



# Bullying in Nursing:

By Mary Pat Szutenbach

ROOTS, RATIONALES, AND REMEDIES

**CE** 3.0 contact hours

**ABSTRACT:** *Bullying and incivility are sadly, far too common in today's healthcare workplaces. This article reviews early to current literature, identifies types of bullying, offers four root causes, and suggests responses to impact these causes using Gibbs' Reflective Cycle, biblical Scripture, and an allegory "How to Swim with Sharks."*

**KEY WORDS:** *bullying, Gibbs' Reflective Cycle, incivility, lateral violence, nursing*

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### A SADLY COMMON STORY

Less than a year after graduation from nursing school I was commissioned in the military and assigned to a combined adult and pediatric unit in a small hospital. While in orientation I was asked to provide one-to-one care for a critically ill child who could not be placed in intensive care. I was lauded for how I handled the child’s care and from that point forward Brenda,\* a nurse several years senior to me, seemed guarded around me. She began to withhold information and gave me assignments that at times seemed unfair.

One particular shift, Brenda was responsible for the pediatric patients in our unit, and I cared for the adults. While Brenda was busy with a patient, the intravenous (IV) pump started to alarm in one of her assigned rooms. I went into the baby’s room and began to troubleshoot. I found the IV

in the baby’s right hand, taped on a padded board with the board pinned to the mattress. I checked the IV and it was patent and showed no signs of malfunctioning, so I reset the pump and returned to the nurses’ station. A little later it alarmed again. When I went in the second time, I noticed

started shouting at me. I convinced her to move our interaction into the medication room, where we could talk in private. Brenda continued to yell at me and told me never to touch her patients. Her statements became increasingly aggressive and she ultimately told me to “go slide down a razor blade.”



I left the interaction feeling stunned wanting to understand what I had done to precipitate Brenda’s attack. I certainly wanted to avoid frustrating her again. My subsequent shifts with her were difficult; Brenda appeared to look for opportunities to find fault in my actions and I felt she was withholding greater amounts of information than before the incident. There was a continued air of hostility between us that diminished slightly over time but never went away.

Similar situations have been occurring between nurses for years and are referred to as *horizontal hostility, violence, or bullying*.

Because nurses’ behaviors have followed these patterns for decades, it is necessary for us to ask why, take a hard look at our history, and attempt to find root causes for these problems.

### EATING OUR YOUNG?

The first literature on bullying among nurses surfaced in the late 1970s and early 1980s. Kohnke (1981) and Duldt (1981) spoke of the vulnerability of nurses in low-level positions and how

the baby was trying to suck his right thumb, putting tension on the tape, which closed off his IV. The baby had no pacifier, so I went to find Brenda who briskly told me she could not be interrupted. I checked the baby’s chart and intake status and made him a clear liquid bottle of half strength apple juice, which stopped him from putting tension on his IV.

When I reported to Brenda what had happened, she became angry and



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\*Names have been changed to protect privacy.

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those nurses were often recipients of verbal abuse. Kohnke suggested nurses felt unable to defend themselves because they feared doing so would place them in jeopardy of losing their jobs. She concluded that patterns of bullying were circular and have been passed from generation to generation within nursing.

In 1987, Cox introduced other reasons for nurse bullying, saying low self-esteem or the loss of self-esteem as a result of repeated criticism contributed to the problem. She added that nurses take on feelings of guilt related to expressions of anger toward them and those guilt feelings keep nurses from defending themselves when verbally attacked. Randle's (2003) research with nursing students reinforced Cox's assertions and provided evidence to show that students' self-esteem diminished during their nursing programs.

Bullying often presents as repetitive acts of verbal aggression and criticism but may take more subtle forms, such as placing someone under increased scrutiny or talking behind another's back. Shortly after starting a new job Noreen,\* a seasoned nurse, observed one of her fellow nurses following behind her after she administered medications. Noreen later realized the other nurse was checking to make sure she gave all the medications correctly. At the end of one shift Noreen overheard the nurse reporting derogatory things about Noreen to their supervisor. Noreen cried all the way home. She found it difficult to return to work. When Noreen mustered the courage to communicate with her manager, the manager merely replied, "Haven't you heard the statement 'nurses eat their young?' That's just the way it is."

In 2000, Freshwater compared nurses' responses to stress and conflict to animal behavior, where stress causes animals to turn on their own young and eat them. There is substantial evidence in the literature describing circumstances where nursing students and new graduates in particular are cannibalized, ostracized, and belittled by experienced staff nurses. The phrase, "nurses eat their young" has been bantered about within and outside of nursing and caused consternation for years. Eating our young is perplexing because nursing is known as the "caring" profession (Unruh, 2005; Zucker et al., 2006).

Most nurses excel in caring—at the bedside to their patients. Yet relationships between nurses often become strained and uncaring. It is difficult to understand how, in one moment, with a patient the nurse is the epitome of caring and, a few moments later that same nurse may attack a colleague.

### **BULLYING DEFINED**

In addition to bullying, these negative behaviors are referred to as aggression, horizontal aggression, horizontal violence, lateral violence, lateral hostility, and incivility. In the last 10 years, vertical hostility has been added to this list, and specifically describes bullying that occurs between people with a "real or perceived power differential" (Selekman & Vessey, 2004, p. 246).

Griffin (2004) reasoned the lack of universal terminology is partially the basis for why literature on this subject has been so diverse. There are equally broad definitions for the terms as there are numbers of labels for these behaviors. The Center for American Nurses (CAN,

2008) defines lateral violence as "overt and covert acts of verbal and nonverbal aggression" (para. 1) between nurses in all types of work centers and at all levels of an organization.

Episodes of lateral violence may occur as single incidents, but bullying is a pattern of behavior that continues over time. Selekman and Vessey (2004) defined bullying among school children (which fits well with behaviors seen between nurses) as "dynamic and repetitive patterns of verbal and/or non-verbal behaviors" aimed at another person with the intent "to deliberately inflict physical, verbal or emotional" harm (p. 246). CAN (2008) quoted the Task Force on the Prevention of Workplace Bullying, defining bullying as "an offensive abusive, intimidating, malicious or insulting behaviour, or abuse of power conducted by an individual or group against others, which makes the recipient feel upset, threatened, humiliated or vulnerable" (p. 1). CAN further clarified that bullying is patterned, repeated, and ongoing. Sadly, these repeated behaviors break the victim's will to defend him or herself (Stevenson, Randle, & Grayling, 2006).

Specific acts of bullying and lateral violence take multiple forms and can be belittling, ignoring, yelling, intimidation, back stabbing, eye rolling, sarcasm, sabotage, withholding of information, unequal care assignments, nonverbal innuendo, disrespect for personal privacy, and threats (CAN, 2008). Kupperschmidt (2008) termed the wounds caused by these hurtful actions "soul scars" (p. 12). Such scars can lead nurses to feel isolated, unworthy, and undervalued.

## OSTRACIZED NURSES

The American Nurses Association (ANA, 2012) cited Hutchinson, Vickers, Wilkes, and Jackson who broke bullying into three forms: (1) “personal attacks,” (2) “erosion of professional competence,” and (3) “attacks through” the way work is assigned, and “the denial of due process” (p. 7). Nurses have identified feelings of being unwelcomed, unaccepted in the team, undervalued, unsupported, undermined, scrutinized, hopeless, labeled, ostracized, powerless, and cheated because others “played dirty.” Other nurses have commented the level of competition was extremely high. Julie,★ a new graduate, asked the manager to please reassign her to a different preceptor, saying her preceptor was an excellent nurse but their personalities were very different and they were not well matched. The manager arranged for a new preceptor, but thereafter Julie was labeled as a troublemaker and ostracized by fellow staff nurses.

Lydia,★ another new graduate, was assigned to a full team of patients and given the oversight of a licensed practical nurse (LPN) who also had a full complement of patients. One of Lydia’s patients was a woman who had just been transferred to her floor from intensive care. At the start of her shift the woman was responsive and oriented, but as the shift progressed the patient became less responsive. Lydia described the patient’s changes to a staff nurse from a neighboring unit and asked the nurse to come and assess the patient. Without assessing the patient the other nurse told Lydia to “just turn the patient onto her side, and the woman would be okay.” Lydia described feeling vulnerable, isolated, and unsupported, saying, “I had no one to turn to. I did not know what was going on, and I did not know what to do.” On her own, Lydia phoned the physician, explained her concerns, and obtained guidance to transfer the woman back to ICU. Because of her isolation and lack of support Lydia made the decision to leave that employer and look for a new job.

Nurses Noreen, Julie, and Lydia were not valued; each suffered from a violation of her dignity by those who should have been mentors and role models.

The acts of bullying and lateral violence are disrespectful, denigrating, and humiliating, injurious to the recipient’s dignity (Dalpezzo & Jett, 2010).

When individuals are undervalued, their trust of others is degraded and often they become isolated. This isolation puts nurses and patients at increased risk for errors. Ostracized nurses must develop new coping skills to help them survive their first years in caustic work environments. Many of them choose to leave their positions and sometimes leave nursing altogether. In fact, evidence supports that newly licensed nurses often leave the profession within the first 2 years of working (ANA, 2012; Domrose, 2002).

**Table 1. Presumed Causes of Bullying in Nursing**

- Longstanding paternalism in healthcare (oppressed group)
- Learned behavior (enculturation)
- Bullying is “normal” (so no one does anything about it)
- Profession primarily made up of women
- Nurses led to believe they should not be assertive
- “Good nurses” are conciliatory (don’t challenge status quo)
- Workplace stress

Hardiness is a quality to help persons cope with bullying (Foster & Dion, 2003). Sá and Flaming (2008), who studied hardiness in the face of bullying, reported a 26% certified absentee rate of persons who had been bullied on the job. Further evaluation of nurses who had high absentee rates showed them to be less hardy than nurses who had minimal absences. Sá added that workers who had been bullied suffered from “more physical and psychological health problems” than those who were not bullied (p. 415). Delsidou (2009) also identified multiple negative physiological and psychological responses to bullying, citing increased episodes

of illness and sleep disturbances among nurses who were bullied.

## ROOT CAUSES FOR BULLYING

In 1983, Roberts asserted the primary reason for the occurrence of lateral violence had to do with nurses being in an oppressed state. Dong and Temple (2011) define oppression as “unfair, unjust cruel governance or use of authority” by those in positions of power (p. 169). These authors added that “oppression deprives individuals and groups of their rights, which leads to feelings of insecurity, shame, self-doubt, and anxiety” (p. 170). Lateral violence is a symptom of oppression and occurs in response to repeatedly being hurt, disrespected, isolated, and undervalued. Those who are mistreated in this way may suffer from a reduction in self-esteem, which depletes overall confidence and increases risk for errors. Oppressed groups feel powerless in the face of their oppressors and turn their frustrations inward and toward other group members, especially those who they perceive to be less powerful.

As an oppressed group, a number of specific root causes for bullying have been identified (see Table 1). The first and most prominent is that nurses’ behaviors have been patterned as a result of the long-standing paternalistic structure within healthcare. Historically, absolute obedience to physicians was imperative. But today nurses are expected to be partners in decision making and effective advocates for patients (Jasmine, 2009; Jinks & Bradley, 2003), willing to question and offer alternatives for care. However, paternalism is multifocal. On one hand, many older nurses and physicians were educated within a paternalistic framework, and physicians have become comfortable with the power associated with their roles. Physicians have a vested interest in maintaining the status quo, and as a result, many nurses have continued to be dominated by physicians. Domination has continued even though nurses have been taught that it is essential to think as professional partners. This paternalistic structure

within healthcare provided a framework for the oppression of nurses and has contributed to the perpetuation of lateral violence. These old patterns will not change unless nurses take action to break out of the status quo (Jasmine, 2009; Larijani, Aghajani, Baheiraei, & Neiestana; 2010; Leiper, 2005; Rowe & Sherlock, 2005).

A second possible reason for bullying has to do with how and what nurses are taught. There is evidence that bullying is a learned behavior, and nurses are enculturated to bully one another. Nursing students in Great Britain have described numerous instances where they were bullied by their preceptors. Those same nursing students gave multiple examples to suggest they were expected to become bullies themselves as a part of their rite of passage into nursing (Curtis, Bowen, & Reid, 2007; Randle, 2003). Deltsidou (2009) provided added evidence of bullying in clinical rotations during school supporting assertions that nurses are socialized to adopt bullying behaviors.

If nurses agree this kind of enculturation takes place while in school, then it would follow that nursing students might accept the behavior as part of being a nurse. This acceptance takes us to the third contributing factor identified in the literature: that bullying and lateral violence are generally accepted as the “norm” within nursing and are commonly considered “a part of being a nurse.”

A number of nurses I interviewed suggested nurses bully one another because the profession continues to

primarily be made up of women. One nurse repeatedly stated women can be “catty” with one another. This dismissive statement suggests nurses have accepted this harmful conduct as normal, and as a result these behaviors have been allowed to continue. Deltsidou (2009) confirmed this impression and cited studies done on subjugation in nursing, showing a correlation between demoralization and the fact that the profession is mostly female. Deltsidou suggested men in nursing also are subjugated and in some



cases may be targeted more than women. Since nurses are subjugated beginning with schooling and into their careers, they come to believe it is a natural part of being a nurse. If nurses perceive bullying as normal behavior, they may turn a blind eye to the bullying around them and in some cases deny it occurs (Daiski, 2004; Lewis, 2006).

The final potential root cause suggests nurses, through their education and work experiences, are led to believe they cannot or should not assert themselves. Subtly nurses come to believe they are incapable of supporting their peers. Nurses are socialized to

believe they should not join together in a collective voice, in solidarity with other nurses. This belief may explain to some extent the incongruity noted between nurses’ abilities to provide compassionate care for their patients and their lack of compassion and respect in their relationships with one another. (Deltsidou, 2009; DeMarco, Roberts, Norris, & McCurry, 2008)

Some nurses recognize destructive behaviors between nurses but do not act. Dong and Temple (2011) raise the

issue of “silencing” and suggest “good nurses do not challenge the status quo and will therefore silence themselves to avoid conflict” (p. 171). Deltsidou’s (2009) work indicated nurses develop conciliatory responses when they feel dominated and overwhelmed. This pattern of appeasement supports Dong and Temple’s description of silencing behaviors, who noted that in clinical experiences weak students may turn to conciliation in order to escape disagreements and bullying. This conciliation ties

in closely with nurses’ lack of assertion and limited application of their collective voice.

## REFLECT, MEDITATE, REHUMANIZE

Knowing these presumed root causes of bullying, behavioral changes can be developed to stop lateral violence within our ranks. We can begin by addressing nursing as an oppressed group. Freire (2000) tells the oppressed they must reflect, apply praxis, rehumanize themselves, and then rehumanize their oppressors. Freire adds that the acts of belittling,

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disempowering, and disrespecting another (all acts of oppression) dehumanize a person and cause him to be fearful of freedom. Praxis speaks to the practical application of theory, the “doing” of a skill. With bullying, praxis is the “passing through” of the rehumanization process; it is in the act of rehumanizing that the oppressed person can rehumanize the oppressor.

The task of rehumanizing ourselves and our oppressors is a form of reestablishing dignity in self and others. This act of rehumanization is especially critical for those of us who are Christians. The charge is given to us: “Love your enemies, do good to those who hate you; bless those who curse you, pray for those who mistreat you” (Luke 6:27–28, NIV). Consider my experience of lateral hostility with Brenda. I now recognize I did not fully follow God’s directions. My initial intentions were good; I attempted to help Brenda and her patients. After her harsh words to me, though, my feelings toward Brenda were quite negative. I felt deeply hurt and initially wanted to lash back at her. I did not bless Brenda, and I did not pray for her. As humans we fall short, but as Christians we should remind ourselves to work to protect our own humanization and the humanization of all around us.

Rather than losing hope in negative situations, we can first take a realistic look at ourselves. In doing so, we address the second and third of the root causes by acknowledging that these patterns were learned (part of our socialization into nursing) and we may have ignored the behaviors

because we believed them to be normal.

Purposeful reflection facilitates a more complete understanding of our actions and the repercussions that result. Freire (2000) offered it takes “reflection—true reflection—[to] lead to action” (p. 66). Jesus’ story of the Good Samaritan offers helpful insight toward reflecting about bullying.

#### **PURPOSEFUL SELF-ASSESSMENT**

From Luke 10:25–29 (NAB) we read:

*On one occasion a lawyer stood up to pose him this problem: “Teacher, what must I do to inherit everlasting life?” Jesus answered him: “What is written in the law? How do you read it? He replied: “You shall love the Lord your God with all your heart, with all your soul, with all your strength, and with all your mind; and your neighbor as yourself.” Jesus said, “You have answered correctly. Do this and you shall live” But because he wished to justify [emphasis added] himself he said to Jesus, “And who is my neighbor?”*

Jesus then told the story of the Good Samaritan (Luke 10:30–37). Consider that maybe the priest and the Levite who walked by the injured man came up with compelling justifications for not stopping to assist the half dead man.

What was Jesus’ message? We are called to treat all individuals justly, respectfully, and with dignity. St. Paul warned the grand Romans, “Do not think more highly of yourself than you ought, but rather think of yourself with sober judgment (Romans 12:3). In purposeful reflection we can ask: do

we attempt to justify ourselves or our actions? Do we overestimate ourselves? Sometimes we misjudge ourselves and believe we are acting humanely when in fact we are not (Dong & Temple, 2011). At times the perpetrators of horizontal violence have no idea they are bullies. All of us need to reflect honestly on our own behaviors and look for indicators of bullying in ourselves.

Another self-assessment is to ask if we have been conditioned through our nursing education or other experiences to accept aggressive behaviors as the norm. Do we unknowingly accept bullying? When we accept lateral violence and bullying as normal, we no longer see the behaviors as problematic and we stop looking for solutions. We can begin to see things more clearly by engaging in regular reflection.

Purposeful reflection requires us to look deeply within ourselves to evaluate our actions. The Gibbs model is a useful framework to guide self-reflection using six steps in our reflections: a description of the events, an examination of feelings associated with the events, an exploration of what was good/bad about the situation, an attempt to analyze the situation, a review of the general and specific conclusion associated with the events, and the development of a plan for the future (Gibbs, 1988; Smith & Loads, 2008; Wilding, 2008). Swanson (2012) offers an excellent visual diagram to help you understand Gibbs’ model.

Successful ways to apply Gibbs’ model are to discuss negative work situations with a trusted friend,

## Through prayer and biblical meditation we can achieve a clearer understanding of **how our actions are perceived by others** and how they **affect those around us.**

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colleague, or manager, or begin by journaling after events and then discuss with someone to gain greater insight. When we achieve a deeper understanding of our feelings and actions related to events, we have a much better likelihood that we will be able to identify how our actions influence the reactions of others and serve to escalate or de-escalate situations (Wilding, 2008).

When I described my situation with Brenda, I took the first step in Gibbs' model. My intent was to help Brenda, and I thought my actions had been appropriate. After our heated interaction, however, I recognized this was an inaccurate conjecture on my part. Our conversation left me feeling confused, hurt, unvalued, and fearful (second step). The only good part of this event (step three) is that my intentions were good, but I incorrectly assumed Brenda would accept my actions as good. Her reaction suggests she felt I had overstepped my boundaries, and my actions threatened her and/or were not consistent with her plan of care for the baby. In analysis (step four), overstepping my boundaries and assuming my actions would be perceived as helpful and graciously accepted, was a bad part of the event. I have no way of validating my assumptions about what Brenda was thinking or feeling, but conclude these things from Brenda's strong reaction (step 5). If I could do things over, I would have looked for measures that would have bought time and allowed Brenda to manage the problem herself when she was available. I could have un-pinned and repinned the baby's arm board

to allow the baby to suck his thumb without putting tension on his IV site. If I were to encounter a similar situation in the future, I would make more attempts to coordinate my actions with the other nurse before taking any independent action (Wilding, 2008).

Other models of reflection can help nurses analyze and deal with bullying. Smith and Loads (2008) and Kofoed (2011) approach reflection using both Gibbs' model and John's Model for Structured Reflection that uses Carper's Ways of Knowing. Lim, Childs, and Gonsalves (2000) approach reflection as a form of debriefing and have prepared a set of questions to help with this process. A table comparing these three models side by side can be found online as supplemental digital content at <http://links.lww.com/NCF-JCN/A17>

### PROFESSIONAL RESPONSES TO BULLYING

The Code of Ethics for Nurses gives us clear guidelines of how we are expected to act in our professional, work relationships (ANA, 2001). Provision 1.5 states, "The nurse maintains compassionate and caring relationships with colleagues and others with a commitment to the fair treatment of individuals, to integrity-preserving compromise, and to resolving conflict" (p. 149). Provision 6.3 states, "The nurse is responsible for contributing to a moral environment that encourages respectful interactions with colleagues, support of peers, and identification of issues that need to be addressed" (p. 162). Nurses can facilitate and maintain professional relationships by being increasingly

self-aware and reflective, and by working toward maintaining one's own humanness and humility. Proverbs 15:1 states, "A mild answer calms wrath, but a harsh word stirs up anger." Nurses need to act humbly to defuse conflict. This does not mean we are passive and let others walk all over us but that we are appropriately assertive with colleagues. Researchers have studied students' and nurses' levels of assertiveness and have concluded greater assertiveness is an excellent tool to combat lateral violence and bullying in the workplace. Several researchers strongly support the inclusion of assertiveness training within nursing programs (Begley & Glacken, 2004; Larjani et al., 2010; Lin et al., 2004).

In 2007, the Joint Commission updated its leadership standards and included provisions to combat disruptive behaviors in healthcare facilities. As a result, nurses and other healthcare professionals have become more aware of the detrimental effects bullying behaviors have in the workplace. The standards stimulate us to evaluate ourselves for behaviors that might enable the continuation of lateral violence in work environments. Our self-reflections help us develop a deeper understanding of whether we have accepted bullying because our nursing work environments have "always been that way."

An entertaining approach to bullying that helps disarm some of the associated fear and anxiety has been developed from Voltaire Cousteau's 1812 primer for sponge divers who swim in shark infested waters (1987). Broome (2008) addressed bullying and

provided a set of assertiveness steps drawn from Cousteau's "How to Swim with Sharks: A Primer." A discussion of Broome's application of Cousteau's shark rules can be found online as supplemental digital content at <http://links.lww.com/NCF-JCN/A15>.

## A CHRISTIAN RESPONSE

As Christian nurses we have the benefit of our prayerful relationship with God, and this communion with him guides our daily actions. We can ask God to open our hearts and minds for a clearer understanding of how our relationships with those around us can be changed and improved. Through prayer and biblical meditation we can achieve a clearer understanding of how our actions are perceived by others and how they affect those around us. We can also ask God to help us to act selflessly as Jesus showed us to do.

Jesus said to the lawyer at the end of the parable of the Good Samaritan, "Which of these three, in your opinion, was neighbor to the man who fell in with the robbers?" (Luke 10:36). How could we be better neighbors to our fellow nurses? We can bless and pray for them, praying to respond with love and respect even when they lash out at us (Luke 6:27-28).

There is strong evidence that lateral violence and bullying are common in healthcare workplaces. The profession of nursing would benefit greatly from working through these issues to find lasting solutions to relational problems. As Christians, we have the advantage of our faith and the resources of reflection and prayer to help us develop alternatives to bullying and lateral violence. 

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