

# Workplace bullying in nursing: towards a more critical organisational perspective

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## Workplace bullying in nursing: towards a more critical organisational perspective

Workplace bullying is a significant issue confronting the nursing profession. Bullying in nursing is frequently described in terms of ‘oppressed group’ behaviour or ‘horizontal violence’. It is proposed that the use of ‘oppressed group’ behaviour theory has fostered only a partial understanding of the phenomenon in nursing. It is suggested that the continued use of ‘oppressed group’ behaviour as the major means for understanding bullying in nursing places a flawed emphasis on bullying as a phenomenon that exists only among nurses, rather than considering it within the broader organisational context. The work of Foucault and the ‘circuits of power’ model proposed by Clegg are used to provide an alternative understanding of the operation of power within organisations and therefore another way to conceive bullying in the nursing workforce.

**Key words:** bullying, employment, horizontal violence, nursing, oppressed group behaviour.

A plethora of literature suggests that bullying is widespread in nursing, and that it can render the workplace a harmful, fearful and abusive environment. Research findings reveal the devastating effect bullying has upon nurses (Duffy 1995; Quine 1999; Farrell 2001; Lewis 2001), yet, there has been little progress on furthering the understanding of bullying within the nursing context in the last decade. In the nursing literature, bullying has predominately been understood in terms of ‘oppressed group’ behaviour and ‘horizontal violence’ (Duffy 1995; Freshwater 2000; Jacoba 2005). As Farrell (2001) has previously highlighted, the continued focus upon this form of analysis has meant that little attention has been given to understanding the causes of bullying in nursing, other than those arising from oppression theory (Roberts 1983; Hedin 1986; Duffy 1995). While these conceptualisations have provided some insightful understanding, they have been restrictive in that they cannot provide a finer-grained analysis of the work environment of nurses.

They fail to acknowledge some of the wider environmental and organisational issues that contribute to an occupational milieu in which bullying becomes (almost) normalised and acceptable. This paper aims to extend current theoretical understandings of bullying in nursing. Clegg’s (1993) ‘circuits of power’ model is used to explain how bullying can become so normalised within an organisational culture that it is almost invisible. In so doing, we aim to generate new and alternative understandings of bullying in the nursing workplace.

## WHAT WE KNOW ABOUT WORKPLACE BULLYING

Over recent decades there has been growing recognition that workplace bullying is a pervasive and harmful feature of modern workplaces, with a number of large-scale studies across a range of industry sectors identifying the damaging effects of bullying for individuals and organisations (Einarsen 1999; Quine 2002; Zapf and Einarsen 2003; Dick and Raynor 2004). This evidence suggests that workplace bullying is a pervasive and harmful phenomenon, which exists in most, if not all, workplaces. It is known that workplace bullying is not a one-off, or accidental event: instead, it is a deliberate and ongoing array

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of often subtle and masked negative behaviours and actions that accumulate over time. Bullying in the workplace has been characterised as a gradual, often invisible, and an intensely individualised and harmful experience (Hutchinson et al. 2004).

Although single acts of aggression or harassment occur in the workplace, bullying is a form of repeated behaviour that occurs over time. Individual acts may appear insignificant, but these apparently insignificant insults have a cumulative effect that is often more harmful than 'one-off' acts of violence (Einarsen and Mikkelsen 2003). In fact, bullying is understood as comprising a constellation of repeated acts, involving an imbalance of strength or power (Yamada 2000; Jackson, Clare and Mannix 2002), in which one or more individuals engage in over time, with the intention to harm others and create a hostile work environment (Archer 1999; Simpson and Cohen 2004).

The outcome of continual exposure to bullying includes trauma such as lowered self-esteem (Randle 2003), depression, anxiety (Quine 2001) and post-traumatic stress disorder (Mikkelsen and Einarsen 2002). The unrelenting, calculated and deliberate nature of bullying has been known to cause not only psychological harm, but also physical illness (Kivimäki et al. 2003), financial loss and, ultimately, an inability to work (Einarsen and Mikkelsen 2003; McCarthy 2003). Further, there is mounting evidence that exposure to bullying in the workplace has serious detrimental outcomes not only for those bullied but also for organisations, workplace colleagues (Lewis 2001; Speedy 2004) and family members (Einarsen 1999; Yamada 2000). For organisations, bullying can result in increased staff turnover, lowered morale, reduced productivity and reduced loyalty (Raynor and Cooper 1997; Quine 1999).

### THE EXTENT OF BULLYING IN THE NURSING WORKFORCE

Nurses have been considered an occupational group at considerable risk of violence-related workplace trauma (Arnetz, Bengt and Soderman 1998; Rippon 2000; Blazys 2001; Mayhew and Chappell 2001; Hegney, Plank and Parker 2003). The experiences of nurses reported in the literature include harassment, bullying, intimidation and assault (Farrell 2001; Fry et al. 2002; Jackson, Clare and Mannix 2002), which may emanate from fellow nurses, nursing managers, other medical and administrative staff, or patients/clients and their families. It is suggested that violent behaviour amongst nurses is 'accepted' within the profession (Hockley 2002) and, as a result, bullying is considered an under-reported phenomenon (Quine 1999; Jackson, Clare and Mannix 2002).

The small numbers of studies undertaken in the health sector confirm the serious nature of bullying occurring in

the nursing workplace. In a survey of 1100 employees in the NHS, including nurses, 70% of respondents reported that they had experienced bullying in the previous year (Quine 1999). In a further study of the NHS nursing workforce by the same author, 44% of respondents reported being bullied (Quine 2001). The effects of bullying have been highlighted by Randle (2003) who studied a small cohort ( $n = 39$ ) of student nurses during their 3-year preparatory training. Findings revealed that 95% of the students perceived themselves as anxious, depressed and unhappy at the end of the 3-year period (Randle 2003). It is known that employees experiencing bullying have a higher propensity to leave the organisation (Quine 2002) and links have been drawn between bullying and the current recruitment and retention crisis in the nursing workforce (Jackson, Clare and Mannix 2002).

Although there have been studies of violence (Fisher et al. 1995; Mayhew and Chappell 2001; Hockley 2002) and aggression (Farrell 1999; Farrell 2001), and some of this literature includes reports of bullying (Farrell 2001; Hockley 2002), to date there have been few substantive studies of bullying in the nursing workforce. Furthermore, authors who have researched and written about bullying in nursing have primarily focused upon nurse-to-nurse violence and aggression (Fisher et al. 1995; Farrell 1999; Hockley 2002). Research in this area has tended to focus upon the interpersonal dyad, and not the broader organisational context in which bullying occurs.

### THE CONCEPTUALISATION OF BULLYING IN NURSING

Bullying in the nursing profession has been largely understood in terms of 'horizontal violence' (Duffy 1995; Dunn 2003; Jacoba 2005) or 'oppressed group' behaviour (Roberts 1983; Hedin 1986; Roberts 2000). These concepts have been used to explain bullying between colleagues who are on the same level within the organisation's hierarchy (Duffy 1995; Dunn 2003; Randle 2003), and who, as a result of their (supposed) low personal self-esteem and poor group identity (Roberts 2000), direct abusive behaviour towards each other.

The work of Freire (1972) and Fanon (1963) provided the theoretical underpinnings for the conceptualisation of nurses as an 'oppressed group'. The psychological aspects of oppression are a recurring theme in Freire's work on emancipatory education (Freire 1972) and critical consciousness (Freire 1987). Freire proposed that the educational system reinforces the belief that the dominant group is superior. Over time this leads the oppressed to believe they are inferior, less worthy and, eventually, 'fearful of freedom' (Freire 1972, 29). A state of psychic alienation occurs in which 'the

disenfranchised internalise their oppression and support rather than resist it' (Abdul-Adil, Griffith and Watts 1999, 257). Fanon (1963) argued that oppression, which occurred as a result of colonisation, led to inter-group manifestations of conflict and violence between black South Africans. In this context, horizontal violence directed towards others in one's group is a form of adaptive behaviour, an attempt to gain control over one's sense of psychic alienation and powerlessness.

Drawing upon oppression theory, it has been asserted that nurses are doubly oppressed through gender and medical dominance (Duffy 1995; Hockley 2002). As a consequence of oppression, nurses are socialised into structures and unequal power relations in the workplace that lead to oppressed personal behaviour turned against colleagues (Taylor 2001). It has been suggested that the internalised beliefs of nurses about their own inferiority result in an inability to take control of their own destiny. This perpetuates a cycle of 'denial, minimisation and ritualisation' (Taylor 2001, 409) that maintains the status quo and allows power relations to remain unchallenged (Roberts 2000). As a result, the 'cultural narration of nursing is for nurses to be subordinate' (Freshwater 2000, 481) and, as such, they display the characteristics of an oppressed group, lacking in self-esteem and directing passive aggression towards each other. From this perspective, workplace bullying between nurses is viewed as a symptom of the dynamics of socio-political oppression, which is acted out through violence towards colleagues (Duffy 1995). The model of oppressed group behaviour developed within nursing has provided a framework for understanding macro structures of oppression and, as such, has served as a useful tool to progress models of critical reflective practice within the profession (Roberts 2000; Taylor 2001).

It has been recognised that oppressed group explanations of bullying provide 'but one consideration in understanding horizontal violence among nurses' (Farrell 2001, 28). Some of the shortcomings of the oppressed group model include a focus upon horizontal behaviours among nurses; this excludes downward and upward bullying and bullying by non-nurses. Also absent from this analysis is consideration of how the inner workings of organisations may contribute to, or perpetuate, bullying. Failure to examine these issues has led to a continued focus in the nursing literature upon bullying as a symptom of the unique socialisation of nurses, without a more complete understanding of the organisational contexts in which nurses work, and the nature of organisational violations (Speedy 2004).

Furthermore, the discourses used within the nursing profession have not been considered from the perspective of

their potential to limit how bullying is understood. Organisations and management structures have been able to remain immune from any further consideration as to their role in perpetuating bullying (Hutchinson et al. 2004) by depicting it as something different and less significant than it really is, and by generating the belief that bullying is solely a nurse-to-nurse phenomenon and a form of interpersonal conflict. In seeking to extend understanding about bullying in the nursing workforce and propose alternative ways for the experiences of nurses to be conceptualised, we will examine power within the organisational environment of nursing and put forward an alternative means of understanding power and bullying.

### **POWER AND THE ORGANISATIONAL WORK ENVIRONMENT OF NURSING**

It is not possible to understand bullying without giving consideration to the concept of power. If we accept that behaviour within organisations is governed by rules and norms, then it is vital that the role of power in negotiating and enforcing these rules is considered. Further, as bullying is often reported to include behaviour that does not involve physical violence and is, rather, subtle and covert, the examination and understanding of micropower is essential. In attempting to further understanding about the relationship between power and bullying in nursing, it is proposed that an alternative model of power to that of the 'oppressed group' needs to be considered. Using Foucauldian conceptions of power (Foucault 1977) allows an alternative understanding of workplace bullying. Foucault described power as diffuse and invisible, and as both a positive and negative force dispersed within social networks. Rather than being located within 'a single socio political apparatus' (Clegg 1997, 104) power operates in complex networks of micropower. To co-ordinate individuals and ensure that they are useful within modern society, individuals are constantly constituted and supervised through power (Alvesson, Wilmot and Briarcliff 1992). In this sense, certain people do not necessarily possess power; rather, it is dynamic, moving through social networks; it is not a 'property of the mighty' (Danaher, Schirato and Webb 1999, 48), it is, instead, a flow of forces that influence our everyday lives.

Foucault developed the notion of disciplinary power to describe power that makes people visible through mechanisms such as accounting practices, architecture and training. He described organisations and management as techniques of 'human dressage by locations, confinement, surveillance, and the perpetual supervision of behavior and tasks' (Foucault 1988, 105). Institutionalised as part of

everyday practice, disciplinary power is so effective that we subject ourselves to its control without conscious awareness. We are shaped through the disciplinary power, but unaware of the shaping. Domination is achieved subtly, through legitimate processes – the dominated come to believe that the dominator has a right to rule over them, as part of the natural order of things (Litvin 2002).

To understand disciplinary power at work within modern healthcare organisations, and their methods of deployment, the administration of these organisations needs to be considered. In Australia, nurses are predominately salaried professionals, employed in the public sector hospital system (Adamson and Wilson-Barnett 1995). Within this system there has been considerable change in institutional structures and interrelationships, resulting in increasing bureaucratisation and managerial control (Fitzgerald and Teal 2004). The central pressure within health-care is clearly cost containment, often expressed in terms of a decreasing length of stay and reductions in per case expenses (Richardson 2003). The goals of healthcare services are often described in terms of efficiency and quality; however, these concepts are at odds with each other and are constantly contested (Bryant 1999).

In this context, nursing work is increasingly driven by managerial imperatives (Young and Brown 1998; Smith 2002). In support of these imperatives complex data gathering, systems of standardised practice, monitoring efficiency, and measuring outcomes have been developed. Nursing activities are constantly under surveillance and increasingly monitored, measured, reported, and scrutinised. On a daily basis nurses are faced with the reality of caring in a 'corporate context' (Padgett 1998; Watson, Jackson and Borbasi 2005). These technical manipulations of nursing activity and systems of surveillance have changed the meaning of 'care' to one often not recognisable by nurses (Jackson and Borbasi 2000). Such 'regimes of truth' and pervasive practices keep individual nurses captive within the constructed organisational identity made available to them (Dunne 1996).

The increasing managerial and bureaucratic focus within healthcare organisations has amplified the monitoring of individual and group performance (Van Eyk, Baum and Houghton 2001). Nurses are not well represented in financial and decision-making forums and are therefore under the constant scrutiny of those in the bureaucracy in a position of power over nursing (Speedy and Jackson 2004, 55). Performance is judged by those who have power and in the terms they describe. The intense scrutiny of resources compounds the stressors experienced in the day-to-day work of nurses (Edwards and Burnard 2003), increasing exposure to aggression and violence (Young and Brown 1998). The

trauma and brutality potentially perpetrated in environments predominately focused upon seeking efficiency, productivity and cost containment have been described as a form of 'organisational violation' (Speedy 2004, 147).

## **CIRCUITS OF POWER WITHIN ORGANISATIONS**

Drawing upon the work of Foucault, Callon (1986) and Lockwood (1964), Clegg (1993) proposed a model of 'circuits of power' that illustrates how power operates within organisations. This theory of power in organisations 'orients towards the explanation of how organisational obedience is produced' (Clegg 1993, 27). Power is conceived to flow through a force field, in which power arrangements are fixed and constituted, and within the force field there are privileged points of practice. Clegg (1993) claims that there are three functions of power within the circuits: agency, system integration and social integration. Agency power is the 'sovereign' power that gets people to do what they would not otherwise do and operates in an episodic manner. The power of social integration focuses upon rules of practice, relationships of meaning and group membership. The focus of the system integration circuit is domination through techniques of discipline and production (Clegg 1993).

Both positive and negative effects flow from the power in the circuits. Clegg (1993) suggests that efficient power makes only one circuit. However, when resistance is met in the circuit against relationship of meaning, membership, or disciplinary techniques of production, forces are deployed from within the circuit to overcome the resistance. Furthermore, the characteristics of an organisation influence the operation of the circuits of power. Therefore, more or less emphasis may be placed upon techniques of discipline or rule fixing among members depending on the characteristics of a particular organisation.

For example, the increasing managerial and bureaucratic focus within healthcare organisations may result in an increase in the focus on disciplinary techniques employed within an organisation (Hou 2004). Techniques such as quality management, output measurement, performance management, industry benchmarking, case management, procedure manuals and proscribed payment systems can be seen as forms of disciplinary technique, reinforcing power within organisations. The increasingly complex systems of control within organisations have been referred to metaphorically as the process of tightening the 'iron cage' (Pushkala and Anshuman 2000, 388). These systems operate to make nurses visible through the constant gaze of an 'other' who is in a position of power and knowledge. Such practices

operate as 'pervasive practices which exercise power of domination over those caught up in them' (Dunne 1996, 142).<sup>1</sup>

## CIRCUITS OF POWER AND BULLYING IN NURSING

The 'circuits of power' can be used to illuminate a number of aspects of the bullying experience of nurses reported in the literature. For example, the more senior nurse may bully a junior nurse (Sunderland and Hunt 2001) and, yet, this can be seen within the organisation as reinforcing rules, relations of meaning (Randle 2003) and membership of the nursing team. An experienced nurse may become the target of bullying by standing out, being more qualified or by seeking to make a change. Such an individual may be denigrated or humiliated by bullies in an attempt to maintain the status quo. For example, Hockley (2002), in her research of violence among nurses, described bullying that arose from 'breaching the rules' (57) and asserted that this bullying acted to reinforce established behaviour. Through this process, accepted organisational values are confirmed and reinforced, and those bullied learn their place in the 'order of things'. Thus, bullying is strategically used to maintain order.

Furthermore, the target, as part of the bullying process, will often be publicly labelled as stupid or less competent. Such remarks, while offensive and insulting, are also important devices for securing legitimacy on the part of the bully (Baumeister 1999, 115). Casting doubt on the competence of a target justifies the action of the bully, reduces their guilt, and expunges the connection between the perpetrator and target. This example illustrates the operation of the social integration form of power within organisations — reinforcing rules, relationships of meaning and membership. The bully who brings attention to rules, relations of meaning and membership, reinforces the power of these forms of social integration by making an example of the person bullied, therefore reproducing and affirming relations of meaning and membership in the organisation. Applying the 'circuits of power' model further, if the bullied nurse is perceived as providing some form of resistance, subsequent circuits become involved, bringing into play techniques of discipline.

Common techniques of discipline reported to be used include mediation, increased observation, disciplinary interviews, remedial training, and performance management (Hockley 2002; Vickers 2002). Importantly, what is not always readily visible within the workplace is the 'network of alliances that such disciplinary practices make possible' (Clegg 1997, 484). Hutchinson et al. (2005) reported the experiences of nurses bullied and the nature of networks of bullies operating within healthcare organisations. Their findings reveal that by working together in networks, bullies were able to (mis)use accepted organisational processes for the purpose of co-ordinated, systematic and targeted bullying. Further, they propose that bullies who were nurse and non-nurse managers, were able to hide their abusive behaviour and activities within legitimate organisational routines and processes. Those who bullied were able to create a veneer of legitimacy and ensure their abusive behaviour remained officially undetected, while reports of bullying were ignored, denied and minimised. By occupying privileged points of practice within the circuit these individuals were able to use techniques of discipline to further their own interests and, in so doing, cause considerable harm to others.

Techniques of discipline operate to make the individual being bullied more visible within the organisation, in effect, turning the focus of attention upon the individual who was bullied, rather than the bully, and highlighting those bullied as the 'problem'. The nurse who provides resistance is made visible to those who are assimilated within the circuit of power. Such resisters are recast as 'failures' (Huntington and Gilmour 2001). The 'target' becomes the focus of the circuit of power in an attempt to overcome resistance and return the normal flow of power within the circuit. Management colludes with perpetrators of bullying, and complaints of bullying are not taken seriously (Jackson, Clare and Mannix 2002). Managers may also support perpetrators, rather than victims (Tidwell 1998). The result is that bullying is often tolerated (Keashly 1998), with the recipient of the bullying being regarded, increasingly, as the problem.

The operation of the techniques of discipline within the circuit may explain the silence of nurses who have been bullied, and possibly those who witness bullying. In effect, speaking out would make matters worse — power within the circuit would increase in an attempt to overcome the resistance presented. The operation of the circuits of power makes the nurse who has been bullied more visible.<sup>2</sup> Practices

<sup>1</sup> While noting these negative aspects of power, we also acknowledge that circuits of power can facilitate positive action within organisations (Clegg 1993, 28) and that, in themselves, they are not causative factors for bullying. Rather, the circuits of power and disciplinary techniques can be co-opted by bullies as vehicles for bullying. By harnessing the power within the circuits towards their own ends, bullies are able to use the operation of the circuits as mechanisms for bullying.

<sup>2</sup> Conversely, we acknowledge that circuits of power can be used by bullies to make targets less visible to important organisational others, through ignoring, diminishing or demeaning the achievements and abilities of targets.

within organisations that support bullies and subjugate those who speak out may be so powerful that they are infrequently acknowledged for what they are. This process may explain how bullying is considered to be a taken-for-granted phenomenon in nursing (Jackson, Clare and Mannix 2002).

In proposing the use of Clegg's (1993) 'circuits of power' as a stance to examine and understand bullying in nursing, it can be seen that there are alternatives to the 'oppressed group' behaviour position. The implications of this alternative way of viewing bullying brings into focus the operation of power within organisations, rather than continuing to view bullying as a unique feature of the nursing workforce, or as a characteristic of individual nurses that exists independent of the context in which nurses work.

## CONCLUSION

Both Foucault and Freire provided a critique of domination with the intent of emancipation. Both the 'oppressed group' behaviour and the 'circuits of power' approaches to conceptualising bullying in nursing seek to establish ways for nurses to critically explore their workplace experiences. Horizontal violence generates understandings of the macro forms of power that operate within society, and draws attention to the sociopolitical oppressive power of gender and medicine within nursing. Conversely, the 'circuits of power' approach seeks to understand micro power at work within organisations and, in so doing, generate an understanding of the rules and disciplinary practices that function to make individuals more calculable, define their reality and shape their behaviour at work. Roberts (2000), in her work on oppressed group behaviour in nursing, proposed that nurses need to develop a positive identity as a critical step in breaking out of the cycle of oppression, towards systematic change in the power structures that create oppression. Clegg's (1993) circuits of power model highlights the complex flows of power that operate within organisations, and sheds light on why the liberal ideal of justice in the workplace can be a difficult reality to achieve.

Workplace bullying causes trauma resulting in considerable harm to nurses and organisations. There is a risk that the continued use of the 'oppressed group' model as the prime means of understanding bullying within nursing generates an image of bullying as an intrinsic occupational reality for nurses. This serves to focus attention upon behaviour among nurses and draw attention away from work environments that condone and perpetuate abusive practices. By continuing to conceptualise workplace bullying as an inherent feature of nursing, we risk passive acceptance that bullying

is a feature of nursing, rather than what it is — an abusive and harmful activity perpetuated within organisations.

Within the nursing profession, it is important to acknowledge that organisational narratives serve as powerful, often invisible, legitimating devices, articulating an organisational reality that is often unquestionably accepted (Litvin 2002). Acceptance of the term 'horizontal violence' within health-care organisations potentially justifies increased observation and the use of disciplinary power upon nurses. Within the horizontal violence framework, nurses belong to a violent oppressed group. This stance risks apportioning blame solely to nurses, and obscures the role of power relations within organisations, inadvertently reinforcing the oppression of nurses. Consideration needs to be given to whether terms such as 'horizontal violence' silence, minimise and normalise the experience of being bullied, depicting it as something different and less significant than it really is. There is a danger that the continued analysis of bullying primarily as a form of oppressed group behaviour perpetuates the notion that bullying is a 'routine' and 'normal' part of the experience of nursing.

In this paper, the work of Foucault and Clegg has been introduced to propose alternate insights into understanding the operation of power in organisations and, in particular, to the phenomenon of workplace bullying in nursing. Drawing upon this work allows closer scrutiny of the ways in which individual nurses are recruited to embrace views about themselves that are in line with powerful organisational interests. Commonly accepted assumptions and frameworks about workplace bullying in nursing need to be extended, allowing for insight into the subtleties of power flows within the workplace. Attention to intergroup conflict has led to an understanding of power and domination, directing attention to broader political processes. A finer-grained analysis of what occurs within the nursing workplace is required to uncover 'hidden' processes of power and their means of deployment for the purpose of bullying. In re-examining what is considered routine and self-evident under the guise of 'horizontal violence', it is imperative that the discourse within nursing be explored from the perspective of its potential to inadvertently silence critical thought and action.

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