Workplace bullying in the nursing profession: A call for secondary intervention research

Kate BLACKWOOD and Bevan CATLEY
Massey University

Introduction

Workplace bullying is devastating to organisations internationally and has been found to be especially prevalent in the nursing profession (Bentley et al., 2009; Mikkelsen & Einarsen, 2001). Not only can bullying result in severe psychological and psychosomatic harm to the target but, in turn, costs organisations significantly in terms of lost productivity, absenteeism and turnover (Agervold & Mikkelsen, 2004; Caponecchia, Sun, & Wyatt, 2012; Leymann, 1996; Lutgen-Sandvik, Tracy, & Alberts, 2007). The risk factors associated with workplace bullying and subsequent recommendations for bullying prevention command the extant literature. The recommendations resulting from such research commonly include the need to develop understanding and awareness of bullying, provide training to managers for addressing bullying, develop and implement zero-tolerances policies, and improve communication and coping mechanisms (Duffy, 2009; Fox & Stallworth, 2009; Gardner & Johnson, 2001; Yamada, 2008). Yet, as these recommendations are rarely the central focus of related empirical research and are largely directed towards primary intervention, much remains unknown about how best to identify and address an existing bullying episode. The lack of understanding in this regard is not only evidenced in the enduring prevalence and severity of bullying in the nursing profession and highlighted in cases that reach the legal system, but is indirectly recognised in much of the related literature. This paper pulls together factors potentially affecting the efficacy of secondary interventions to put forward an argument for the urgent need for research into how best to identify and address cases of
bullying in the nursing profession.

A case example from New Zealand's legal system

The responsibility for preventing and intervening in workplace bullying lies with the organisation. In New Zealand, targets of bullying who believe that their complaint was addressed unfairly or insufficiently by their employer have the option to lodge a personal grievance claim under the Employment Relations Act (2000). The case highlighted below is one such case, whereby a lack of management understanding about best to address a bullying episode resulted in the situation escalating in complexity to a point where, regardless of the outcome, all of the parties involved could not be satisfied. As a result, the target suffered severe psychological harm, strained and stressful dynamics developed at the team level, and the organisation spent significant time and effort over a number of years attempting to reach a resolution to the case. Although the New Zealand employment legislation outlines the obligations of employers in regards to general employment disputes, and many cases that are heard under this legislation feature evidence of good practice on the part of the employer, cases such as this demonstrate the difficulties in effectively addressing complex bullying experiences and provide support for the need for further knowledge of secondary interventions.

The applicant was employed as a registered nurse in a New Zealand public hospital and had been under the leadership of the current clinical team leader since 1987. Initially, the working relationship between the two women had been healthy and productive but, over a period of time, the work relationship severely deteriorated and became increasingly stressful and unhealthy. The applicant claimed that she was subjected by her team leader to numerous behaviours over an extended period of time that she believed to be workplace bullying. Such behaviours included the team leader’s unnecessary supervision of her work and becoming increasingly controlling over her. It was not until 2000 that the applicant first complained to the area manager and a subsequent investigation resulted in the team leader

1 Clear v Waikato District Health Board (Auckland) [2007] NZERA 33 (13 February 2007)
being advised of the need for a more nurturing team environment, however the investigation failed to confirm the complaint of bullying. The negative behaviour from the team leader towards the applicant intensified as a result of being informed of the complaint to the point where the applicant believed a further complaint was warranted. Although witnesses had previously acknowledged the vendetta the team leader appeared to have against the applicant, they were not willing to offer their support to the complaint and no conclusion was able to be reached.

In 2001, the appointment of a new area manager saw the introduction of a new system of filing incident reports regarding further incidents between the two women intended to address any concerns at the time they occurred. Although five incident reports were filed by the applicant over a period of six months, in May 2002 she submitted a further complaint. Looking to enforce the new reporting system and believing that the majority of the applicants concerns were relatively minor and trivial, the area manager investigated only the current issue and communicated the outcome to the parties involved. When the current area manager resigned in 2003 she noted that there had been no further complaints and the issues appeared to be resolved. Yet, it was the applicant's evidence that the bullying continued and had begun to cause damage to her health.

At the appointment of the third area manager since the situation developed, the applicant raised a third complaint and was offered temporary separation from the team leader and EAP counselling as a result, however by this time the applicant was maintaining that the dismissal of the team leader would be the only resolution satisfactory to her. Soon after, the applicant took sick leave as a result of the alleged bullying and sought legal representation. By this time, the DHB's Board and the CEO had become involved and called on the expertise of an employee relations consultant. A full investigation found the allegations to be unjustified and the refusal by the applicant to provide a psychiatrist's report resulted in no further action being taken and extended sick leave payments refused. Despite the refusal, the applicant continued to take unpaid sick leave and in December 2004 the applicant was advised of the termination of her employment on the grounds of continued absence from work.
At the initial hearing before the Employment Relations Authority in 2007, the applicant was awarded NZ$15,000 for stress and humiliation, a cost the employer was obliged to pay. However, numerous appeals and subsequent claims over the following four years saw a further $40,000 paid by the employer to the applicant, not to mention the costs they accrued in paying for the expertise of lawyers, employment relations specialists and court proceedings. Indeed, failing to effectively address this case of bullying resulted in lengthy and costly consequences.

Conceptualising workplace bullying

Although there is no one definition, it is generally agreed that workplace bullying consists of systematic behaviours inflicted over a period of time that forces a target into a position where they feel unable to defend themselves and can cause the target psychological and psychosomatic illness (Einarsen, Hoel, Zapf, & Cooper, 2011). Many of the behaviours said to constitute workplace bullying, such as being given unmanageable workloads or unreasonable deadlines, excessive monitoring or criticism of work, or withholding information, could be interpreted as normal if experienced in isolation (Einarsen, et al., 2011; Leymann, 1996). However, it is the systematic and persistent exposure and the context in which they are experienced that shapes the interpretation of the behaviours; thus, bullying is a subjectively-constructed phenomenon (Rayner & Cooper, 2006). Bullying behaviours may not be solely work-related and can also include for example gossip, humiliation and ridicule, social exclusion, or threats of physical abuse, and they can be either overt or covert (Einarsen, et al., 2011). Regardless, the harmful consequences for targets, witnesses and the organisation can be devastating.

Numerous reports of harm caused to targets of workplace bullying can be found in the academic literature (Einarsen, 1996; Mikkelsen & Einarsen, 2002), legislated cases, and in media coverage (Butcher, 2010; Chrisafis, 2012), ranging from stress and upset through to psychological breakdown and even suicide. Anxiety, depression and post-traumatic stress disorder are common illnesses exhibited by targets (Agervold & Mikkelsen, 2004; Einarsen, 1996; Hauge, Skogstad, & Einarsen, 2007), whilst resulting musculoskeletal health complaints have also been reported (Edelmann & Woodall, 1997). However, the harm caused
by bullying is not restricted to the direct target. Witnesses have been found to exhibit lower job satisfaction, increased negativity, and heightened levels of role conflict (Jennifer, Cowie, & Ananiadou, 2003; Lutgen-Sandvik, et al., 2007). This, in turn, increases absenteeism and turnover and reduces productivity, resulting in significant costs to the organisation (Caponecchia, et al., 2012; Rayner & Keashly, 2005). Although the costs to New Zealand organisations have yet to be determined, one study estimated that workplace bullying costs Australian organisations up to AUD $13 billion per annum (Sheehan, McCarthy, Barker, & Henderson, 2002).

Internationally the prevalence of workplace bullying typically varies between 11 and 18 per cent (Nielsen, Matthiesen, & Einarsen, 2010) and the findings of a recent New Zealand study suggests that bullying in New Zealand organisations lies at the higher end of this spectrum, with 17.8 per cent of respondents being bullied in the last six months (Bentley, et al., 2009). The study included 727 respondents from the health industry, of whom 18.4 per cent were found to have been the target of bullying. Further, international research suggests that up to 85 per cent of nurses have been exposed to bullying at some point in the duration of their career (Lewis, 2005). The nursing profession has received a substantial proportion of academic bullying research attention internationally and has been identified as a context highly susceptible to workplace bullying (Hutchinson, Wilkes, Jackson, & Vickers, 2010; Randle, 2003; Vessey, Demarco, Gaffney, & Budin, 2009).

**Understanding bullying in the nursing industry**

The nursing industry in New Zealand has undergone several reforms in past years, creating new structures, processes and policy under which healthcare employees are required to work. Further, increasing public expectations, increasing patient numbers, and limited resources has contributed to further internal changes and stressors for employees (Huntington et al., 2011). The role of the New Zealand nurse is strongly governed by legislation and industry policy, including for example the Health Practitioners Competence Assurance Act 2003 (formerly, the Nurses Act 1977) and an industry-wide Code of Conduct which incorporates compliance with legislation, acting ethically and maintaining standards of practice, respecting patient rights, and justifying the trust and confidence of the public.
In May 2010, the enrolled nurse scope of practice was amended, resulting in changes to the daily workload of the enrolled nurses and those registered nurses who previously covered those components of the amended workloads. Previous research suggests that organisations that are high in instability and change (Salin, 2003) and high in internal issues and time pressures (Soares & Jablonska, 2004) are likely to exhibit role conflict and ambiguity. Role conflict and ambiguity are commonly recognised risk factors for bullying, providing opportunities to feign ignorance, increasing the risk of interpersonal conflicts, and allowing managers and employees to take advantage of vague or unfamiliar structures and processes (Hutchinson, Vickers, Jackson, & Wilkes, 2005; Notelaers, De Witte, & Einarsen, 2010; Salin, 2003). This appears to be the case for the New Zealand nursing profession according to recent research conducted by Huntington et al (2011). Huntington and colleagues found a number of contextual and organisational concerns that act as precursors for bullying: New Zealand nurses are often under significant physical and emotional stress in their work, with high workloads, limited resources and community expectations resulting in an inability to reach a satisfying level of patient care. Further, a dominating politicised climate exists, where power and ego rather than patient care and staff wellbeing is nurtured, leading to a climate of nurses eating their own and a lack of collegiality (Huntington, et al., 2011).

Bullying in the nursing industry is often attributed to oppressed group behaviours (Hutchinson, Jackson, Wilkes, & Vickers, 2008; Johnson & Rea, 2009; Strandmark & Hallberg, 2007). Oppressed group behaviours are said to occur in groups that are powerless to confront authority and subsequent low self-esteem and attempting liberation results in aggression towards others in the group (Freire, 1971). For healthcare in particular, bullying is strongly embedded in industry culture. Bullying is often passed down from experienced nurses, with nurses commonly reporting being exposed to bullying during their training and induction years (Foster, Mackie, & Barnett, 2004; Jennifer, et al., 2003; Randle, 2003). Such exposure to bullying throughout socialisation processes normalises bullying behaviours from the point of entry into the industry (Josephson, Lagerström, Hagberg, & Wigaeus Hjelm, 1997). The ability to bully is also strengthened by informal organisational alliances (Josephson, et al., 1997). Hutchinson and colleagues found evidence to suggest that such alliances support the misuse of legitimate authority and fortify organisational tolerance for bullying (1997).
Factors affecting secondary interventions in workplace bullying

Strategies for the intervention and management of workplace bullying are typically categorised as primary, secondary, or tertiary measures. Primary interventions are directed towards bullying prevention, secondary interventions generally refer to processes and systems that an organisation has in place to address workplace bullying once it has been identified, and tertiary interventions aim to reduce the negative impacts of bullying and restore individual and organisational health and well-being (Vartia & Leka, 2011). As previously discussed, the clear majority of research attention has been focused on primary prevention, specifically to intervene in a culture of bullying and thus prevent its future occurrence. The development and implementation of a zero-tolerance policy is a component of many these prevention recommendations. Generally, a zero-tolerance policy outlines the organisation's expectations of behaviour, provides information to clarify reporting channels, and details the formal process of complaint investigation including the disciplinary repercussions for employees found guilty of bullying (Richards & Daley, 2003). Yet, as a preventative tool, a zero-tolerance policy must be seen as legitimate and authoritative in the eyes of employees in order to be effective. Hence, to establish policy legitimacy and send a strong message that bullying is no longer tolerated, cases of bullying must be able to be identified and then addressed efficiently. However, academic advocates for zero-tolerance policies are many whilst empirical research into their efficacy as a secondary intervention tool is lacking. Further, dynamics at play in bullying episodes are likely to make addressing and resolving such cases more complex than ensuring that the processes advocated in the policy are adhered to.

According to Leymann (1996), a bullying episode is often triggered by a critical incident, commonly a conflict, from which bullying and stigmatisation develops. Leymann's identified stereotypical course of bullying resonates with recent definitions in that this phase of bullying development can be endured for quite some time and the behaviours, regardless of their meaning to the external observer, are based on the intent to punish the target. Leymann then goes on to suggest that once the organisation intervenes, the episode formally becomes a 'case' where he recognises the tendency for management to side with the
perpetrator, especially when they are in a position of power. Finally, failures in intervention are said to lead to the target's expulsion from working life. Academic research has since found evidence to suggest that the development of a bullying episode is not as linear as hypothesised by Leymann, yet the stereotypical course supported by recent cases such as that highlighted at the beginning of this paper, clearly acknowledges the complexities of bullying episodes should they be allowed to develop over time. This calls for consideration of three largely unexplored topic areas for establishing effective secondary interventions: awareness of the bullying episode, when the organisation should intervene, and how the organisation should intervene. These three topic areas provide the focus of the remainder of this discussion.

When and how the target interprets the behaviours they are being subjected to is an aspect of the bullying experience that has received little research attention from an intervention perspective, yet is likely to be of importance in the shaping of subsequent events in a bullying episode. As previously discussed, bullying is a subjectively-constructed phenomenon in which the target's perceptions of the behaviours they are subject to change with the frequency and duration of exposure (Einarsen, et al., 2011; Leymann, 1996). Often, it is not until the target has been systematically subjected to behaviours, particularly those that are covert or work-related, that they are likely to interpret the situation as bullying (Aquino, 2000). It has previously been suggested that organisational factors play a pivotal role on the likelihood of an employee identifying themselves as a target of bullying (Aquino & Thau, 2009).

The NAQ-R, a popular tool for measuring bullying prevalence, requires an employee to have been subjected to at least one behaviour a week for a period of six months in order to constitute being a target of workplace bullying (Einarsen & Raknes, 1997). However, quantifying bullying in such a way is questionable, evidenced in the significant differences revealed in self-reported prevalence findings. Using a self-reporting measure, Mikkelsen and Einarsen (2001) found that approximately 2 per cent of hospital employees felt they had been bullied, yet according to the NAQ-R's operational definition, 16 per cent of the same population had been targeted in the past six months. One explanation for this result may be that the bullying culture in the nursing profession contributes to a failure on the part of the
target to interpret the behaviours as bullying and instead attribute behaviours to the nature of the work required of employees within the industry’s ‘toughen-up’ culture. Obviously, it is not until a target identifies themselves as a victim of bullying that they are able to take action to avoid the situation from developing further.

Once an employee identifies themselves as a target of bullying, a significant concern for effective secondary intervention becomes the organisation’s awareness of the situation. Recent research conducted in New Zealand’s healthcare industry found evidence to suggest that, despite having policies in place, managers are often unaware of the prevalence and severity of bullying in their organisations (Bentley, et al., 2009). Although the reasons for this were undetermined, related research suggests that under-reporting and acceptance of bullying in organisational culture may be contributing factors (Deans, 2004; Green, 2004). In 2009, a study of registered nurses in the United States (Vessey, et al., 2009) revealed that 65 per cent of targets do not use formal channels to report their experience, despite being aware of the employee assistance programmes and harassment policies available to them. This was attributed to fear of retaliation from the bully and having little faith in the reporting system. An Australian study (Hutchinson, Vickers, Jackson & Wilkes, 2007) also revealed that 64 per cent of targets did not report their experience for fear of being blamed or being perceived as incompetent. Other studies which focus on the response of the organisation to complaints from the perspective of the target reveal that many complainants are blamed or seen as trouble-makers (Hutchinson et al., 2007) and have their problems deflected back with little or no support from administrative personnel (Gaffney, DeMarco, Hofmeyer, Vessey, & Budin, 2012).

Bullies in the nursing profession are commonly found in supervisory positions and alleged inaction and tolerance of the behaviours from management contributes to the silencing of bullying complaints (Stevens, 2002). Further to this, nursing cliques also provide opportunity for nurse bullies to be nurtured, encouraged, and protected from the repercussions of their harmful behaviour (Lewis, 2005). Studies have found, despite having harassment policies, these informal alliances encourage behaviours that are counterproductive to that encouraged by the policies by ensuring that complaints are discouraged or ignored (Josephson, et al., 1997). Of course, the often covert nature of bullying behaviours contributes
to the ability to hide much of the bullying that exists in the nursing profession (Aquino, 2000). It would seem that the ability to identify bullying early is advantageous in terms of enforcing the legitimacy of a policy, preventing further harm, and avoiding the complexities associated with a developed bullying episode. However, the current research focus on creating safe and clear reporting channels places the responsibility of organisational identification on the target in an environment where numerous variables discourage them from speaking out.

Whilst encouraging reporting remains a complex concern that warrants further investigation, the witness to bullying has been acknowledged as playing an influential role in shaping the bullying experience and its resolution. Paull, Omari and Standen (2005) identified 13 roles a witness to bullying could potentially assume. Based on the previous discussions of the nature of bullying in the nursing profession, it is likely that witnesses often take action in one of two ways: witnesses to bullying that associate themselves with a nurse clique may be more inclined to assume an instigating, manipulating, collaborating or facilitating role. In this sense, the witness encourages the bully or creates situations for the perpetrator to victimise the target, often for their own personal benefit. Alternatively, the witness may be inclined to choose an abdicating or avoiding role whereby they allow the perpetrator to continue bullying or simply walk away from the situation – such a role is likely to be considered by those nurses in cliques or who fear victimisation as a result of becoming involved. Other roles of the witness include intervening, defusing, empathising, or defending, whereby the witness takes an active role in support of the victim. Assuming such roles, it would seem, influences target understanding and shapes their interpretations of the behaviours they are being subjected to, and in some situations, may encourage them to speak up. Indeed, the witness role can strongly influence the outcome of a bullying episode (Östergren, et al., 2005) and warrants further investigation as a factor in the identification and resolution of bullying experiences.

As previously mentioned, superior-subordinate bullying is especially prevalent in the nursing profession. Not only does this create concerns in term of encouraging reporting and identifying bullying at an organisational level, but also in terms of ways in which bullying episodes should be investigated and resolved. The employment legislation in New Zealand requires the employer to carry out a thorough investigation of complaints of bullying, yet
the formal position of power often held by the perpetrator causes complexities in doing so and can potentially result in a biased investigation outcome. Previous cases of bullying heard under the Employment Relations Act (2000) in New Zealand have seen organisations held accountable for relying on the word of the superior perpetrator and failing to conduct an investigation because of their position in the organisation. Others have seen the investigator bias towards the senior perpetrator in terms of the evidence the parties put forward, thus failing to attribute blame to the bully. In such cases, a generalised investigation process may be ineffective, with witness evidence skewed in the favour of the perpetrator, or lack of for fear of retaliation, and perpetrator evidence being favoured over that of a powerless target. The organisation’s ability to obtain objective evidence of a bullying episode and take action that minimises costs to all parties involved remains a complex concern for which empirical research-based recommendations are scarce.

Such concerns with the power imbalance in the investigation of bullying episodes can also be found in the current debate over the efficacy of mediation as a means of finding a resolution to bullying situations. As acknowledged by the Department of Labour, “mediation is designed to be an empowering process that gives the parties a direct input into the outcome of their dispute, in contrast to litigation, where the outcome is decided by a third party” (McLay, 2010, p. 19). However, where the perpetrator is in a position of power, despite whether that power is formal or informal, mediation is likely to enforce the existing power imbalance and thus favour the perpetrator. As suggested by Needham (2003), the nature of bullying is such that, through the eyes of the perpetrator, it is often “a game to be won – not issues to be discussed, compromised and action jointly agreed” (p. 36). Hence, if bullying is instigated by an initial conflict, it may only be at this early stage of development when target has not yet been forced into a defenceless position that mediation is likely to be successful.

The debate surrounding the efficacy of mediation further supports the need for consideration of the type of intervention depending of the stage of development of the bullying episode. As highlighted in the case example, bullying episodes that are allowed to develop and escalate over an extended period of time are likely to require organisational intervention different from those of an episode in its adolescence. However, understanding of the type

---

3 McCullough v Otago Sheetmetal and Engineering Ltd [2008] NZERA 413
4 Suh v Topsco International Ltd [2008] NZERA 593
of intervention most effective at the different stages of bullying episode development is currently lacking.

**Conclusion**

As highlighted by the bullying case detailed in this paper, ineffective intervention strategies can result in devastating consequences for the target, the organisation, and for others exposed to the situation. The case, alongside supporting empirical research, suggests that the nature and characteristics of bullying are such that the identification and investigation of bullying episodes may not always be straightforward. The argument draws attention to these concerns, highlighting a number of influential factors in bullying identification and investigation that require further attention in order to develop a thorough understanding of effective intervention strategies. Specifically, the paper advocates further empirical research into the identification of bullying for both the target and organisation, the point at which action at a secondary level should be taken to address bullying and the type of action that should be taken at differing stages of bullying episode escalation. Should such an understanding be obtained, the consequences of bullying are better able to be minimised and the legitimacy and authority of advocated preventative measures, such as zero-tolerance policies, is likely to be enhanced.

**References**


Workplace bullying in the nursing profession: A call for secondary intervention research


