

Adult Bullying Within Nursing Workplaces:
Strategies to Address a Significant Occupational Stressor
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Abstract

This learning module summarizes the empirical evidence and theory encompassing the issue of adult bullying within nursing workplaces. Unlike normal disciplinary action and interpersonal conflict, bullying is persistent workplace abuse, non-physical and non-sexual in nature, involving an imbalance of power, usually progressing from lesser to more severe behaviors, and culminating in negative effects for the nurse and organization. A comprehensive literature review reveals that workplace bullying reaches far beyond the borders of the United States and profession of nursing. Empirical evidence supports that bullying is fostered by organizational culture, the social system, and traits of the victim and bully. Researchers have identified typical patterns of workplace abuse akin to schoolyard bullying and intimate partner violence. The consequences of adult bullying lead investigators to name it as a significant occupational stressor in the workplace. Nursing interventions include strategies for short term crisis management and long term prevention of bullying within nursing workplaces. Ultimately, policies, practices, and laws need to be created, amended, and enforced to protect nurses from workplace bullies. Actual testimonials punctuate that nurses will no longer remain quiet about this “silent epidemic”.

Adult Bullying Within Nursing Workplaces: Strategies to Address a Significant Occupational Stressor

There has been a tremendous amount of media coverage and empirical studies about the phenomenon of schoolyard bullying (Geffner, Loring, & Young, 2001). In the last 15 years, adult bullying has received international attention as a “silent epidemic” in the workplace (Namie & Namie, 2000, p. 6). Despite its tenets of caring, nursing is not immune to bully behavior from coworkers, nurse managers, and physicians. The purpose of this learning module is to examine bullying as a substantial problem in nursing workplaces, review relevant literature on bullying from a variety of disciplines, and propose strategies for protecting oneself personally and professionally from bullying. Testimonials from nurses who have witnessed or experienced bullying are interspersed throughout the article. Names have been changed to protect their identity.

Bullying Defined

Conceptualization of bullying

Bullying has been difficult to conceptualize because there is no consistent definition (Paterson, McComish, & Aitken, 1997). Literature distinguishes bullying from “bad behavior” and “disciplinary action” which are intermittent. Overall, bullying is “generalized workplace abuse” (Namie & Namie, 2000, p. 6) that is persistent, nonsexual, occurs without physical violence, involves an imbalance of power or privilege, escalates from less to more severe behaviors, and result in a negative effect on the nurse (Keashly & Jagatic, 2003; Rayner & Hoel, 1997). Based on research, the attributes, frequency, duration, and degree of bullying vary, but generally encompass overt and covert behaviors such as in Table 1:

Table 1

Bullying Behaviors

Hostility	Dirty looks/gestures	Invasion of personal space
Curt tones of voice	Social exclusion/isolation	“Silent treatment”
Making light of bullying	Calling the nurse “crazy”	Referring the nurse to workplace counselors
Harassment	Pressure not to claim employee benefits (e.g. sick time, conference time, travel expenses)	Excessively critical
Repeated reminders of errors and mistakes	Intolerance	Inpatience
Intimidation	False/exaggerated incident reports against the nurse	Shouting/yelling/swearing at the nurse
Throwing objects (e.g. surgical instruments)	Failure of manager to maintain hostile-free work environment	Insulting or threatening phone messages/emails
Theft	Attempting to turn others against the nurse	Unfair treatment
Gossip/rumor-mongering	Threats	Humiliation
Condescending	Deception/lying	Vindictive
Punishing	Hinting that the nurse should quit or transfer	Verbally attacking the nurse in public/private
Excluding the nurse from important meetings or activities	Withholding pertinent information from the nurse	Blocking opportunities for promotion/training
Unjust used of authority	Excessive monitoring	Unreasonable deadlines
Ignoring/undervaluing belittling the nurse’s work	Defamation: false attack against the nurse’s reputation	Excessive teasing or cruelty
Questioning the nurse’s competence	Excessive sarcasm	Destruction of property

(Cowie, Naylor, Rivers, Smith, & Pereira, 2002; Farrell, 1999; Farrell, 2002; Glendinning, 2001; Hoel, Faragher, & Cooper, 2004; Jackson, Clare, & Mannix, 2002; Keashly & Jagatic, 2003; Quine, 1999).

Sexual harassment and discrimination against age, race, sex, and disability are all forms of bullying, but victims of bullying fall outside of these protected classes under Title VII of the Civil Rights Act of 1964. Adult bullying is very similar to the dynamics of intimate partner violence (Tepper, 2000). Like the bully, the batterer is cunning, uses repetitive tactics of emotional abuse, isolation, minimization, denial, blames the survivor, coerces, threatens, and intimidates to obtain and maintain power and control over the survivor (The Domestic Violence Project & Inc./SAFE House, 1999). (also see <http://stop-the-violence.net/firms.com/emhpowercontrol.pdf>)

Operationalization of bullying

The concept of bullying has been difficult to find in the literature, describe, and operationalize because there are many synonyms analogous to bullying, and many interpretations (Hoel et al., 2004). Bullying has been internationally studied under the guise of (Table 2):

Table 2

Bullying Synonyms

Mobbing (i.e. many coworkers bullying and scapegoating a victim)		
Horizontal violence (e.g. a staff nurse bullies a staff nurse of similar professional standing)		
Non-physical aggression	Harassment	Disruptive physician behavior
Workplace trauma	Workplace violence	Abusive supervision
Workplace aggression	Intercollegial aggression	Colleague abuse
Psychological violence	Whistle blowing	Verbal abuse

(Cox, 1991; Farrell, 1999; Jackson et al., 2002; McKenna, Smith, Poole, & Coverdale, 2003; Rosenstein, 2002; Tepper, 2000; Zapf, 1999).

Researchers disagree on how to operationalize bullying in terms of frequency, duration, and attributes (Cowie et al., 2002). Bullying has been difficult to operationalize because many methodologies rely heavily on the victim's interpretation. Yet, perceptions and thresholds of bullying for the same event may vary from person to person (Cowie et al., 2002; Quine, 1999; Tepper, 2000). Hoel et al. (2004) write, "people with mental and physical health problems are more likely to report bullying or are more vulnerable to bullying in the first place" (p.379). Some studies, however, document eye-witness accounts of bullying and admissions from bullies themselves (Greenfield, 1999; Quine, 1999; Zapf & Einarsen, 2003). Regardless of conceptual and operational variations in research, bullying is a worldwide phenomenon supported by empirical and anecdotal evidence with significant prevalence, antecedents, and consequences. The following is one person's description of bullying:

I am very overweight. My coworkers and nurse manager were more slender than me. I was regularly teased about my weight and encouraged by my nurse manager to lose weight. She always had unsolicited 'helpful tips' and 'healthy recipes' to give me. I caught a couple of male nurses making faces, gestures, and imitating me behind my back! They put a picture of a piggy with my name above it next to the Omnicell where nurses obtained drugs. I put inspirational (not religious) quotes on my locker and they were torn down on several occasions. I started isolating from my coworkers. I felt ashamed and ate more. My nurse manager started inventing reasons that my work didn't 'measure up' in the workplace. She repeatedly called me into her office to tell me 'this place isn't right for you'. She was nice and supportive of me in public, but insensitive, intolerant, and cold toward me in private. My coworkers and medical director also became excessively critical of me and my patient care. I KNOW I am a good nurse and I was forced out of the workplace. –A., RN, emergency department, 27 years old.

Background

Prevalence

Three research approaches to bullying dominate the literature: qualitative interviews, descriptive and epidemiological questionnaires, and theories and constructs in organizational psychology, occupational health, and human psychology. Accurate prevalence figures may be hampered by overreporting and underreporting (Paterson et al., 1997). Demographics and results vary internationally, but reveal significant prevalence in the general workplace and nursing. Many literature reviews refer to landmark work in Scandinavia which has large sample sizes across several occupations (Leymann, 1990, n=2,428; Einarssen & Skogstad, 1996, n=7,986), powerful public awareness, and in Sweden and Norway, groundbreaking legislation against bullying (Rayner & Hoel, 1997).

International research in nursing demonstrates that 38% (n=1,110) of nurses in a United Kingdom (UK) survey reported being bullied over the previous year, with 42% witnessing acts of bullying of nurses by other staff (most commonly senior managers and physicians, then fellow nurses) (Quine, 1999). Victims' age, gender, and hours of work were evenly represented. Sixty-seven percent of those bullied in Quine's (1999) study attempted to take action but most (74%) were unhappy with the results. These findings are similar to a study by Aiken, Clarke, Sloane, & Sochalski (2001) who reported that less than half of nurses were satisfied with the way administration, human resource (HR) departments, and unions addressed their concerns (n=43,000, in more than 700 hospitals in the United States (US), Canada, Germany, England, and Scotland in 1998-1999). In 2001, the UK implemented a "Dignity at Work" law outlawing bullying in the workplace. Further, the UK has broadcasted anti-bullying public service

announcements (Paterson et al., 1997). No follow-up studies documenting a decrease in incidence rates since these interventions could be located.

In Australia and New Zealand, similar prevalence rates were found in nursing populations spanning all clinical settings from public to private institutions, critical care and emergency departments, to general care floors (Farrell, 1999; McKenna et al., 2003). McKenna et al.'s (2003) national survey of New Zealand's new graduate nurses, the majority on inpatient units, revealed that 31% (n=551) experienced severe incidents of "horizontal violence" from senior staff nurses resulting in loss of confidence and esteem, absenteeism, somatic and psychological symptoms, transfer, or termination. Nearly half did not file a complaint. Only 12% received "formal debriefing, and the majority of respondents had no training to manage the behavior" (p. 90). In Farrell's (1999) study (n=270), bully behaviors occurred from physicians, staff nurses, and nurse managers. Of the three, physician-bullies were the most frequent and nurse-bullies were the most distressing. The Australian Nursing Federation and the International Council of Nurses have addressed bullying in position statements (International Council of Nurses, 1999; SAEBOW, 2000). Additionally, Australia and New Zealand have anti-bullying legislation with one Australian study reporting a decrease in their nursing turnover rate from 28.4 to 21.9%; however, there may be other factors responsible for the drop in turnover rate (Stevens, 2002). Although these studies may not be generalizable to nurses in the US, there is a global trend amongst nurses to attend to the problem of bullying.

In the US, research and legislation on adult bullying seems to be less developed, especially in the field of nursing. As a result, workplaces do not have specific policies prohibiting bullying. The reasons for underdevelopment are unclear; but it may be the

work ethic and culture in the US is different than other countries. For instance, from 1980 to 1993, Fortune magazine outright admired and condoned bully behavior in its regular review of “America’s Toughest Bosses” (Dumaine, 1993). Mackay’s (1988) book, “How to Swim with the Sharks without Being Eaten Alive” teaches employees how to tolerate abusive workplaces rather than confront unprofessional behaviors. In the name of entertainment, television producers find reality stars, like Chef Ramsay on FOX network’s “Hell’s Kitchen”, to weekly terrorize, intimidate, and verbally abuse contestants vying for employment.

Nevertheless, the US is making progress. Gary Namie, a social psychologist and director of the Workplace Bullying and Trauma Institute in Bellingham, Washington, has led investigators in increasing awareness of and research on bullying in the US. Namie and Namie’s (2000) most recent study of 1,335 people across the country reported that 90% endure bullying at sometime in their career. The average duration of bullying was 16.5 months. Women were primary victims (77%) with 84% of perpetrators being other women. Of those who sought help from their boss or human resources, only 18% stated they had positive results. An additional study (n=2492) of employees at the University of Illinois-Chicago revealed that bullying was four times more prevalent than sexual harassment (Richman, Rospenda, Nawyn, & Flaherty, 1999). Wayne State University professors Keashly and Jagatic (as cited by Keashly & Jagatic, 2003) provide the most recent approximation of bullying in the American workplace. In a stratified random sample of 1,110 Michigan residents, results showed 59% were bullied at least once by a coworker in the last 12 months. Twenty percent suffered five or more abusive behaviors in the last year, with 62% experiencing severe distress as a result. Forty-two percent stated they have experienced bullying at some

point in their careers with 64% reporting severe distress as a result. The results should be accepted cautiously since researchers include incidences of “once a year” in their definition of bullying.

US nurses have generated several opinion and anecdotal articles on bullying, but there is a significant gap in empirical research. Cox (1991) and Araujo and Sofield (2000) have conducted studies on the prevalence of verbal abuse against nurses. Cox (1991) surveyed 1,168 nurses nationwide and found that 97% experienced verbal abuse at least five times a month, mostly from physicians, then from staff nurses and nurse managers. Nine years later, Araujo and Sofield (2000) replicated Cox’s study with similar results. Anderson (2002) randomly surveyed 67 nurses in Texas and 71% experienced verbal abuse, with physicians as the most common perpetrators (41.3%). Even though verbal abuse is just one component of bullying, it appears that the incidence of verbal abuse against nurses is not decreasing.

“Disruptive physician behavior” towards nurses has been a specific point of interest in research. Greenfield (1999) asserts that “two thirds of nurses claim to be verbally abused by physicians at least once every two to three months” (p.282). Rosenstein’s (2002) survey of 1,200 US nurses, physicians, and hospital administrators indicate that on average, 92.5% had witnessed disruptive physician behavior such as “yelling, raising the voice, disrespect, condescension, berating colleagues, and using abusive language” (p28). Results also showed a direct relationship between disruptive physician behavior, nurse morale and nurse retention.

Nurses who experience bullying in the workplace have difficulty building legal cases unless they are unlawfully discharged or fall into the protected classes (Namie & Namie, 2000; US Equal Employment Opportunity Commission, 1964). California was

the first state to propose anti-bullying legislation in February, 2003. This bill estimates that 16-21% of California employees experience health-altering bullying, proposes that bullying be unlawful for all people, and suggests monetary sanctions against the employer (McCleod, 2002). For unknown reasons, the bill did not pass and continues to be revised. However, Namie and Namie's (2004) Workplace Bullying and Trauma Institute has assisted other state lobbyists in Massachusetts, Northern California, Washington, Oregon, and Oklahoma in beginning anti-bullying legislation.

Alternative explanation for "bullying"

It's important to recognize that the prevalence of bullying may be overreported when incidences of "interpersonal conflict" are included in research findings. "Against the background of communication theory and the psychology of interpersonal conflict, any one-sided and mono-causal explanations (for bullying) are highly unlikely" (Zapf & Einarsen, 2003, p. 166). Moreover, systems theory might best explain the dynamic interplay of factors that result in a breakdown of the relationship (Kerr & Bowen, 1988; Rayner, Sheehan, & Barker, 1999). Sometimes a series of dysfunctional exchanges occur over time and resentments build for both people. When relationships fail, little behaviors like not saying 'hello' or snapping at requests can be interpreted as aggressive. There are "perceptions of injustice even when no real injustice exists" (Neuman & Baron, 2003, p. 199). The interpersonal conflict escalates until there is a blow-up that results in the accusation of bullying (Tehrani, 2003).

As in all relationships, interpersonal conflicts with colleagues and supervisors are normal within an organization. Further, the process of resolving them can actuate stronger relationships, creativity, and innovation. To clarify, bullying has many

qualifiers and those who equate ‘bullying’ with ‘interpersonal conflict’ run the risk of either normalizing bullying in the workplace or vilifying interpersonal conflict.

Antecedents

Bullying is a complex phenomenon, and while bullies are clearly responsible for their behaviors, investigators have analyzed several potential factors that prime the workplace for bully behaviors: organizational culture, the social system, character traits of the victim, and character traits of the bully. Most of these dynamics lie outside the awareness of the individual, workplace, and organization.

Organizational culture

Investigators have identified the role of organizational culture in bullying (Araujo & Sofield, 2000; Farrell, 1999; Namie & Namie, 2000; Offermann & Malamut, 2002; Zapf, 1999). “Heinz Leymann, one of the founders of bullying research, categorically claims that organizational factors and quality of leadership behavior (are) the main causes of bullying; (not) the personal characteristics of the victim” (Zapf & Einarsen, 2003, p. 165). Poor working conditions, inadequate staffing, job stressors, and ineffective management styles can all create a hostile work environment, fostering victim and bully behaviors. Bullying may be underreported because nurses concede that a hostile work environment comes with the job (Jackson et al., 2002). Also, several studies found that victims perceived organizational pressure to remain silent about bullying (International Council of Nurses, 1999; Namie & Namie; Offermann & Malamut, 2002). A victim’s fear of retaliation may prevent the nurse from seeking help (RCN, 1997; Rosenstein, 2002; Sweet, 2005). Additionally, a lack of negative sanctions for bullying sends an implicit message to nurses that these behaviors are condoned or denied by managers and administrators (Glendinning, 2001; Malcolm, 2001;

Offermann & Malamut, 2002). Further, organizations tend to blame the victim for the difficulties in the workplace instead of the bully, until the victim has little choice but to leave (Namie & Namie, 2000; Zapf, 1999).

Social climate

Qualities within the social circle have fostered bully behavior. In several studies, about 50% of respondents witnessed workplace bullying and did nothing to stop it, allowing the bully to further perpetrate unimpeded (Hoel, Faragher, & Cooper, 2004; Namie & Namie, 2000; Quine, 1999; Stevens, 2002). Since bullying occurs in front of coworkers, societal norms that protect victims against aggression do not seem to apply in the workplace of a bully (Neuman & Baron, 2003). Neuman and Baron's (2003) research found that the inverse of the Golden Rule applied in some hostile work environments: "people tend to do unto others as others have actually done unto them" (p.186). Nurses are socialized into bullying and rankism; power, privilege, status given to higher "ranked" staff in the workplace (Sweet, 2005). For example, nurses that torment their new employees justify this behavior as "the way we do things around here" (Stevens, 2002, p. 191). Other reasons for inaction of bystanders include fear of being the next victim, a social climate of fear, and minding their own business (Farrell, 1999; Namie & Namie, 2000; Quine, 1999). Even witnessing acts of bullying can be traumatic and is "associated with worse mental and physical health than those who had neither experienced nor witnessed bullying" (Hoel et al., 2004, p. 380). When bullying is not reprovved by the group at a social level, there is a cumulative effect of resentment, mistrust, suspicion, retaliation, and competition. The result is a hostile work environment.

Character traits of the victim

Research findings are mixed regarding the role of victims in bully situations. Namie and Namie's (2000) study revealed that 67% of victims had no history of psychological problems, childhood victimization, or adult bullying. Sixty-three percent of victims in Zapf's (1999) (n=96) study saw no personal involvement in their bullying. Bullying was a strong predictor of depression and cardiovascular disease in previously healthy Finnish hospital workers (n=5,432) (Kivimaki et al. 2003). Yet, prior victimization has been shown time and time again to predict revictimization in adults. Abusive physicians link their bully behaviors to prior victimization in medical school from other nurses and physicians (Greenfield, 1999). Smith, Singer, Hoel, and Cooper's (2003) findings (n=5,288) suggest that people at highest risk of revictimization in the workplace were those who were either victims, bullies or both while in school. Anderson's (2002) study found that about 70% of bullied nurses also witnessed or experienced a form of child abuse or intimate partner violence. Moreover, "survivors of abuse reported more workplace violence than nonsurvivors of abuse, especially at an earlier stage in their nursing career" (p.361). Desai, Arias, Thompson, and Basile (2002) randomly surveyed 8,000 men and 8,000 women in the US by telephone. Findings showed that female victims of physical or sexual child abuse or both were at least twice as likely to experience revictimization as an adult (by any perpetrator). Similarly, men who were victims of physical or sexual child abuse or both were at least five to six times more likely to experience revictimization as an adult (by any perpetrator). Hence, prior victimization may increase a nurse's vulnerability to bullying in the workplace.

Various studies have outlined characteristics that may elicit bully behavior at work (Araujo & Sofield, 2000; Cox, 1991; Einarsen, 1999; Namie & Namie, 2000; Quine, 1999; Zapf, 1999; Zapf & Einarsen, 2003). Characteristics of the victim include:

- Preexisting psychological history of depression, anxiety, social phobia, posttraumatic stress disorder, and personality disorders
- Underdeveloped coping and conflict resolution skills
- Unassertive and passive behavior
- Avoidant of conflict
- Doesn't stand up for herself
- Obliging
- Naïve
- Nice and cooperative
- Optimistic and enthusiastic
- Highly tolerant of unhealthy workplace because of history of unhealthy relationships
- Vulnerable because of the way she talks, carries herself, previous victimization
- Conscientious
- Rigid
- Annoying
- Refuses to be controlled by bully
- Possesses skills or knowledge that the bully lacks
- Demonstrates little effort to connect with work group
- Underdeveloped communication skills
- Lacks confidence
- Low self-esteem
- Negative affect
- Low sense of belonging and views self as different from the group
- Unable to defend self or opinions
- Highly suspicious
- Quiet
- Less competitive than coworkers
- Humorless
- Oversensitive
- Many psychosomatic complaints resulting in frequent absenteeism

Character traits of the bully

Why do some people become bullies? The literature describes four origins of bully behavior: personality development, organizational culture, by accident, and substance abuse (Einarsen, 1999; Namie & Namie, 2000). First, some bullies have a personality

disorder (PD), described by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) as enduring negative character traits developed early in life, misperceptions of themselves/others/ situations, pervasive interpersonal dysfunction, unstable emotions, and poor impulse control (American Psychiatric Association, 2000). These are pathological and characterological bullies. Studies link schoolyard bullying and childhood victimization to adult bullying (Desai et al., 2002; Smith et al., 2003). If bullies do not meet DSM-IV-TR criteria for a PD, they often exhibit many traits of different personality disorders such as narcissistic, antisocial, borderline, obsessive-compulsive, passive-aggressive, and paranoid PD (for brevity, only narcissistic and antisocial PD will be discussed here).

Narcissistic bullies classically lack empathy and understanding for other people, view themselves as superior to others, and need excessive admiration from others (American Psychiatric Association, 2000). They are preoccupied with thoughts of success, intelligence, power, and beauty. One study states that bullies are envious/threatened by those that are “more attractive, confident, successful, qualified, and popular” than the bully (as cited by Sweet, 2005, p. 16). Although they are grandiose, their self-esteem is quite fragile. They are easily wounded, and vindicate their wounded ego by lashing out, punishing, devaluing, and criticizing others. They have a sense of entitlement, expect others to comply, and will manipulate to get what they want.

Persons with antisocial PD may also be bullies. Ironically, antisocial bullies usually do not lack social skills. They can be charming, affable, and likable in order to con someone. They are antisocial in terms of not abiding by societal norms/laws and not possessing a conscience. They view others as weak and deserving of abuse (Einarsen,

1999). Character traits of antisocial PD include bully behaviors before the age of 15, lying for personal gain, irritability and aggressiveness, irresponsibility and impulsiveness, and indifference toward mistreatment of others (American Psychiatric Association, 2000). Einarsen (1999) describes one type of antisocial bully as a “predatory bully” because “the victim personally has done nothing provocative that may reasonably justify the behavior of the bully. The predator is either demonstrating power or trying to exploit an accidental victim into compliance” (p. 22-3). Other bully character traits are listed at the beginning of this article.

Second, sometimes organizational culture creates workplace bullies via a system of reward and punishment (Einarsen, 1999; Zapf & Einarsen, 2003). This bully is typified by the shrewd businessman or the savvy politician that “is a master at reading cues from the workplace. If competition is encouraged, she knows that beating up other people will lead to winning” (Namie & Namie, 2000, p. 16). Unlike the bully with a PD, this person can change his/her behavior if the organization rewards cooperation and punishes the “mistreatment of others” (Namie & Namie, 2000, p. 16). Third, some people are “accidental bullies” because they are unaware of how their negative behaviors impact others (Namie & Namie, 2000, p. 17). They lack social graces and can feel remorseful when confronted. Like the previous type of bully, their behaviors are adaptable with environmental reward and punishment. Lastly, bully behaviors can originate when substance abuse and dependence is involved (American Psychiatric Association, 2000; Namie & Namie, 2000). Substance abusers are impulsive, erratic, paranoid, and disinhibited in terms of social etiquette. Their behaviors do not change without intervention. Next, organizational culture, social climate, and character traits of

the victim and bully might be personified best by discussing typical phases of bully behaviors.

Self-differentiation: A mediating factor to bullying antecedents

Differentiation of self, a concept of Bowen's family systems theory, may mediate the influence of antecedents on bully behaviors (Charles, 2001; Kerr & Bowen, 1988). Within a system such as a family, group, or workplace, individuals take familiar roles they learned in earlier groups. Self-differentiation is the degree of one's ability to separate one's thinking from one's feelings, and to "achieve emotional maturity and independence without losing the capacity to connect emotionally with others" (Charles, 2001, p. 281). People with a poorly-differentiated self may be a victim, bully, or switch between both roles (Neuman & Baron, 2003). Bullies and victims with low levels of self-differentiation have greater instability in relationships than well-differentiated people. "The self is so poorly developed that use of the pronoun 'I' is confined to narcissistic pronouncements such as 'I want', (and) 'I hurt'" (Kerr & Bowen, 1988, p. 101).

Interactions between poorly-differentiated people are reciprocal and lack autonomy (e.g. the person who gives the most will find someone who takes the most) (Charles, 2001). Needing the approval and acceptance of others, poorly differentiated bullies and victims reflexively adapt to what others think, say, or do. This may lead to a phenomenon known as "group think", in which members must give up autonomous thinking for pathological conformity (Kerr & Bowen, 1988). "Group think" is prevalent in street gangs and mobbing scenarios. Similarly, workplace bullies instinctively absorb power and control over passive members, and chide them to comply or suffer consequences (Leymann, 1990; Zapf, 1999).

In contrast, well-differentiated people can choose to be dependent, interdependent or independent of the group (Charles, 2001; Kerr & Bowen, 1988). External pressures do not dictate the well-differentiated person's thoughts and feelings in the moment. The person is aware of his/her anxiety in group situations; he/she manages it, and does not reactively alleviate his/her anxiety by giving in or rebelling from the group. He/she knows him/herself; the person is calm when faced with conflict and rejection, and thoughtfully considers decisions. The person contemplatively balances his/her needs with the needs of the group. He/she is neither a disciple nor bully. Therefore, the well-differentiated person is able to withstand pressures to conform to an organizational culture or social climate that supports bullying. They are aware of their individual triggers to feel victimized or to bully others and can decide against them. Self-differentiation is not an "all or nothing" concept. Kerr and Bowen (1988) note that individual and group differentiation is on a continuum, and the well-being of the group depends on the level of differentiation of its members and leaders.

(For quick information on this topic, see

<http://www.thebowencenter.org/pages/theory.html>).

Phases to bully behaviors

Akin to intimate partner violence, adult bullying in nursing workplaces is a "gradually evolving process" (Einarsen, 1999, p. 19). The literature reveals that different researchers have described similar phases of bullying (Einarsen, 1999; Hoel et al., 2004; Namie & Namie, 2000; Tepper, 2000). To summarize, the nurse starts off excited about his/her job and eager to please. Meanwhile, the bully is looking for his/her next target. The first aggressive acts are often subtle and in front of coworkers. The bully makes his/her presence and power known. The victim remains polite and

works harder to please but his/her efforts are unsuccessful. Good work goes unrecognized. The bully cannot be pleased. The victim believes he/she needs to change. He/she tries to adapt but he/she is under the bully's control. Bully behaviors are interspersed with normal and kind gestures. Therefore, the nurse is confused and remains hopeful that the abuse will stop. Acts of aggression become more blatant and frequent. The nurse avoids the bully, but to no avail. The bully recruits allies and the workplace becomes polarized. The nurse questions him/herself and wonders why this is happening. Finally, the nurse recognizes the cycle of abuse, but he/she is already in the process. He/she feels powerless to change. "Over time, the bully can penetrate the psyche of the strongest, most optimistic person alive in an attempt to 'convince' her that she is wrong" (Namie & Namie, 2000, p. 179). The stress wears on the nurse and he/she becomes symptomatic. His/her absenteeism may increase, which aggravates his/her problem.

When the nurse becomes frustrated and angry enough, he/she fights back. He/she lashes out at the bully which worsens the situation. Coworkers hesitate associating with the victim and he/she feels alone and isolated. The organization observes the turmoil in the workplace and labels the victim as a "problem employee". The victim is referred by management to an employee assistance program (EAP) for counseling. When the victim attempts to expose the bully behavior to external units such as human resources (HR), a collective bargaining group, and EAP, they question why he/she waited so long to report the problem. Bully bosses are particularly difficult to challenge. "Sadly, HR knows which bully (bosses) have long rap sheets and long histories of cruelty" (Namie & Namie, 2000, p. 231). The bully counterattacks the complaint with assassinations to the victim's character, psyche, and work. A swift mediation usually involves

transferring the victim to another unit or firing him/her. Einarsen (1999) labels the last phase of bullying as “severe trauma” (p. 19). Ultimately, bullying results in severe consequences for the victim and organization.

I used to work in a prestigious unit of the hospital. Nurses were required to have at least five years of nursing experience and several qualifications to work there, so they weren't 'new grads'. Every new nurse that came into my workplace was subject to at least a six-month 'hazing process' or military 'boot camp' which included social exclusion, the 'cold shoulder', having to 'prove' oneself personally and professionally, insults, 'ganging up' on the 'newbie', whispering campaigns about the nurse in the nurse manager's office, belittling at team meetings, magnifying/misrepresenting mistakes and lack of knowledge, and negative gossip. The senior nurses and nurse manager, J., did not support or welcome the new nurse during the orientation. They weeded out nurses. Many new nurses were told repeatedly, "No one wants you here. Everyone has said so. You're not cutting it here. Leave!" I reassured new nurses that those exact words were said to nearly everyone and they wanted to see how tough you are. "It's character-building!" said a senior nurse. If a new nurse put up with the abuse for about a year, she was accepted into the group. If there wasn't a new nurse to pick on, there was always at least one nurse "in the doghouse" or scapegoated by J. and the group. When it was my turn to be scapegoated, one nurse said to me "I'm so glad it's you. It keeps J. off the rest of us!" J. role modeled for my coworkers that it's ok to lash out and be curt, bossy, punitive, mean, to give dirty looks, and to ignore someone. However, to the public, her fellow managers, and her boss, she was charming, fun, and successful.

This bullying culture permeated the entire workplace and extended to all ancillary staff. J. empowered a core group of employees to perpetrate her abuse on the rest of us. There was an implicit expectation that they would report all happenings in the unit to her. In return for their loyalty to J., they basked under her umbrella of protection from bullying, and enjoyed being in her favor. They were given the best projects and leadership status. Staff members that spoke about the bullying culture or complained to J. were severely reprimanded with bullying and vindictiveness from the whole group. They were forced to transfer to another unit or forced to re-comply with the culture. Some attempted to change the culture by going to the unions that represented them, human resources, and J.'s boss. In the 20 years that J. has been a nurse manager, no one has succeeded in holding J. accountable for her actions. Memorably, J. said, "You can't change organizational culture!" In the 8 years I worked there, I watched 6 great nurses and 6 ancillary staff bullied out of their job, many times within the first year, because they wouldn't or couldn't adjust to the abuse. When I spoke out against J. after witnessing an egregious injustice, I was forced to transfer out too. –F., RN critical care, 38 years old.

Consequences

The personal and organizational costs of bullying are staggering. While physical violence often results in visible wounds, the outcome of bullying may not be readily apparent to the observer. Over half of the respondents in Farrell's (1999) survey of Australian nurses rated colleague bullying as "the most distressing aspect of their work" (p. 540). In the literature, the bio/psycho/social/professional consequences of bullying range from mild to severe, and are listed in Table 3.

Table 3

Bio/psycho/social/professional consequences of bullying

Headache	Hypertension	Cardiovascular disease	Insomnia
Stress	Stomach disorders	Anger	Anxiety
Panic	Depression	Fatigue	Weight changes
Embarrassment	Rumination	Conflicts with intimate relationships	Social isolation/ social phobia
Substance abuse	Suicidal/homicidal thoughts	Loss of income	Career damage

(Araujo & Sofield, 2000; Hoel et al., 2004; Kivimaki et al. 2003; McKenna et al., 2003; Namie & Namie, 2000; Quine, 1999; Tepper, 2000). Additionally, Jackson's et al. (2002) and Quine's (1999) surveys revealed an increased consumption of cigarettes and alcohol by 20-44%. Some authors liken the effects of work trauma to Posttraumatic Stress Disorder (PTSD) (McKenna et al., 2003; Hoel et al., 2004; Namie & Namie, 2000). According to the DSM-IV-TR, PTSD criteria include persistently reexperiencing the trauma, nightmares, flashbacks, avoiding thoughts/activities/people that remind victims of the incident, emotional numbing, hyperarousal such as insomnia, difficulty

concentrating, heightened startle response, symptoms lasting more than one month, and significant impairment in one or more areas of functioning such as work, school, or home life. (American Psychiatric Association, 2000). Although victims of bullying may experience the same symptoms as PTSD survivors, according to current criteria PTSD (and Acute Stress Disorder) cannot be diagnosed without experiencing/ witnessing events that result in death, serious injury, threat of bodily harm, combined with an immediate reaction of “intense fear, helplessness, or horror” (American Psychiatric Association, 2000, p. 467). A diagnosis of an (acute/chronic) Adjustment Disorder may be appropriate because it can encompass any level of trauma.

American businesses may not endorse tough work environments when they see that it is draining money from their pockets. Fifty-seven percent of 9,000 US federal workers recently admitted to workplace bullying, costing the government 180 million dollars over two years due to absenteeism and low productivity (as cited by Farrell, 2002). Workplace bullying also contributes to the nursing shortage with its subsequently high turnover rates and difficulty in nurse recruitment (Araujo & Sofield, 2000; Farrell, 1999; Jackson et al., 2002; Namie & Namie, 2000). Without “interpractice partnership and collegiality” (Misener, 2001, p. 91), nurses have low morale and decreased job satisfaction (Farrell, 1999; Tepper, 2000). Other organizational expenses associated with bullying include increased errors, diminished commitment to the organization, altered patient care, poor customer service, employee theft, and increased health care costs for the treatment of stress-related illnesses (Araujo and Sofield ; Glendinning, 2001; Farrell, 2002; Namie and Namie, 2000; Tepper, 2000).

Interventions

Research has shown that adult bullying is a significant problem that should be further explored and addressed. Ultimately, policies, practices, and laws need to be created, amended, and enforced to protect nurses from workplace bullies.

“Organizational justice” is often cited as the mediating factor in bullying (Tepper, 2000, p.178). However, organizations look for convincing empirical data when considering change. Hence, short and long term strategies are required to address bullying in the nursing workplace. The following suggestions are based on empirical and anecdotal evidence that have been helpful in intervening with bullies. The focus of immediate interventions is to manage the fallout after bullying. Long term strategies seek to prevent bullying.

Short term strategies: Focus on crisis management

These short term strategies emphasize crisis management skills that may be useful during and after bully incidences. The first three interventions can help to prevent abusive interactions from developing into a bullying dynamic.

1. **Speak up.** Dr. Phil McGraw says, “We teach people how to treat us”. Avoid “spineless flexibility” (Namie & Namie, 2000, p. 150). Prevent bullying by standing up for oneself during the first or second incident. Learn to set limits on other people’s behaviors. Speak to the bully’s behavior and avoid labels. Be firm. Remain rational and centered during abusive incidences. Be conscious of one’s breathing and body position. When possible, use humor either internally or externally to defuse the situation. Even if the nurse successfully manages the situation, report the incident to a manager for future reference.

2. **Help each other.** In order to change the organizational culture and social climate in one's workplace, bystanders must assist victims of bully behaviors. "Code Pink" is a technique initially developed by operating room nurses in one hospital. When a bully physician began to berate and belittle a nurse, all nurses within earshot gathered around the doctor and nurse, calmly confronted his/her behavior, asked for an apology and a commitment to not behave like this again. According to a study by Namie and Namie (2000), every doctor submitted after this technique.
3. **Play the game.** Some employees are bullied because they refuse to "play the game" in the workplace. For example, narcissists are much easier to get along with when the nurse "sucks up", admires and compliments them! When possible, don't disagree or criticize a narcissist. They are easily wounded and will lash out at you. Remember, the narcissist is "always right" (wink, wink)!
4. **Seek support.** If a nurse is already in a bullying relationship, implementing the first three suggestions may worsen the victim's position. Farrell's (1999) research found that the most beneficial action for nurses after a bullying incident was to seek support from a family member, friend, and/or trusted colleague. This study also revealed that the least helpful action was remaining quiet about the incident. More specifically, Quine's (1999) research revealed that support from allies at work mitigated consequences of bullying. One disadvantage to relying solely on support from untrained counselors is that they may inadvertently blame the victim and/or give harmful advice (Hubert, 2003).
5. **Keep accurate records.** As soon as the nurse is aware that he/she is a victim of bullying, start documenting all bullying incidences with specifics, dates, times, witnesses, direct quotes, evidence, and his/her reaction (Richards & Daley, 2003). Also,

document phone calls and save emails pertinent to bullying incidences. Be cautious about emails sent to other people because they might be used as evidence against the nurse.

6. **Locate policies.** Most workplaces do not have specific policies that address bullying in the workplace. Locate existing policies that refer to discrimination, harassment, failure to maintain a hostile-free work environment, and an employee's right to be treated with dignity and respect. In 2001, the American Nurses Association released a statement that nurses deserve safe working environments. For more information, see <http://www.nursingworld.org/osh/wp5.htm>

7. **Seek professional help.** Namie and Namie (2000) recommend “bullyproofing” oneself before attempting to “bullybusting” someone else because the process can be traumatic. Seek professional help for mental and physical health. Medical doctors can help to stabilize physical health. Trained counselors (preferably outside the workplace) can assist in regaining self-confidence, debriefing the incident, and changing beliefs about oneself, others, and the situation through cognitive restructuring. Take inventory and responsibility for one's role in the dynamic with the bully (Tehrani, 2003). What is working in this situation? What is not working? The nurse should review her strengths and weaknesses in the workplace. Is there any truth to the bully's complaints? When exploring these questions, remember that excessive self-criticism leads to depression and despair. Monitor self for suicidal and homicidal thoughts. Also monitor for self-destructive coping such as overeating or drinking. Take measures to improve sleeping, eating, and exercise regimes.

8. **Obtain professional documentation.** Have clinicians document one's mental and physical side effects from bullying (Namie & Namie, 2000).

9. **Review options and formulate a plan.** Defuse anger and frustration before approaching the bully about multiple incidences. Take this opportunity to learn new interpersonal, negotiating, and conflict management skills. Read more about the phenomenon of bullying. Articulate wants and needs and how to communicate them to others. Not everyone in the workplace is bullied. Observe how other staff manage the bully.

10. **File an informal complaint.** If the bully does not stop when confronted, file an informal complaint with the bully's manager, collective bargaining unit, EAP, or HR before seeking outside representation (Hubert, 2003). Follow the chain of command starting as close to the bully as possible. Involve as few people as possible so that the bully can change her behavior without losing face. Review prior documentation about bullying incidences and prepare a statement. Remove the affect (emotion) from it (Namie & Namie, 2000). There are a few notes of caution from the literature...Studies repeatedly show that employees are disappointed, on average, 75% of the time by the response to their complaints by these groups (Aiken et al., 2001; Farrell, 1999; Namie & Namie, 2000; Quine, 1999). Also, if the bully is the nurse manager, consider that the manager's boss has protected her from corrective action in the past.

11. **File a formal complaint.** If displeased with the results, consider filing a formal complaint to the organization's grievance committee. Typically they make recommendations to the organization about how the case should be managed and suggestions for "after-care" of the victim, bully, and workplace (Hubert, 2003).

12. **Seek legal representation.** If displeased with the results, consider legal representation from outside the workplace as a last resort (Hubert, 2003). Attorneys, however, often tell employees that the bully has done nothing illegal and there is no

case unless civil rights have been violated. Also, once an attorney is involved, the workplace will stop at nothing to build a case against the nurse (Namie & Namie, 2000). Even if the nurse “wins”, the person is often traumatized (Hubert, 2003). Details are difficult to contain from coworkers and management, and the nurse will likely need to leave the workplace (Hubert, 2003).

13. Transfer to another workplace and start anew. This is not giving up or giving in to the bully. This is likened to leaving any unhealthy relationship.

14. Research potential workplaces. Interview future staff and managers for bully characteristics and unhealthy work environments.

The following testimonial illustrates how early nursing interventions changed a physician’s abusive behavior and prevented future occurrences.

My workplace has had difficulties with the pediatric surgery residents verbally abusing the nurses. Recently, I paged a first-year surgery resident to the intensive care unit to examine an unstable child. When he returned my page, he was upset that I asked him to the unit. He began yelling at me and I ended the phone conversation. Soon thereafter, he stormed into the patient’s room hot as hell and accused me of hanging up the phone on him. When I denied it, he continued to accuse me of hanging up the phone on him. When I attempted to redirect him to the patient, he would not address the patient’s needs until I “promised” to never hang up the phone on him again. Fortunately, another nurse witnessed my phone and personal interaction with the resident. We immediately told my nurse manager who promptly paged the resident to speak to her. He returned to my room and profusely apologized for his behavior. I have not observed any inappropriate behavior from him again.- P., RN, Pediatric ICU, 36 years old.

Long term strategies: Focus on prevention

The focus of long term strategies is to prevent bullying in nursing workplaces.

1. Survey nurses at a local and national level. Research can provide data to change and enforce public policies against bullying in the workplace. One way to minimize some of the methodological problems encountered in the research is to develop self-administered questionnaires that not only elicits the victim’s perspective, but also the

bystander's, bully's, nurse administrator's, and nurse manager's perspective on bullying. Since bullying has been difficult to conceptualize and operationalize, further research or a concept analysis is needed to clearly define bullying. Ideally, a research study on bullying in nursing workplaces would also obtain statistics and measurable outcomes on the demographics of victims and bullies, location of workplace, sources of abuse (excluding patients and families), incidence of bullying, most frequent attributes of bullying, average duration of bullying, level of distress, feelings after bullying, situation preceding bullying, consequences of bullying, history of anxiety and depression, level of reporting, and level of satisfaction with reporting.

2. **Increase awareness.** Give language to the phenomenon of bullying (Hoel et al., 2004). Disperse informational brochures about bullying for nurses at inpatient and outpatient settings. One Australian hospital created a video about bullying. They also developed annual nursing mandatories and quizzes about recognizing/reporting bullying (Sweet, 2005).

3. **Create workplace violence teams within hospitals** (Richards & Daley, 2003; Sweet, 2005). This team would be responsible for developing an anti-bullying policy, developing procedures for lodging complaints and sanctions against bullies, and increasing awareness. Nurses must feel safe and protected from retribution to report bullying (McKenna et al., 2003). Therefore, a crucial role of workplace violence teams includes monitoring the effectiveness of the anti-bully program (Quine, 1999; Rosenstein, 2002).

4. **Report bullying.** Nurses must be encouraged to report every incident of bullying, "even in cases that are not clear cut" (RCN, 1997, p.6).

5. **Change group norms and values** (Hubert, 2003). Policies are not enough.

Organizations need to consistently hold bullies accountable for their actions with zero tolerance for bullying. (Offermann & Malamut, 2002; Rosenstein, 2002). For example, an Idaho hospital fines physicians \$10,000 for every angry outburst that occurs after a warning plus requires them to complete an anger management course (Araujo & Sofield, 2000).

6. **Lobby lawmakers.** Armed with anecdotal and evidenced-based research, lobby state and national legislators to enhance laws protecting victims from bullying in the workplace.

Conclusion

In conclusion, most full time nurses spend more waking hours at work than they do with their families and friends. Therefore, nurses should be protected against the hostile work environment created by bullies. Bullying in the nursing workplace is a significant source of occupational stress that results in negative, life-altering consequences. Short term and long term interventions that target the antecedents to bullying can impact outcomes.

My former nurse manager has a history of harassing nurses when they used a day of PTO and especially when they were off on medical leave. Nurses are required to call him at home at any time, day or night, if they are going to use unscheduled PTO. This is a form of intimidation. Most units are only required to call the charge nurse. The unit culture is such that “you better be dying if you’re calling in sick!” If you complained to HR about him, he jokingly said, “You’ll pay for it”.

I sustained a work-related injury and was off work for about 2 weeks. While I was off, nurses told me that he made disparaging comments about me and my injury. He clearly expressed his displeasure to my coworkers that I was off work. During phone conversations with him, he was snippy with me, made many snide comments, and hung up the phone on me on three occasions without saying goodbye.

I was cleared to return to work on light duty but he didn’t want me to return until I was 100%. It was a financial burden for me to stay off work on workman’s

compensation. I spoke to the case worker about this and she strongly suggested to my nurse manager that I return to work on light duty. My nurse manager relented. When I called to tell my nurse manager that I could start work the next day, Saturday, he said, "Oh, no you won't. You will work during the week when I can watch you work! And don't be coming into my office and telling me that you want to work from home!" That comment made no sense; I had told him I wanted to be at work and couldn't afford to be off on workman's comp. He warned me that if I returned to work on light duty, "you will be entering the lion's den."

When I returned to work on light duty, I received the silent treatment from him and a few of my coworkers. He excessively monitored me during my light duty status, despite my last 4 yearly evaluations, in which he praised me for my self-motivation and attention to detail. He told me to work from a desk in the center of the unit where he could "watch me". Via email, he demanded that I turn in daily reports of my work when other staff only needed to turn in monthly reports. Despite minute-by-minute accounts of my time in writing, he repeatedly questioned the amount of time I spent on my project. He pushed and rode me to work faster on the project, and accused me of "milking the system". Then he told me that "ALL of your peers have negative comments about your work on the project", which was not true.

I had completed 85% of the project, but he said I had done enough for now and he had no more desk work for me to do. So I was off work again on workman's comp. As soon as I left, he reassigned the project to other people without telling me or involving me...people who had no experience with this project. I found out from the unit clerk and other nurses! When the project was completed, I received an email addressed to the whole staff from him thanking and crediting other nurses for their work on the project, but not me.

When I confronted him on this, he said, "Well, I knew that you complained about me to HR. We were not on speaking terms and you were not answering my emails." That was a blatant lie. I have treated him with professionalism this entire time. He encouraged me to look for another job while on leave and I said no. He said, "Why would you want to stay here?"... Implying, why would you want to put up with this abuse? I told him that he was being abusive and vindictive during my leave and that I wanted him to stop harassing me. He said, "Don't use those psychology terms with me. Your time off is hostile to the unit. Your PTO gets down to the bear bones". I had 80 hours of PTO in my bank at the time of my leave.

To make a long story short, the harassment continued and my coworkers withdrew from me. He failed to maintain a hostile-free work environment. I asked for a meeting with HR and my manager, but HR would never address his behavior as wrong during the meeting. I met with an EAP counselor, and she never addressed this behavior as wrong. I consulted an employment attorney who told me that my case did not meet Title VII criteria for discrimination against my disability (ie. my work-related injury). The bullying was much worse after our meeting with HR, so I filed a formal grievance with the institution. I am not allowed to discuss the details of the proceedings, but I was "assisted" in relocating to another unit.

He's still in the same unit bullying staff. Two more nurses have been forced out of the workplace since I've left. And no, I've never been "bullied" before this incident. K., RN, medical-surgical floor, 40 years old.

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