%). Most worked on either medical-surgical units (51.7%) or critical care units (22.4%) on a full-time basis (57.9%). With the exception of education, the demographics of our sample were not noticeably different from the national database of registered nurses (Canadian Institute for Health Information, 2010).

Descriptive statistics and correlations. The means, standard deviations, Cronbach's alpha reliabilities, and intercorrelations among major study variables are presented in Table 2. On average nurses did not rate their immediate supervisors highly on their use of resonant leadership behaviors ($M=3.22$), suggesting considerable room for improvement. This was also the case for nurses' ratings of empowering conditions in their work environments ($M=3.22$). On the other hand, it was encouraging to find nurses' self-reported exposure to uncivil behaviors from co-workers was very low ($M=0.70$ on a scale ranging from 0-6). Table 3 presents a detailed breakdown of the mean, standard deviation, and percentage frequency for each of the uncivil behaviors measured. The most frequently cited forms of incivility were not having attention paid to one's input, having one's judgment doubted, and condescending remarks, while the least cited forms of incivility were unprofessional behaviors and

rude or derogatory remarks. Nurses' levels of emotional exhaustion ($M=2.87$) were just below Leiter and Maslach's (2004) cut-off for severe burnout (>3.0). Finally, nurses reported only moderate

levels of satisfaction with their job ($M=3.18$). Resonant leadership was most strongly correlated to empowerment and job satisfaction ($r=0.47$ and 0.43 , respectively), although it was significantly nega-

Table 1.
Demographic Profile

Demographic Variables	Mean	Standard Deviation
Age	41.52	11.07
Years as an RN	16.80	11.72
Years in Current Organization	11.99	10.12
Years on Current Unit	7.56	7.64
	N	Percentage
<i>Gender</i>		
Female	1,161	93.6
Male	80	6.4
<i>Degree</i>		
Degree	643	51.8
No Degree	598	48.2
<i>Work Setting</i>		
Hospital	1,089	87.8
Community	106	8.6
Both	36	2.9
<i>Unit Specialty</i>		
Medical-Surgical	641	51.7
Critical Care	278	22.4
Maternal-Child	139	11.2
Mental Health	51	4.1
Community	79	6.4
Long-Term Care	53	4.3
<i>Employment Status</i>		
Full Time	719	57.9
Part Time	397	32.0
Casual	98	7.9

Table 2.
Mean, Standard Deviation, Cronbach's Alpha, and Correlations for Study Variables

	M	SD	Range	α	1	2	3	4	5
1. Resonant Leadership	3.22	0.94	1-5	0.94	—				
2. Global Empowerment	3.22	0.95	1-5	0.87	0.47	—			
3. Co-worker Incivility	0.70	0.90	0-6	0.93	-0.19	-0.25	—		
4. Emotional Exhaustion	2.87	1.39	0-6	0.90	-0.19	-0.42	0.23	—	
5. Job Satisfaction	3.18	0.92	1-5	0.79	0.42	0.65	-0.20	-0.44	—

Table 3.
Means, Standard Deviation, and Percentage Frequency of Uncivil Co-Worker Behaviors

	<i>M</i>	<i>SD</i>	Never	Sporadically	Now and Then	Regularly	Often	Very Often	Daily
1. Put you down or was condescending to you in some way.	0.84	1.13	51.6%	26.1%	15.8%	3.0%	1.5%	1.2%	0.7%
2. Paid little attention to a statement you made or showed little interest in your opinion.	0.91	1.14	47.0%	29.2%	16.7%	3.4%	1.9%	1.3%	0.6%
3. Made demeaning, rude, or derogatory remarks about you.	0.49	0.96	70.8%	17.9%	7.3%	1.6%	1.0%	0.9%	0.5%
4. Addressed you in unprofessional terms, either privately or publicly.	0.48	0.97	72.4%	16.1%	7.4%	1.8%	1.0%	0.8%	0.6%
5. Ignored or excluded you from professional camaraderie.	0.71	1.14	61.8%	19.5%	12.1%	3.1%	1.5%	1.0%	0.9%
6. Doubted your judgement in a matter over which you have responsibility.	0.84	1.13	51.5%	27.6%	13.7%	3.5%	1.8%	1.2%	0.6%
7. Made unwanted attempts to draw you into a discussion of personal matters.	0.63	1.11	66.6%	17.6%	8.6%	3.5%	2.0%	0.9%	0.6%

tively correlated with both co-worker incivility ($r = -0.19$) and emotional exhaustion ($r = -0.19$). Empowerment had a significant negative relationship with co-worker incivility ($r = -0.25$) and emotional exhaustion ($r = -0.42$), which were all strongly correlated with job satisfaction (empowerment, $r = 0.65$; incivility, $r = -0.20$; and emotional exhaustion, $r = -0.44$). Exposure to co-worker incivility had a significant positive relationship with levels of emotional exhaustion ($r = 0.23$).

Test of the hypothesized model. The test of the original hypothesized model did not meet acceptable model fit requirements according to Kline (2005) and Hu and Bentler (1999), although all hypothesized paths were significant and in the expected direction ($\chi^2 = 57.33$, $df = 4$, $p = 0.000$, $\chi^2/df = 14.33$, $IFI = 0.964$, $CFI = 0.963$, $RMSEA = 0.104$) (see Table 4). However, the modification indices

suggested a theoretically plausible direct path from resonant leadership to job satisfaction. Thus a revised model in which resonant leadership having both direct and indirect effects was analyzed. The revised model revealed an adequate fit to the data ($\chi^2 = 8.742$, $df = 3$, $p = 0.033$, $\chi^2/df = 2.914$, $IFI = 0.996$, $CFI = 0.996$, $RMSEA = 0.39$), and all hypothesized paths were significant and in the expected direction providing support for the model (see Table 4 and Figure 2). Resonant leadership had a strong positive direct effect on workplace empowerment ($\beta = 0.47$), which in turn had a significant negative effect on co-worker incivility ($\beta = -0.25$). Co-worker incivility had a significant direct effect on emotional exhaustion ($\beta = 0.14$), which in turn, had a significant negative effect on job satisfaction ($\beta = -0.20$). Empowerment influenced job satisfaction both directly ($\beta = 0.49$) and indirectly

through co-worker incivility and emotional exhaustion ($\beta = 0.085$). Resonant leadership also had a significant direct effect on job satisfaction ($\beta = 0.16$) and all indirect effects in the model were significant at the two-tailed $p < 0.05$ level.

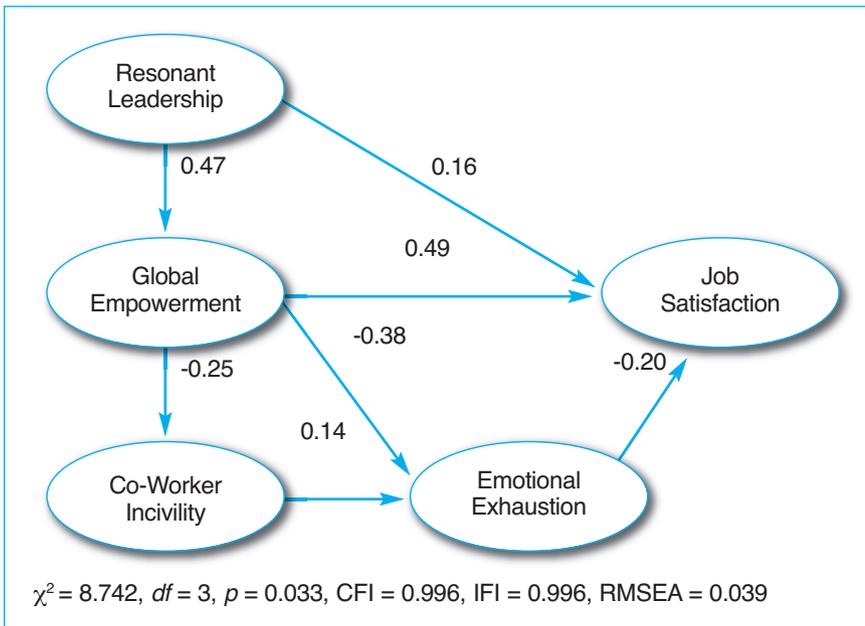
Discussion

According to the Canadian Nurses Association (2009), "leadership plays a pivotal role in the immediate lives of nurses and it has an impact on the entire health system and the Canadians it serves" (p. 1). The continually changing climate of health care has required a simultaneous transformation of the nursing profession. The role of the nurse leader has evolved such that it is no longer enough to establish a practice environment that promotes quality care, these new leaders must now possess additional business skills (Kleinman, 2003) and political savvy (Cook, 2001).

Table 4.
Direct and Indirect Standardized Coefficients for Hypothesized and Final Model Structural Paths

Structural Paths	Standardized Direct Effect (β)	Standardized Indirect Effect (β)
A. Hypothesized Model		
Resonant Leadership → Global Empowerment	0.47	—
Resonant Leadership → Co-worker Incivility	—	-0.12
Resonant Leadership → Emotional Exhaustion	—	-0.29
Resonant Leadership → Job Satisfaction	—	0.30
Global Empowerment → Co-worker Incivility	-0.25	—
Global Empowerment → Emotional Exhaustion	-0.38	-0.05
Global Empowerment → Job Satisfaction	0.57	0.08
Co-worker Incivility → Emotional Exhaustion	0.14	—
Co-worker Incivility → Job Satisfaction	—	-0.03
Emotional Exhaustion → Job Satisfaction	-0.20	—
B. Final Model		
Resonant Leadership → Global Empowerment	0.47	—
Resonant Leadership → Co-worker Incivility	—	-0.12
Resonant Leadership → Emotional Exhaustion	—	-0.20
Resonant Leadership → Job Satisfaction	0.16	0.27
Global Empowerment → Co-worker Incivility	-0.25	—
Global Empowerment → Emotional Exhaustion	-0.38	-0.03
Global Empowerment → Job Satisfaction	0.49	0.09
Co-worker Incivility → Emotional Exhaustion	0.14	—
Co-worker Incivility → Job Satisfaction	—	-0.03
Emotional Exhaustion → Job Satisfaction	-0.20	—

Figure 2.
Final Model



Nurse leaders are expected to demonstrate and preserve the values of nursing, while balancing the competing priorities and demands of the patients, families, professionals, and the overall organization despite fiscal restraints. This study is the first to demonstrate the role of resonant leadership behaviors in nursing leaders and their influence on the nursing work environment and resulting nursing outcomes.

Previous studies have demonstrated the essential role of nursing leaders in creating empowering work environments and retaining a satisfied nursing workforce (Duffield et al., 2009; VanOyen Force, 2005; Weberg, 2010). The role of resonant leadership behaviors, however, had received little attention in the nurs-

ing and management literature. Our results showed resonant leadership had both a direct influence on job satisfaction as well as an indirect effect through creating a greater sense of empowerment and subsequently lower incivility and burnout. These results support Boyatzis and McKee's (2005) explanation of how resonant leaders create positive work environments that empower their followers. The results are also consistent with those of Squires and colleagues (2010) who linked resonant leadership to lower levels of burnout and subsequent turnover intentions and provide empirical support for resonant leadership theory.

Our results are consistent with previous findings regarding the influence of empowerment on workplace incivility (Laschinger, Leiter et al., 2009; Smith et al., 2010), burnout (Greco et al., 2006; Laschinger et al., 2009) and job satisfaction (Laschinger, Leiter et al., 2009). However, this study offers the unique contribution of national data. Given the strong relationship between resonant leadership and empowerment and the subsequent influence of empowerment on incivility and burnout, our results highlight the importance of leadership in creating healthy work environments. These results are consistent with previous research demonstrating the impact of relationship-focussed leadership approaches for empowering nurses (Laschinger et al., 2012; Wong & Laschinger, 2012). Experiences of incivility from co-workers significantly influenced nurses' levels of emotional exhaustion; however, there was a stronger effect on emotional exhaustion from workplace empowerment, echoing the importance of empowering work environments in mitigating negative nursing outcomes and thus the indispensable role of strong positive leaders in ensuring these conditions are in place.

Significant discrepancies exist

in the rates of incivility reported in the literature as well as a lack of clarity and consistency in the definition and measurement of incivility. Thus, this study provides a valuable contribution to the understanding of the prevalence of incivility in nursing by providing a detailed account of the reports of incivility using a well-established measure of the construct in a large-scale national sample. Depending on the classification used, our rates of exposure to incivility range from 4%-7% if we included those who experienced incivility on a regular basis to as high as 28%-53% if we included all of those who reported experiencing any incivility. Future research in workplace incivility should attempt to standardize the definition and mode of reporting frequency of incivility to gain a more accurate understanding of its prevalence.

Implications

Findings from this study suggest some practical implications for nurse leaders and faculty teaching management courses. The value of nursing leaders' relationships with nursing staff in fostering empowering work structures that ultimately facilitated lower incivility and burnout and higher job satisfaction was underscored in this study. Specifically, managers who integrate the resonant leadership skills of empathy, relating, listening, and responding to concerns in their everyday interactions with nurses create empowering respectful and civil climates that lead to quality relationships among leaders and staff (Squires et al., 2010). Seeking feedback from staff even when it is difficult to hear, supporting and role modeling teamwork as the desired way to achieve goals, actively mentoring staff toward optimum performance, and allowing staff the freedom to make important decisions in their work are essential ways for managers to develop effective working condi-

tions that ultimately increase staff job satisfaction (Cummings et al., 2005).

Faculty teaching management courses should emphasize the value of relational leadership theories and styles and their connection to creating conditions that facilitate positive working relationships among staff, specifically addressing the leader's role in facilitating respectful and civil work climates. Various approaches by which leaders can develop resonant styles in structured leadership development programs have been studied (Boyatzis & McKee, 2005; McKee, Boyatzis, & Johnston, 2008), which may inform efforts to develop these skills in nursing and other health care leaders. Leadership development programs in health care organizations need to underscore the development of emotional intelligence skills and competencies necessary to build effective work relationships which ultimately link with quality of care and staff outcomes (Cummings et al., 2008).

Limitations

The results of this study must be interpreted with caution in light of several methodological limitations. The cross-sectional design precludes our ability to attribute strong causal effects and the use of self-report measures raises concerns about common method variance. However, the large national sample and the strong psychometric properties of the study instruments help offset these concerns. However, the results should be replicated using a longitudinal design and additional objective measures of work outcomes.

Conclusions

The results of this study provide support for the role of positive leadership approaches that empower nurses and discourage workplace incivility and burnout in nursing work environments. The findings also provide empirical support for

the notion of resonant leadership, a relatively new theory of relationship-focused leadership approaches. This research adds to the growing body of knowledge documenting the key role of positive leadership practices in creating healthy work environments that promote retention of nurses in a time of a severe nursing shortage. \$

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continued on page 44

Reducing Workplace Incivility

continued from page 15

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