Recognizing, Confronting, and Eliminating Workplace Bullying

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Abstract: Workplace bullying (WPB) behaviors negatively affect nurse productivity, satisfaction, and retention, and hinder safe patient care. The purpose of this article is to define WPB, differentiate between incivility and WPB, and recommend actions to prevent WPB behaviors. Informed occupational and environmental health nurses and nurse leaders must recognize, confront, and eliminate WPB in their facilities and organizations. Recognizing, confronting, and eliminating WPB behaviors in health care is a crucial first step toward sustained improvements in patient care quality and the health and safety of health care employees.

Keywords: workplace violence, mental health, occupational hazards, safety, ethical decision-making, occupational health and safety team, best practices

Workplace bullying (WPB) affects nurses' productivity, satisfaction, and retention, hindering safe patient care (Berry, Gillespie, Gates, & Schafer, 2012). Repeated and frequent unacceptable behaviors may or may not be perceived as WPB. Examples of WPB include harassment, exclusion, humiliation, belittlement, gossip, and unfair workload assignments (Einarsen, Hoel, Zapf, & Cooper, 2011). Some individuals may carefully tailor WPB in creative and opportunistic ways to reduce targets' ability to defend against these behaviors (Cleary, Hunt, & Horsfall, 2010). Because nurses, in any stage of practice, can become targets, the purpose of this article was to review and apply the constructs of WPB within the nursing profession. However, this article is also applicable to all organizations. Informed occupational and environmental health nurses and organization leaders may be more proactive in recognizing, confronting, and eliminating WPB in their facilities and offices.

The behaviors that constitute WPB remain discordant due to the multiple definitions provided by researchers and targets (Einarsen et al., 2011; Vessey, DeMarco, & DiFazio, 2011). Untargeted and ambiguous acts of WPB are symptoms of an uncivil work environment (Childre, Wachs, & Lim, 2011). Delineating and measuring WPB provides an essential linkage to further understanding WPB predictors and consequences. Einarsen et al.'s (2011) WPB constructs are reviewed here to increase the clarity among incivility, social norms, and WPB.

Recognizing WPB, Incivility, and Social Norms

Einarsen et al. (2011) developed six WPB constructs (i.e., target orientation, frequency, duration, intentionality, nature of the behavior, and power imbalance) through synthesis of European bullying research beginning in the early 1990s.

Target Orientation (Self-Labeling)

The target's perception determines whether WPB occurred by self-labeling as a target (Einarsen et al., 2011). As an example, Berry et al. (2012) asked novice nurses about negative acts directed toward them in the previous 6 months. Even though 92.9% ($n = 183$) of the participants had experienced negative behaviors, only 44.6% ($n = 88$) self-identified as having been bullied. This finding reflects that not all negative behaviors are perceived as WPB.

Frequency

WPB is not a single behavioral event. WPB must occur repeatedly, at least once weekly (Einarsen et al., 2011). An example of WPB within the nursing context is when a charge nurse assigns an unmanageable workload to a particular nurse compared with other nursing staff (e.g., charge nurse's friends) daily or weekly. In Berry et al. (2012), a similar incident was described as a "rite of passage" by a novice nurse.

An example, highlighting a behavior not easily placed in the frequency category of repeated behavior, is spreading rumors or gossip (Einarsen et al., 2011). A coworker initiates a rumor to

increase political standing without the intent of harming the other worker (Archer & Coyne, 2005). The coworker does not repeat the rumor, but others do. As the rumor spreads through the organization, changes in social support from peers occur, leaving the target socially isolated (Einarsen et al., 2011). The target may be unaware of the rumor until peer or organizational relationships have changed significantly. As an example, a coworker alludes to a sexual liaison between two employees working on a shared project. This rumor causes their manager to separate the team from the project; the coworker who started the rumor becomes project manager.

Duration

Einarsen et al. (2011) established the 6-month period to distinguish WPB from incivility and interpersonal conflict. This 6-month period has created a criterion to measure WPB behaviors. The 6-month period does not mean WPB behaviors go unrecognized before 6 months or that WPB ends after 6 months. WPB has been documented to occur on average 18 months until nurses take extended sick leave, transfer, resign, or are terminated (Vessey, Demarco, Gaffney, & Budin, 2009; A. Yildirim & Yildirim, 2007).

Intentionality

WPB is intentional from targets' perspectives. Einarsen et al. (2011) asserted only perpetrators can verify intention, giving them the power to deny the intent of their actions to harm targets. In an uncivil environment, a predatory bully may deny any intention to harm until the damage to the target is irrevocable (Einarsen et al., 2011). Because of this situation, the target's perception of intention supersedes the perpetrator's declared intent (Einarsen et al., 2011). If targets state they were bullied, they were.

Unintentional harm may play a more significant role in health care. Instrumental aggression, an aggressive act to gain something of value, increases an aggressor's political power. Nurses have recognized that bullying behaviors occur for individual, political, and competitive reasons (Neuman & Baron, 2011).

Coworkers, managers, occupational health nurses, and nurse leaders may be unaware that their actions negatively affected the target (Childre et al., 2011). In health care organizations, assigning mandatory overtime to nurses who are new, single, or male without asking or rotating mandatory overtime is an example of WPB behavior. The exclusive assignment of excessive workloads as a way of "making or breaking" a nurse to a specific work environment is also WPB. What once was a social norm or tradition in health care is no longer acceptable behavior and now is clearly understood as bullying (Dellasega, 2011).

Nature of the Behavior

WPB and incivility are manifestations of work stress (Roberts, Scherer, & Bowyer, 2011). Einarsen et al. (2011)

divided WPB into two categories: conflict-related and predatory bullying. WPB is not a conflict between opponents of equal power; however, work conflict can accentuate interpersonal power imbalance (Neuman & Baron, 2011). With predatory bullying, the perpetrator seeks to exert power and control over a target. Predatory bullying occurs for many reasons and may be linked to poor self-esteem, personality traits, or simply entertainment (e.g., teasing a foreign-born nurse because of her accent; Neuman & Baron, 2011).

Poorly resolved incivility between the target and predatory perpetrator can escalate from incivility to WPB to physical violence (Einarsen et al., 2011). However, predatory bullying is purposeful in its selection of a target who is believed to be unable to defend against WPB. Nurses are often targets in an uncivil environment, whether they are able to respond and WPB behaviors escalate, or unable to respond to WPB behaviors because of a power imbalance (the perpetrator has a leadership position), confusion on how to respond, or deniability by the perpetrator (Berry et al., 2012; Einarsen et al., 2011).

Power Imbalance

Power differences, due to the perceived power of seniority or the actual power of a position (e.g., charge nurse, nurse educator, supervisor, manager), are usually present between the perpetrator and the target. Targets believe they are powerless and, therefore, unable to defend against the bully's actions (Salin, 2003). Salin (2003) reported that power imbalances align with overall societal beliefs about powerful (e.g., White male, chief executive officer, government official) and powerless individuals (e.g., female, ethnic minority, individuals with disabilities); these same societal beliefs flow into organizational cultures.

Other Considerations in WPB

To measure WPB, targets must perceive intentional, frequent, and systematic negative behaviors directed toward them with an inability to defend against those behaviors due to perceived power differences between targets and perpetrators for 6 months (Einarsen et al., 2011). However, the target may be aware of WPB immediately.

Social norms also may play a role in shaping or reinforcing WPB behaviors (Neuman & Baron, 2011). A social norm is a spoken or unspoken rule or particular way of doing things (e.g., everyone facing the door in an elevator) which imposes expected behaviors for a group (Bicchieri & Muldoon, 2011). WPB may have a long organizational history (e.g., military, paramilitary, nursing), rooted in and unrecognized as socialization through indoctrination or ritualistic initiations of new employees (Hutchinson, 2012). In other words, perceived WPB behaviors may be a culturally supported form of instrumental aggression mingled with good intentions of molding novice nurses into the organizational culture.

Hutchinson, Wilkes, Jackson, and Vickers (2010) found that informal organizational alliances, along with organizational tolerance, reward, and misuse of legitimate authority, processes, and procedures, lead to WPB in health care. Furthermore, synthesis of WPB study narratives has suggested a socialization process within nursing that normalized bullying behavior (Hutchinson, 2012). Organizational tolerance and reward of WPB in nursing management led to silence, minimization, and under-reporting of WPB by target nurses (Hutchinson et al., 2010). This same socialization also may cause under-reporting of injuries, violent or verbal attacks by patients, and no compensation to nurses for lost work breaks and lunches or worked overtime.

A strong predictor of bullying behaviors is having been bullied (Hauge, Skogstad, & Einarsen, 2007). Bullied participants in three nursing studies confirmed use of bullying behaviors defensively (Vessey et al., 2009; A. Yildirim & Yildirim, 2007; D. Yildirim, Yildirim, & Timucin, 2007). Hoel, Giga, and Davidson (2007) noted that student nurses adopt the norm of the collective nurse work group, instead of challenging WPB behavior. Given the adoption of social norms within the group culture, understanding how nursing culture plays a role in the continuation of WPB is a crucial first step to changing that culture to a culture of safety and health for nurses.

Confronting and Eliminating WPB

The previous sections provided a description of WPB to assist occupational health nurses work with nurse leaders in recognizing and understanding the complexity of WPB behaviors within nursing culture. WPB negatively affects nurse retention and leads to presenteeism, so the need for occupational health nursing interventions is imperative (Conway, Clausen, Hansen, & Hogh, 2015). The following actions are recommended to confront and eliminate bullying behaviors in health care.

Occupational and Environmental Health Nursing Interventions

Occupational health nurses focus on workforce health and productivity, tailoring interventions to manage health care costs (Randolph, Scully, & Bertsche, 2011). Occupational health nurses also collaborate with other departments and professionals to maintain metrics associated with work injuries, occupational illnesses, and use of sick leave. Occupational health nurses serve as consultants to nurse leaders, human resource professionals, and employees distressed by WPB. Employees may complain of somatic symptoms (e.g., stomachache, headache, depression, anger, lost time) that can accompany stress and burnout from frequent exposure to WPB behaviors (Vessey et al., 2009; D. Yildirim, 2009).

Practice recommendations

Patient care has become more complex, time-consuming, and stressful. Essential job functions and descriptions in health care organizations may be outdated, unable to meet current demands. Occupational health nurses should use injury and illness surveillance to determine at-risk units within health care organizations. Using cost-benefit studies of health risks associated with WPB, occupational health nurses can estimate the costs of attrition and benefit use. With this information, occupational health nurses can estimate the impact of unresolved work conflict and WPB behaviors on employers' bottom line (Randolph et al., 2011). Using cost savings, corporate image, productivity, and business risk as critical business concerns, occupational health nurses can lobby for WPB interventions (Randolph et al., 2011). In addition, occupational health nurses, as well as nurse leaders, should communicate and model appropriate behavior and professional communication in the workplace.

If a culture of disrespect and incivility is endemic to the facility, occupational health nurses should carefully monitor bullying and increase interventions as needed while instituting and supporting culture change (Childre et al., 2011). Nurse leaders must be attentive to staff communication on and off their units as WPB can occur between units and floors, causing less participation and productivity. Frequent, non-threatening contact (i.e., open door policy) may provide opportunities for employees to share issues arising on and between the units with their nurse managers. In addition, confidential focus groups encourage nurses to share experiences in a safe environment; role playing WPB has also proven helpful (Gillespie, Brown, Grubb, Shay, & Montoya, 2015). Skill-based education on building collaborative relationships, confronting uncivil behavior, coaching, and conflict resolution are essential to nurse leaders' abilities to manage staff effectively (The Joint Commission, 2008).

Regardless of why WPB occurs, WPB continues. In some health care organizations, WPB is tolerated, enabled, or rewarded, creating social and cultural acceptance in health care workplaces (Hutchinson et al., 2010). Given that most instances of bullying are learned behaviors, responses to stress, or social norms of an organization, the behaviors can be unlearned. Occupational health nurses and nurse leaders must clarify that WPB is unacceptable and will be confronted and documented. If coaching or corrective action fails, termination is an acceptable consequence to continued bullying (The Joint Commission, 2008; Patterson, Grenny, McMillan, & Switzler, 2005).

A hierarchical organization can create a perception of power imbalance and barriers to reporting issues through the corporate structure, leading to a perception of bullying (Patterson et al., 2005). To minimize power imbalances within hierarchical organizations, effective nurse empowerment through shared governance is recommended. Shared responsibility and transparency in decision making for patient-centered care can positively affect health care organization metrics on nurse satisfaction, retention, and patient safety (Barden, Griffin, Donahue, & Fitzpatrick, 2011).

In Summary

Workplace bullying (WPB) is not a single event but behaviors targeted weekly to daily toward the nurse. The perpetrator may carefully tailor WPB to reduce the target's ability to defend themselves. Occupational health nurses may be the first individuals employee targets see because of the somatic symptoms associated with WPB. Occupational health nurses are resources to recognize and quantify the impact of WPB to productivity, corporate image, and businesses' bottom line.

Conclusion

Skilled occupational health nurses and nurse leaders recognize WPB, confront unprofessional behaviors, and empower staff to do the same. Health care administrators should collaborate with occupational health nurses to prevent individual and group responses to stressful work environments. Occupational health nurses, collaborating with corporate officers, nurse leaders, staff nurses, and other health care staff, can manage the systems and cultural changes necessary to reduce WPB. Education of and collaboration between occupational health nurses, administrators, nurse leaders, and other health care staff can create transparent and productive workplaces.

Online Resources for Workplace Bullying

www.workplacebullying.org: Workplace Bullying Institute has resources, books, and videos to assistant targets of bullying. Drs. Gary and Ruth Namie have been workplace bullying advocates since the early 1990s.

eden-therapy.com: Jessie Brown provides professional coaching by telephone to individuals facing the injurious effects of being targeted by bullies in the workplace. The confidential phone sessions, a form of consultation (not therapy), offer education, emotional support, and customized strategies for effectively addressing workplace bullying situations.

www.apaexcellence.org: The American Psychological Association provides references and additional links on workplace bullying.

www.lni.wa.gov: Washington State resources for intervening on workplace bullying.

newworkplace.wordpress.com: Minding the Workplace blog by David Yamada delves into legal issues. He also has a helps list.

www.suicidepreventionlifeline.org: A free resource to bullied targets, LifeLine helps find a reason to keep living. By calling 1-800-273-TALK (8255) callers are connected to a skilled, trained counselor at a crisis center in the caller's area, anytime 24/7.

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