BULLYING
IN A CARING PROFESSION
Reasons, Results, and Recommendations

Barbara S. Broome, PhD, RN, FAAN; and
Shiphrah Williams-Evans, PhD, RN, PMHNP-BC
ABSTRACT
The theories of Florence Nightingale and Jean Watson provide a framework for the caring work of nurses. Ironically, this caring profession struggles with bullying. Bullying has both physiological and psychological ramifications for the person being bullied and a negative impact on the organization and patient care. Strategies to address bullying include education, developing codes of acceptable conduct for the workplace, and a zero-tolerance policy. Mental health nurses have a vital role in helping nurses return to roles of caring.

Caring is an integral part of nursing. Jean Watson identified carative or caritas factors as a core guide for nursing. Her model, the Theory of Human Caring, focuses not only on the nurse’s ability to provide compassion to ease patient suffering, but on how caring can contribute to the nurse’s own self-actualization (Watson, 2008). Florence Nightingale (1859), in her classic work Notes on Nursing: What It Is, and What It Is Not, also attributed to nursing those caring behaviors that are used to support the natural process of healing.

In stark contrast to the acknowledged caring nature of nursing is the prevalence of bullying in nursing. Vessey, DeMarco, Gaffney, and Budin (2009) found that 70% of U.S. nurses surveyed reported being bullied at work. Similarly, in another study, 87% of Turkish nurses reported being bullied (Yildirim & Yildirim, 2007). Evidence shows that bullying among nurses affects both retention of nurses at the bedside and patient outcomes. MacKusick and Minick (2010) used qualitative analysis to explore factors influencing the RNs’ decision to leave clinical practice and found that horizontal hostility and bullying were common reasons cited for leaving clinical practice. Strong evidence supports the finding that unhealthy communication and unprofessional relationships can have a direct impact on patient safety and outcomes (The Joint Commission, 2008; MacKusick & Minick, 2010; Weinand, 2010).

BULLYING DEFINED
Heinz Leymann (1996) first described bullying in a 1984 publication by the National Board of Occupational Safety and Health in Stockholm, Sweden. More recently in New South Wales, Australia, Workcover NSW (2009) defined bullying as “repeated unreasonable behaviour directed towards a worker or group of workers that creates a risk to health and safety” (p. 4). The intent of this unreasonable behavior or bullying is to harm others and create a hostile work environment (Cleary, Hunt, & Horsfall, 2010; Hutchinson, Vickers, Jackson, & Wilkes, 2006; Hutchinson, Vickers, Wilkes, & Jackson, 2009; Luparell, 2011), while diminishing a person’s ability to cope (Hansen, Hogh, & Persson, 2011). Woellle and McCaffrey (2007) also described the aggressive and destructive behavior of nurses against each other as bullying. There are two primary types of workplace bullying: (a) horizontal or lateral and (b) vertical or hierarchical. Bullying can be verbal, physical, or in writing, and can extend beyond working hours (Edwards & O’Connell, 2007).

Horizontal violence, a term used frequently to describe peer-to-peer aggression, was defined by Longo (2007) as “an act of subtle or overt aggression perpetrated by one colleague toward another colleague” (p. 177) who are at the same level. The Center for American Nurses (2008) identified the most common forms of lateral violence as nonverbal innuendo, verbal affront, undermining activities, withholding information, sabotaging, infighting, scapegoating, backstabbing, failure to respect privacy, and broken confidences. Vertical or hierarchical violence differs from horizontal violence in that the perpetrator of the abusive behaviors is a superior (Thomas & Burk, 2009). Interestingly, the most common types of bullies are managers and supervisors, where the superior uses his or her status as a mechanism to control the victim through work assignments, promotion, and work evaluations (Cleary et al., 2010). This power imbalance makes it extremely difficult for the target to defend against the bully.

REASONS FOR BULLYING
There are numerous explanations for why vertical and horizontal violence occurs. One view is that the bully has pathological narcissistic characteristics coupled with the need to dominate in interpersonal relationships. This bully is both controlling and manipulative. The psyche of the archetypal bully demonstrates a pattern consistent with exploitative behavior and a lack of empathy. This bully has the need to act out fantasies and revenge against previous aggressors, stemming from a cyclic victim-
perpetrator behavior in childhood that continues into adult relationships (Turkel, 2007).

Another view is based in the theory of oppression, which proposes that horizontal violence is a response to a situation and is not directed at the individual. Responding to the situation may result in punishment so the frustration is exhibited as interpersonal conflict (Longo & Sherman, 2007). Often, the oppressed group will exhibit self-hatred or low self-esteem that can result in a group that is fragmented and divisive. The nursing profession is primarily a female profession, functioning in a male-dominated system of their knowledge of the dynamic nature of human behavior. Their ability to communicate and engage in crucial conversations in a nonthreatening manner enables information to be obtained and used to develop appropriate interventions (Cleary, Hunt, Walter, & Robertson, 2009).

BULLYING AND THE NURSING PROFESSION

Nursing has bullies. New graduates, students, and subordinates may experience vertical or horizontal violence—a phenomenon known in nursing as “eating our young” (Thomas & Burk, 2009, p. 226). A significant number of nurses either have observed bullying (Stanley, Martin, Nemeth, Michel, & Welton, 2007; Vessey et al., 2009) or have been bullied in the workplace (Dunn, 2003). In this case, a powerful and prestigious group (physicians) controls a less-powerful group (nurses) (Dunn, 2003). The result is a perceived lack of autonomy, accountability, and control over the profession. Unable to generate the confidence to cope with the situation, the less-powerful group displaces its anger and emotional hostilities, and the end result is infighting and horizontal violence among nurses (Dunn, 2003).

Mental health nurses are in a unique position to intervene because of their knowledge of the dynamic nature of human behavior. Their ability to communicate and engage in crucial conversations in a nonthreatening manner enables information to be obtained and used to develop appropriate interventions (Cleary, Hunt, Walter, & Robertson, 2009).

Physiological Effects

Several studies on bullying noted that eating disorders, weight loss, fatigue, headaches, hypertension, and angina were common occurrences (Hurley, 2006; Murray, 2009; Longo & Sherman, 2007). Cardiovascular disease and digestive disturbances can occur with stress, resulting in increased sickness and sick leave time (Olender-Russo, 2009). In addition, mental and physical distress may play a role in some nurses’ decision to leave a job—or even the profession—to escape the stress of horizontal violence and bullying.
Issues of Retention

Institutions are confronted with the impact of horizontal violence in the form of financial loss as they struggle to fill the positions of nurses who resign or leave the profession to escape the stress of bullying. New RNs’ decision to either leave practice or change positions within the first 3 years of clinical practice can be related to exposure to workplace bullying (Cipriano, 2006; Olender-Russo, 2009). Thus, bullying may be a factor in recruitment and retention of nurses in the profession (Longo & Sherman, 2007; MacKusick & Minick, 2010; Olender-Russo, 2009; Simons, 2008). The Cleveland Clinic (2011) examined workplace relationships and the subsequent impact on job satisfaction and performance and found that bullying was associated with emotional exhaustion and job dissatisfaction. The Governance Institute (2009) also found that: intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and preventable adverse outcomes, increase the cost of care, and cause qualified clinicians and managers to seek new positions in more professional environments. (p. 22)

PROFESSIONAL RECOMMENDATIONS

Several professional organizations have taken a stance on disruptive behavior and bullying in the workplace. The Joint Commission created a leadership chapter to address disruptive and inappropriate behaviors when evaluating performance (The Governance Institute, 2009). Elements of performance in this document require that hospitals have a code of conduct and a process that manages disruptive and inappropriate behaviors. The American Nurses Association (2001) Code of Ethics for Nurses advocates for an environment that promotes the provision of quality health care. Recommendations from the Center for American Nurses (2008) include guidelines for disruptive behaviors and the responsibility of organizations to maintain a safe work environment. Several interventions have been suggested for effectively intervening and halting the cycle of horizontal violence. These interventions are intended to create an environment where bullying is not tolerated.

Education

Education is a critical element to combat bullying in the workplace. The Center for American Nurses (2008) advocates for the dissemination of education on bullying to include strategies on recognizing bullies and how to address the behavior, as well as for inclusion of this educational information in academic curricula at schools of nursing and in continuing education programs. Proactively, many states have enacted legislation requiring employers to have comprehensive prevention programs with penalties for anyone convicted of an act of violence against a nurse. Education and legislation will create an environment that will empower people to identify bullying behavior. No longer can excuses such as “kidding around,” “joking,” or “helping a person to develop a thick skin” be used to validate demeaning and antagonistic behavior toward coworkers. Mental health nurses can teach other nurses the valuable skills of conflict management, communication, and maintenance of personal self-worth in an adverse environment (Weinand, 2010; Woelfle & McCaffrey, 2007).

Gaining Control

Developing a code of conduct so organizations can identify disruptive behaviors that will not be tolerated will help in gaining control (American Medical Association, 2000). Nurses must be involved in the development of this code of conduct, as this allows them to

KEYPOINTS


1. Bullying is an act of subtle or overt aggression with the intent of demeaning and devaluing a person. There are two primary types of workplace bullying: horizontal or lateral and vertical or hierarchical.

2. Consequences of bullying may include psychological (e.g., depression, anxiety) and physiological (e.g., weight loss, fatigue) changes in the victim, as well as increased absenteeism and difficulty retaining employees in the organization.

3. Strategies to combat bullying are related to education, gaining control through a code of conduct and zero-tolerance policy, documentation of events when they do occur, and holistic care to ensure victims return to normal functioning.

Do you agree with this article? Disagree? Have a comment or questions? Send an e-mail to the Journal at jpn@slackinc.com.
take ownership and responsibility for their working environment (Rocker, 2008). The environment created by such a policy is geared toward a climate of dignity, respect, and fairness, with zero tolerance of inappropriate and disruptive behavior (Ramos, 2006).

Documentation
Even with clear policies in place, bullying may occur. It is imperative that any event of bullying be reported, and the events clearly documented (Broome, 2008; Leiper, 2005). Although reporting bullying behavior may be stressful for the victim, it is imperative that any infractions of the zero-tolerance policy be reported in a formal complaint. The formal complaint should include a detailed log of all bullying incidents, including dates of occurrence and witnesses’ names. This information is used as evidence when the bully is confronted (Leiper, 2005). In the event the aggressor is a supervisor or manager, victims should involve human resources and follow their recommendations. It is important that copies of all documents be kept in safe place and that legal counsel be obtained before signing any statements or reports. Legal ac-

A holistic approach must be used to return the nurse who has been bullied to an optimal level of functioning; thus, a cadre of supportive services need to be available.

Care for Victims
A holistic approach must be used to return the nurse who has been bullied to an optimal level of functioning; thus, a cadre of supportive services need to be available (McKenna et al., 2003). Depression, changes in self-esteem, and symptoms consistent with PTSD are psychological changes that may occur in people who are bullied. Enlisting the help of mental health nurses and professionals is vital when helping nurses return to optimal mental and physical health. Mental health nurses can aid in the identification of appropriate therapy, support groups, and medications. They can also assist in the referral process to identify services to treat physiological symptoms.

CONCLUSION
Bullying is an act of subtle or overt aggression with the intent of demeaning and devaluing a person. Individuals who are bullied report a variety of changes in mental and physical health, including chest pain, gastric discomfort, headache, depression, anxiety, and eating disorders. The organization may experience increased absenteeism and difficulty retaining employees. Several professional organizations, including The Joint Commission and the American Nurses Association, are advocates for a work environment free of disruptive and inappropriate behaviors.

REFERENCES


Mental Health Nursing, 47(12), 34-41. doi:10.3928/02793695-20091103-03

Dr. Broome is Associate Dean and Chair, and Dr. Williams-Evans is Associate Professor, Community/Mental Health Nursing, University of South Alabama, College of Nursing, Mobile, Alabama.

The authors disclose that they have no significant financial interests in any product or class of products discussed directly or indirectly in this activity, including research support.

Address correspondence to Barbara S. Broome, PhD, RN, FAAN, Associate Dean and Chair, Community/Mental Health Nursing, University of South Alabama, College of Nursing, 5721 USA Drive North, Room 3068, Mobile, AL 36688-0002; e-mail: Bbroome@usouthal.edu.

Received: May 5, 2011
Accepted: July 25, 2011
Posted: September 16, 2011
doi:10.3928/02793695-20110831-02