Incivility and Bullying in the Workplace and Nurses’ Shame Responses
Dianne M. Felblinger

ABSTRACT
Incivility and bullying in the workplace are intimidating forces that result in shame responses and threaten the well-being of nurses. Some nurses are accustomed to tolerating behaviors that are outside the realm of considerate conduct and are unaware that they are doing so. These behaviors affect the organizational climate, and their negative effects multiply if left unchecked. Interventions for incivility and bullying behaviors are needed at both individual and administrative levels.

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Incivility, bullying, and subsequent shame responses are formidable forces that threaten the well-being of both nurses and patients. This article provides a description of the disruptive behaviors associated with incivility and bullying and their subsequent adverse clinical outcomes. A description of incivility and bullying in the workplace is followed by a discussion of nurses’ risk for shame responses to these negative behaviors. Implications for nursing practice are presented and nursing interventions proposed.

Prevalence and Effects of Disruptive Behaviors in the Workplace
Since the 1990s, recognition of negative workplace behaviors has increased (Lutgen-Sandvik, Tracy, & Alberts, 2007). These disruptive behaviors include use of verbally abusive language, intimidation tactics, sexual comments, racial slurs, and ethnic jokes. Additional disruptive behaviors include shaming or criticizing team members in front of others; threatening team members with retribution, litigation, violence, or job loss; throwing instruments, and hurling charts or other objects (Pliffering, 2003; Porto & Lauve, 2006). In a poll by U.S. News and World Report, 89% of Americans identified incivility as a serious social problem and 78% agreed that it had worsened in the past 10 years (Marks, 1996). Incivility continues to invade the workplace regardless of setting (Hutton, 2006), and the psychological harassment of nurses at work is an ongoing concern.

Incivility and bullying flourish in unsupportive work groups that normalize competitive and abusive behaviors. Nurses work in groups; they negotiate complex interpersonal relationships in highly politicized settings with economic restrictions. As the nursing shortage persists, nurses take on increasing responsibility and are expected to provide leadership in situations that are often unpredictable and chaotic. Under these circumstances, many nurses encounter verbal abuse when coworkers ineffectively cope with difficult work-related challenges by lashing out at each other (Taylor, 2003). In some situations, nurses engage in destructive nurse-to-nurse or “horizontal” hostility, through actions such as critical commentary, career sabotage, and gossip (Thomas, 2003).

Prevalence of Abusive Behavior
Previous research indicates that coworker incivility and bullying are more prevalent than blatant and overt types of violence such as battery or homicide (Baron & Neuman, 1996, 1998). Verbal abuse is described as a common experience among health care providers, with a prevalence of 80% to 90% (Sofield & Salmond, 2003). Bullying prevalence rates have been reported between 1% and 4% (Einarsen, 2000).

Incivility … begins long before fists fly or lethal weapons extinguish lives. Where resentment and aggression routinely displace cooperation and communication, violence has occurred.
—Bernice Fields, Arbitrator (Namie, 2003).

Keywords
incivility
bullying
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violence
workplace violence
harassment

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Andersson and Pearson (1999) defined workplace incivility as behavior that violates the ideal workplace norm of mutual respect. Psychological harassment and emotional aggression are forms of incivility. In general, incivility is seen as a form of aggression, a breech of etiquette, and representative of moral decay. The literature provides various definitions of incivility. In order to eradicate incivility and bullying behaviors, nurses and administrators must first understand fully what they are. The literature provides various definitions of incivility. In general, incivility is seen as a form of psychological harassment and emotional aggression that violate the ideal workplace norm of mutual respect. Andersson and Pearson (1999) defined workplace incivility as “low-intensity deviant behavior with ambiguous intent to harm the target, in violation of workplace norms for mutual respect.” Pearson, Andersson, and Wegner (2001) further characterized workplace incivility as inclusive of “rude and discourteous behavior, displaying a lack of regard for others.” Incivility includes both subtle and obvious levels of rude and discourteous behavior, exclusion from important work activities, taking credit for another’s work, withholding important information, yelling, screaming, verbal attacks, and expression of negative verbal comments in front of others. During life-threatening situations, women’s health nurses and physicians may verbally criticize or blame team members for unfavorable outcomes. Other common examples of incivility include berating colleagues or workers in e-mail communications; exhibiting emotional tides, angry outbursts, or overt temper tantrums; interrupting others; and disrupting meetings. Incivility can lead to harmful and injurious outcomes that damage a coworker’s reputation, name-calling, and discounting input from others at any organizational level also contribute to a hostile work environment (Table 1).

Keashly (2001) further postulated that the most frequent form of workplace aggression is emotional and psychological in nature and stated that behaviors become increasingly improper when they are repetitive, result in harm or injury, and are experienced as a lack of recognition of the individual’s integrity. Keashly’s focus on the meaning of the behaviors for the target provides an enriched perspective of the definition of incivility. Incivility as a Precursor of Bullying Although incivility is considered professional misconduct, a breach of etiquette, and representative of moral decay, the question of intent to harm distinguishes incivility from bullying or other forms of aggressive behavior. Namie (2003b) considered incivility a type of organizational disruption and rated it at a level of 1 to 3 on a 10-point continuum, with bullying rated as 4 to 9 and battery or homicide rated as a 10. Incivility has been seen as a precursor to harassment, aggression, and physical assault (MacKinnon, 1994). However, the relationship of incivility to bullying remains under investigation.

More than half of nurses surveyed by Joint Commission on Accreditation of Healthcare Organizations reported that they had been subject to verbal abuse.

Risks to Patients

When incivility and bullying are sustained through disruptive behaviors in the workplace, nurses suffer and patient care is adversely affected. Twenty-five percent of health care workers saw a strong link between disruptive behaviors and patient mortality, and as many as 53% and 75% of health care providers saw a strong link between disruptive behavior and adverse clinical outcomes, such as patient safety, errors, adverse events, quality of care, and patient satisfaction (Rosenstein & O’Daniel, 2005). In a study by the Institute for Safe Medication Practices (ISMP, 2004), 49% or almost half of all respondents stated that intimidation interfered with the way they clarified medication orders or dispensed a product or led them to administer a medication despite concerns.

Incivility

Characteristics of Incivility

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### Incivility, Bullying, and Shame Responses

Bullying

**Characteristics of Bullying**

Workplace bullying is a form of aggression at work (Neuman & Baron, 2005) that goes beyond incivility. Bullying is a more deliberate and repetitive form of interpersonal behavior that adversely affects the health or the financial well-being of the targeted person. Workplace bullying consists of recurrent and persistent negative actions toward one or more individual(s), which involve a perceived power imbalance and create a hostile work environment (Salin, 2003). Bullying is a form of interpersonal mistreatment that escalates the intensity of verbal assault, directs attention and energy away from the job, and may subsequently render the targeted nurse at risk for unsafe clinical performance (ISMP, 2004). Intimidating workplace behavior can include threats to professional status, threats to personal standing, isolation, overwork, and destabilization (Rayner & Hoel, 1997).

Bullying is persistent and has detrimental or negative effects on the victim (Cusak, 2000; Quine, 1999; Randall, 1997). Bullying, or “mobbing” as it is called in many Continental European countries, is defined by Namie (2003) as a “status-blind interpersonal hostility that is deliberate, repeated and sufficiently severe as to harm the targeted person’s health or economic status.” Randall described bullying as “the aggressive behavior arising from the deliberate intent to cause physical or psychological harm.”

**Power and Control Are Key to Bullying**

Both stress theory and conflict theory provide a context in which to understand bullying. In the context of stress theory, bullying is perceived as a severe form of social stress at work. In conflict theory, bullying signifies an unsolved social conflict that has reached a particularly high level of escalation with an increased imbalance of power (Zapf & Gross, 2001). An example of this type of “power-over” situation occurs when hospital administrators continually expect obstetric, gynecologic, and neo-natal nurses to provide safe care with inadequate and unsafe levels of staffing.

Einarsen (2000) identified predatory bullying as the abuse of power over another individual. Zapf and Gross (2001), building on work from Einarsen, Einarsen and Skogstad (1996), and Leymann (1996), strictly defined bullying as occurring when someone is “harassed, offended, socially excluded, or has to carry out humiliating tasks and if the person concerned is in an inferior position.” To consider a behavior as bullying, it must occur repeatedly (at least twice a week or more) and for a long time (at least 6 months or more) in situations where targets find it difficult to defend against and stop the abuse (Lutgen-Sandvik et al., 2006). A single event is not bullying, nor is an event categorized as bullying if two equally strong parties are in conflict (Zapf & Gross).

Bullying, more than incivility, involves systematic harassment for a long period of time and the instigator’s desire to control the target. This obsession with control drives the instigator’s actions and invokes psychological pain on the part of the target. Targets of workplace bullying endure their pain for an average of 22 months if they are unwilling or unable to react assertively to unwanted aggression (Namie, 2003). Bullying, similar to intimate partner violence, escalates when the target finally decides to assert independence, moves ahead in the corporate environment, or begins to set limits on the instigator’s behavior. As the target becomes more independent, the instigator asserts more control. With increased instigator exertion of “power over,” the target diverts emotional energy away from work-related responsibilities and focuses this energy on coping with the situation. As the target is victimized by continued bullying and controlling behaviors, self-blame develops. Internalization of this blame, self-reproach, and self-recrimination enables revictimization of the target. While the target is preoccupied with self-blame, the instigator’s behaviors go unimpeded. Rude and discourteous behaviors are often ignored or minimized by management despite the repetitive and aggressive nature of the offense. These recurring sublethal behaviors may render the targeted nurse professionally unsafe (ISMP, 2004).

**Effects of Bullying on the Target**

Bullying causes serious health problems in the target of the bullying (Einarsen, 2000). Many targets of bullying suffer from post-traumatic stress disorder and symptoms of low self-esteem, anxiety, sleep disturbance, recurring nightmares, somatic problems, concentration difficulties, irritability, depression, and feelings of self-hatred (Mikkelsen & Einarsen, 2002). Some targets feel that their health is permanently impaired and

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**Table 1: Common Examples of Workplace Incivility**

<table>
<thead>
<tr>
<th>Description</th>
<th>Example</th>
</tr>
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<tbody>
<tr>
<td>Exclusion of important work activities</td>
<td>Yelling, screaming, verbal attacks</td>
</tr>
<tr>
<td>Taking credit for another’s work</td>
<td>Emotional trades, angry outbursts</td>
</tr>
<tr>
<td>Refusing to work collaboratively</td>
<td>Overt temper tantrums</td>
</tr>
<tr>
<td>Interrupting others</td>
<td>Gossiping</td>
</tr>
<tr>
<td>Disrupting meetings</td>
<td>Name-calling</td>
</tr>
<tr>
<td>Discounting input from others</td>
<td>Condescending speech, rudeness</td>
</tr>
<tr>
<td>Berating workers on email</td>
<td>Spreading rumors</td>
</tr>
<tr>
<td>Failing to share credit for collaborative work</td>
<td>Inability to empathize</td>
</tr>
<tr>
<td>Withholding important information</td>
<td>Damaging coworker’s reputation</td>
</tr>
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they will never function normally or resume work again (Leymann, 1996). Bullying results in the loss of bright, talented, and motivated women’s health and neonatal nurses. Since mistreatment of nurses in the workplace may result in adverse clinical and personal outcomes, there is a need to develop a deeper understanding of the nurses’ reaction to nonphysical types of violence such as incivility and bullying. The link between incivility, bullying, and shame is worthy of discussion and further investigation.

**Shame**

Psychological effects of bullying may include a shame response that results in an “attack-self” phenomenon. When nurses are first victimized by emotionally abusive behaviors, their immediate response may be one of shame and anger. The nurses’ initial shame response to violence can elicit an attack-self coping reaction that is characterized by inner-directed anger (Nathanson, 1992). When nurses attack themselves and direct their anger inward, they once again become victimized, which is known as revictimization (Figure 1). Concurrent with eradication of incivility and bullying, nurses may also benefit from learning to manage their own shame response to these negative behaviors. Eliminating the shame response may facilitate the avoidance of revictimization and leave nurses free to invest more psychological energy in safe patient care.

To grasp the magnitude of the shaming process and its proposed relationship to coworker violence, it is helpful to first understand that everyone experiences shame. The phenomenon of shame has been documented in the literature since the late 1800s. Freud wrote that shame is an affective response to exposure and a component of intrapsychic conflict. Freud (1892-1899) believed that people “keep back part of them they ought to tell—things that are perfectly well known to them—because they have not got over their feeling of timidity and shame.” This historic perspective is certainly congruent with the behavior of the bully’s target, who “keeps back” and endures the pain for an average of almost 2 years (Namie, 2003).

**Shame Impairs Development of a Healthy Self**

In the 1960s, Erikson investigated shame from a developmental perspective. Erikson proposed eight psychosocial stages during the human life span. Autonomy versus Shame and Doubt is the second stage and occurs initially at ages 1 to 3 of life. During this stage, children who are consistently criticized for expressions of autonomy or for lack of control develop a sense of shame about themselves and doubt their abilities. Children learn to develop increasing independence in a supportive, nonshaming atmosphere, and this need for supportive relationships continues throughout adult life. It follows that adult nurses would also thrive in an environment where they are not constantly criticized, where incivility and bullying are not tolerated, and where shame is not a norm of behavior.

Kohut (1971) also discussed the concept of evolution of the self. Kohut saw the condition of self developing more positively and “unfolding in an affirming environment.” The work of both Erikson and Kohut emphasizes the importance of development in a supportive environment with norms that do not tolerate a hostile environment of incivility and bullying.

Kaufman (1996) described shame as “an affective experience that violates both interpersonal trust and internal security.” Kaufman believed that everyone experiences self-doubt, looks internally to find the source of discomfort, and blames the self for any inadequacies. This self-blame leads to insecurities about one’s identity. “Where we once stood secure in our personhood, now we feel a mounting inner anguish, a sickness of the soul” (Kaufman, 1965). When nurses become targets of incivility or bullying, look internally, blame themselves for the situation, and mobilize an attack-self coping mode, shame may be imminent.

**Effects of Shame Responses**

In situations where incivility or bullying, or both occur, the targeted nurse may not recognize or be able to label the subtle or overt aggression and shaming experience. The nurse consequently develops a self-blaming attitude, silently endures the situation, and may subsequently exhibit unsafe clinical behaviors in an intimidating work environment (ISMP, 2004). Mounting shame in this negative situation often leads to anger (Pastor, 1995). As the nurse experiences difficulty discharging this anger appropriately, there is a propensity for emotional self-blame in conjunction with an internalized, attack-self mode of coping. According to Lewis (1971), the experience of shame is a direct precursor to a negative self-evaluation on the part of the target.

Tomkins (1963), an experimental psychologist, published much of the seminal work about Affect Theory and shame. Tomkins viewed shame as an affect with “relatively high toxicity” that leaves a person emotionally defeated, alienated and lacking in dignity.” Tomkins believed that shame occurs when the positive affects of excitement and enjoyment are blocked and reduced. For example, incivility and bullying behaviors in the nursing workplace may act as impediments to feelings of interest-excitement or enjoyment-joy and invoke a shame response in the individual. When nurses are the
When nurses are the targets of abusive behaviors, their work-related interest and enjoyment dissipate and their safe clinical performance may suffer. For women’s health and neonatal nurses who take pride in their professional competence, this adverse situation may result in overwhelming shame.

Nathanson (1992) built on Tomkins work and described the shame affect as “a highly painful mechanism that operates to pull the organism away from whatever might interest it and make it content. Shame is painful in direct proportion to the degree of positive affect it limits” (p. 138). This painful experience leads to decreased contentment and increased shame. In the work environment, “shame is by far the more commanding affective experience in the life of mature, successful people. It is the fall from grace, the loss of face, the forfeiture of social position accompanying exposure, that we fear most” (p. 144).

Nurses’ Responses to Shaming
When shame is triggered, individuals respond in one of four defensive patterns: withdrawal, avoidance, attack-others, and attack-self (Nathanson, 1992). Withdrawal into the self provides respite from the shame experience and is considered a healthy response because it provides safety from any further shame that might occur in the presence of others (Nathanson). An avoidance reaction to shame occurs when no portion of the shame experience is emotionally tolerable to the target. Avoidance involves the self-deceptive patterns of ignoring, disavowing, or distracting oneself from the painful situation. The defensive pattern of attack-others involves put-down, ridicule, contempt, and character assassination. The targeted nurse may outwardly direct this defensive behavior toward nurse peers or patients. A targeted nurse who exhibits this attack-others response is at risk for the adverse consequences of conflict escalation, one of which is further bullying or actual physical violence. Becoming a bully creates even more dangerous terrain (Nathanson).

For nurses who move into an attack-self mode, the self-mantra seems to be “do unto yourself what you fear others may do to you” (Nathanson, 1992, p. 329). Problems occur when the process of attacking the self feels better than having someone else do it. Those who feel helpless in the face of bullying and incivility are most likely to use attack-self scripts to modulate shame. This attack-self tactic associated with inner-directed anger is a revictimization of the nurse.

Interventions are needed to prevent the initial incivility and bullying behaviors that precede unsafe care and also activate an ensuing cascade of shame and anger, leading to destructive, attack-self behaviors in the nursing workplace. When nurses realize that they are experiencing shame as a result of workplace abuse, they are in a prime position to obtain assistance to stop the abuse, avoid shame and revictimization, learn new coping skills, prevent unsafe clinical behaviors, and confidently confront similar malicious situations.

Nursing Implications
Interventions for incivility and bullying behaviors are needed at both individual and administrative levels. Depending on the nurse’s background and temperament, the parameters of acceptable, respectful behavior may require definition. Some nurses are unfortunately accustomed to tolerating behaviors that are outside the realm of considerate conduct and are unaware that they are doing so. Education is needed at the individual and the unit level in an effort to raise the awareness of everyone involved. Once the boundaries of appropriate interpersonal behaviors are identified and internalized, nurses and administrators can begin the serious business of creating a respectful work environment.

The American Association of Critical Care Nurses (AACN) has developed a powerful position statement that supports zero tolerance for abuse. This statement addresses the issue of intimidation and verbal abuse by peers, colleagues, and coworkers as a barrier to the provision of safe, quality care (AACN, 2004). To encourage a culture of safety and excellence, the AACN has also published six essential, evidence-based, and
relationship-centered standards for establishing and sustaining healthy work environments (Table 2). In this document, AACN calls for the development of communication skills equal to the desired level of clinical practice skills (AACN, 2005). As communication skills increase, the level of incivility and bullying in the workplace may decrease.

Efforts such as the AACN Standards and Zero Tolerance statement help eliminate incivility, bullying, and the associated disruptive behaviors. The goal is the development of an emotionally safe work environment that empowers nurses and ultimately fosters the well-being of their patients. Implementation of AACN standards and a zero tolerance of abuse policy are two concrete steps institutions can take to create and sustain a healthy work environment.

Porto stresses the need for strong policy statements and a strong code of conduct, in addition to clear reporting mechanisms and instant access to senior leaders who are empowered to take immediate action (Joint Commission Resources, 2006). Establishment of an emotionally safe workplace benefits both nurses and their patients.

Although empirical evidence has linked a range of unjust, harassing, verbally abusive, or psychologically aggressive workplace behaviors with adverse job-related consequences in individual targets (Cortina, Magley, Williams, & Langhout, 2001), little organizational research has tested interventions to reduce coworker mistreatment in the forms of incivility and bullying. The presence of these behaviors affects the organizational climate, and the negative effects multiply if left unchecked. Often the target is silenced and the instigator of the mistreatment avoids detection. Interventions need to be focused on altering the rewards and sanctions that instigators experience as part of the workplace culture (Namie, 2003a).

The lack of intervention research to assess administrative and behavioral measures and address interpersonal mistreatment represents a significant gap. Intervention research needs to draw on appropriate theoretical frameworks, address the contexts in which incivility or bullying occurs, and employ strong evaluation research designs, including attention to process and outcome measures (Runyan, Zakocs, & Zwerling, 2001).

Interventions that create a positive organizational environment, retain nurses, and decrease interpersonal mistreatment are essential. When administrators intentionally or inadvertently ignore the adverse effects of incivility and bullying, employees respond with increased absenteeism (Barling & Phillips, 1993), increased turnover (Rosenstein & O’Daniel, 2005), and heightened turnover intentions (Maxfield, Grenny, McMillan, Patterson, & Switzer, 2005). Reduced commitment to the organization also occurs (Barling & Phillips; Leather, Beale, Lawrence, & Dickson, 1997).

As employees react to interpersonal mistreatment with a shame response and gravitate toward an attack-self mode of coping, they begin to distrust and resent the unresponsive organizational hierarchy. Administrative indifference and insensitivity to negative nuances, in turn, stifle employee participation, innovation, and creativity (Pearson et al., 2001). In a world where business survival is based upon efficiency, productivity, and innovation, it is increasingly clear that the development of a safe workplace, devoid of interpersonal mistreatment, is both desirable and necessary.

**Conclusions**

Fostering a workplace in which nurses feel safe from intimidation directs valuable human energy toward attainment of organizational goals and contributes to increased productivity. Insights into the relationship between incivility, bullying, and shame can help nurses

| Table 2: AACN Standards for Establishing and Sustaining Healthy Work Environments |
|-------------------------------|---------------------------------|
| **Topic**                     | **Standard**                    |
| Skilled communication         | Nurses must be as efficient in communication skills as they are in clinical skills |
| True collaboration            | Nurses must be relentless in pursuing and fostering true collaboration |
| Effective decision making     | Nurses must be valued and committed partners in making policy, directing and evaluating clinical care and leading organizational operations |
| Appropriate staffing          | Staffing must ensure the effective match between patient needs and nurse competencies |
| Meaningful recognition        | Nurse leaders must fully embrace the imperative of a healthy work environment, authentically live it and engage others in its achievement |
| Authentic leadership          | Nurse leaders must fully embrace the imperative of a healthy work environment, authentically live it and engage others in its achievement |
understand the traditional nursing work environment from a different perspective. Development of interventions to facilitate a positive work environment will require application of new and exciting paradigms, as well as thoughtful exploration and recreation of the conventional work environment.

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**Objectives**

After reading this article the learner will be able to:

1. Identify disruptive behaviors associated with incivility and bullying.
2. Describe adverse outcomes of disruptive behaviors associated with incivility and bullying.
3. Identify standards that help to create and sustain a healthy work environment.

**Post-Test Questions**

1. Since the 1990s recognition of negative workplace behaviors has
   a. decreased
   b. increased
   c. remained the same

2. Disruptive behavior associated with incivility is present when health care providers
   a. address each other with rude, condescending speech
   b. deliberately intend to harm a co-worker
   c. exert power over other workers who have less formal authority

3. Incivility and bullying behaviors flourish in
   a. competitive groups
   b. emergency situations
   c. supportive work groups

4. Nurses who engage in horizontal hostility
   a. attempt to thwart hospital polices and procedures
   b. do not speak up when an administrator makes sexual comments
   c. sabotage other nurses’ careers through the use of critical commentary

5. More than half of nurses surveyed by the Joint Commission on Accreditation of Healthcare Organizations reported that they had experienced
   a. aggressive physical contact
   b. threats of job loss
   c. verbal abuse

6. Between 53% to 75% of health care workers surveyed saw a strong link between disruptive behaviors and
   a. job satisfaction
   b. patient mortality
   c. patient safety

7. In a study by the Institute of Safe Medication Practices almost half of respondents reported that intimidation
   a. led them to administer a medicine despite concerns
   b. rarely occurred on their own clinical unit
   c. stimulated nurse cohesiveness and collaboration

8. Bullying is present when health care providers
   a. direct occasional negative behavior toward equally strong co-workers
   b. systematically and repeatedly harass and attempt to control co-workers
   c. take credit for the work of others during an annual evaluation

9. Nurses who are the targets of bullying behaviors may develop
Incivility, Bullying, and Shame Responses

In Focus

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a. increased focus on safe patient care
b. obsessive-compulsive behavior
c. post traumatic stress disorder

10. Nurses who are targets of bullying behaviors may endure the pain for an average of almost
   a. 6 months
   b. 1 year
   c. 2 years

11. Nurses who experience a shame response to bullying have an initial tendency to
   a. blame others for the situation
   b. blame themselves for the situation
   c. talk to administrators about the bullying and subsequent shame

12. The healthiest defensive responsive response to shame is
   a. attacking others
   b. avoidance
   c. withdrawal

13. To achieve a respectful work environment, one of the first steps for nurses and administrators is to
   a. define appropriate interpersonal boundaries
   b. develop techniques for counter-attacking abusers.
   c. learn how to ignore persistent bullying

14. AACN Standards for Establishing and Sustaining Healthy Work Environments state
   a. nurses must be as efficient in communication skills as they are in clinical skills
   b. nurses must be rated by the value each brings to the work organization
   c. nurses must recognize that some abuse is an acceptable outcome of interdisciplinary collaboration

15. Development of an emotionally safe work environment that empowers nurses requires
   a. delineation of specific abusive behaviors that are acceptable under stress
   b. implementation of a zero tolerance of abuse policy
   c. further research to determine if abusive behaviors foster job-related consequences in individuals.