



Perspectives on bullying in the New Zealand health and hospitality sectors

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Increasingly, workplace bullying is becoming an important issue for OHS professionals and employers. This exploratory study sought to understand the perceptions of key industry informants from the New Zealand health sector regarding workplace bullying, and to compare these perceptions with those in the New Zealand hospitality sector. The study involved semi-structured qualitative group interviews and individual face-to-face interviews with key industry informants. For the health sector, bullying was reported as being fairly widespread across subsectors, while in hospitality, bullying was associated with a number of "hot spots" (notably, the kitchen). Perceived risk factors for bullying were mainly related to the social organisation of work, including issues of hierarchy, resourcing and leadership. An absence of adequate reporting and poor human resources practices were identified as further organisational-level risk factors.

KEYWORDS

- HEALTH SECTOR
- HOSPITALITY SECTOR
- PSYCHOSOCIAL HAZARDS
- RISK FACTORS
- WORKPLACE BULLYING

Introduction

Workplace bullying has been the subject of growing research interest during the past two decades and, increasingly, it is becoming an important issue for OHS professionals and employers. A number of synonyms for workplace bullying have been used to describe the problem during this period, including psychological harassment, psychological violence, workplace aggression and emotional abuse, and mobbing.¹⁻⁴ Workplace bullying has also been described as persistent negative interpersonal behaviour experienced by people at work, and the repeated mistreatment by one or more perpetrators of an individual or a group.^{4,5} Key features of bullying at work are an imbalance of power between the two parties involved, and repeated negative actions or practices over an extended period of time, directed at one or more people, which are unwanted and cause distress and/or damage.^{3,5-7} Indeed, the negative outcomes of bullying can include long-term psychological and occupational impairment, and damage to the target's self-esteem, physical health, cognitive functioning, and emotional health.^{8,9} There is also growing evidence of the costly and counterproductive nature of workplace bullying in organisations.⁵

Awareness of the problems associated with bullying is often relatively low.^{10,11} Until recently, there has been a tendency to focus on the characteristics of targets but, without robust longitudinal studies, it is difficult to identify the characteristics that predispose individuals to being targeted from those which are the result of being bullied.¹²⁻¹⁵ Research generally suggests that determinants of workplace bullying have less to do with the characteristics of the target than with the nature and organisation of the workplace.¹⁶ Stressful and poorly organised work may give rise to conditions that result in bullying.¹⁷⁻¹⁹ Organisational efforts to address workplace bullying need to focus on the risk factors associated with HR practices and leadership, as well as organisational communication and culture.^{10,20}

The targets of bullying are often subjected to numerous types of abuse.²¹ Moreover, while bullying

at work can include physical aggression, many bullying behaviours are covert in nature, including withholding information, social isolation, undermining, intimidation, micromanagement of work duties, and attacks on credibility.^{5,22} Consequently, while there are tangible bullying behaviours, the behaviours that people do *not* exhibit are also important.²² However, workplace bullying is not always attributed solely to interpersonal interactions, but can also occur when the organisation itself (rather than individuals) is perceived to be responsible for bullying practices.²³ Organisational bullying therefore refers to situations where organisational practices and procedures are frequently and persistently experienced as oppressive and demeaning.^{5,7,23}

Although the literature clearly identifies bullying as a significant workplace issue, determining the extent of workplace bullying internationally is not straightforward because inconsistent terminology and operational definitions make comparisons difficult.⁵ Prevalence rates identified from international studies on workplace bullying vary considerably between different countries, across different occupational groups, and where different measures are used.^{24,25} For instance, a recent study involving United States employees from various occupational groups using the Negative Acts Questionnaire to measure bullying reported a bullying prevalence rate of 9.4%–28%, while a study published in the same year using a similar scale found French employees to have prevalence rates of 10.95%–21.84% (men) and 12.78%–26.81% (women).^{8,26} Much higher prevalence rates have been found in studies that use alternative measures of bullying, such as behavioural exposure measures or measures of perceived victimisation.²⁷⁻³⁰

A number of studies have focused on bullying in the health care sector (where high levels of bullying have been reported^{27,28,31}), including relatively small sample studies in New Zealand where prevalence rates of 90% (nurses) and 50% (doctors) were recorded.^{32,33} Findings from the most recent of these studies suggest that junior doctors, including first-year house officers or first-year registrars, are at

relatively high risk of being the targets of negative acts, with the source most commonly being consultants and nurses.³³

Based on these findings, the present exploratory study sought to understand how key industry informants from the New Zealand health sector perceive the problem of workplace bullying. For comparison, the study also considered the perceptions of key informants from the New Zealand hospitality sector. The aims of this study, which is the first to examine the perspectives of key industry informants on the workplace bullying problem in New Zealand, were to explore the extent and nature of bullying in these sectors and to identify perceived key risk factors for bullying. The findings from this preliminary study will help inform further detailed quantitative research to determine the incidence, nature and impact of workplace bullying in these and other New Zealand industry sectors.

Methodology

The study used a qualitative research strategy, as the focus was to explore the perceptions of key informants rather than the testing of specific hypotheses. Data collection involved the use of semi-structured qualitative group interviews and individual face-to-face interviews with key industry informants. The following sections outline the study sample, procedure and interview questions.

Sample and procedure

The two industry sectors involved in this study were health and hospitality. The New Zealand health sector can be divided into three major areas: primary care, District Health Boards (DHBs), and residential care, with a large range of occupational groups within these areas, including nurses, junior doctors, consultants, dentists, technicians, residential care workers, emergency workers, auxiliary staff, social workers, and primary care workers. The health sector has a mix of very large and medium-sized enterprises and very small organisations. District Health Boards are the dominant players across the sector. The hospitality sector in New Zealand

contains two major subsectors, that is, hotels and restaurants. Each of these subsectors is made up of a mix of large and small businesses, with small organisations mostly run by owner-operators, and large hotels and restaurants often part of a chain or multinational organisation. Occupational groups in the hospitality sector include hotel and restaurant managers, cleaning staff, chefs and kitchen staff, waiting staff, gaming staff, and bar staff.

The health sector key informant group comprised 13 OHS managers and two HR managers. In addition, three smaller group interviews were undertaken with national umbrella organisations representing different occupational groups in the health sector. Individual interviews were conducted with 10 respondents, with a further two respondents completing questionnaires containing the same questions as those used in the interviews. Respondents were mainly high-level industry stakeholders, including representatives from nursing, rest home associations, DHBs, HR, and OHS.

In the hospitality sector, two group interviews were undertaken with Safer Industry Forum members (an Accident Compensation Corporation-sponsored, but industry-owned, high-level industry group which acted as the industry stakeholder group for the project). These groups comprised between eight and 10 members, and also included a small number of government (Accident Compensation Corporation and Department of Labour, Occupational Safety and Health Division) representatives who chaired and contributed to discussions. Individual interviews were conducted with six key informants from the hospitality sector. Respondents were mostly industry group leaders and offered a high-level perspective on the industry in terms of the problems in question. Two respondents worked in operations and HR for major hospitality organisations.

As the study focused on the perceptions of key industry-level informants, participants were selected on the basis that they had an industry perspective on the problem of bullying. There were no refusals to requests to participate. Participants were not

randomly selected as they were sought from all major industry-level groups. In addition to the research participants, a range of other non-industry-specific stakeholders were also surveyed and/or consulted as part of this data collection exercise, including workplace bullying consultants and experts, Department of Labour personnel responsible for workplace stress and OHS policy, Accident Compensation Corporation program managers associated with the industries included, and union representatives.

Interview questions and analysis

In all cases, a facilitated discussion was conducted around the following key points:

- the extent of the bullying problem in each sector;
- key hot spots and risk factors for bullying;
- perceived risk factors for bullying; and
- industry initiatives, policies and practices to manage bullying.

The semi-structured individual interviews covered the same discussion points and were mainly conducted face-to-face. Analysis involved thematic content analysis to identify key areas of risk and constructs to be included in subsequent research stages. An initial list of key themes was identified from the group interviews for each sector, organised under the following theme headings: extent of the problem; bullying hot spots; and perceived risk factors. Detailed analysis focused around grouping data related to hot spots and perceived risk factors, and these were collapsed into subthemes by grouping similar themes from a large initial list. Data from subsequent group and individual interviews were organised under these subthemes through an iterative approach that involved adding to or amending the subthemes to cope with data from subsequent interviews that related to additional hot spots and perceived risk factors.

Results

The findings for each of the two sectors included in the analysis are summarised below, with comparisons made where appropriate.

Hospitality sector

Perceived extent and nature of bullying

Respondents from the hospitality sector argued that the industry experienced a lot of bullying, but this tended to be focused around a few specific hot spots rather than being a general problem across the sector. Bullying was not a well-recognised problem according to some respondents, and when it occurred was often accepted “as part of the way of doing things” in the sector, or as “normalised”. Indeed, it was argued that bullying was “in the nature of the industry”, although the industry is becoming more professional and the problem may not be as great in the future as a result.

The kitchen was mentioned most often as the area where bullying occurred. This was described by all respondents as a high-stress environment, with very hot, cramped conditions and a lot of pressure to perform to a high standard in quick time. The bullying source is usually the chef or head cook, who directs negative behaviour towards front-of-house staff, waitresses and junior kitchen hands. Chefs were described as “notorious bullies” and “prima donnas”, as highlighted in previous research.³⁴ Respondents suggested that the TV chef Gordon Ramsey is often viewed as a role model by young chefs. However, senior chefs suggested that some young chefs mistake Ramsey’s perfectionism for bullying and copy only the aggressive behaviour. Aggressive behaviour and abuse are primarily learned through working under bullying chefs, and this behaviour may be replicated once junior chefs have their own kitchen or rise through the system. There is a significant power imbalance between chefs and other staff who work in the kitchen and front-of-house, and some respondents believed that there was an acceptance of rude and bullying behaviour under pressure, particularly where waiting staff made “silly mistakes”.

It was argued that the bullying by chefs did not continue after the high-pressure work periods, as everyone relaxed once the pressure was off. There appears to be an acceptance of bullying from chefs, and some respondents noted that junior chefs will work for nothing just to learn from the top chefs — despite the abuse they may receive. Young chefs want to be trained by the best, as do professional waiting staff. Respondents indicated that they know they need to put up with bullies for a few years, but some of the bullying behaviours “rub off” during this time.

Bullies may be hired more frequently in small organisations, as recruitment practices can be very lax and a shortage of talent in the labour pool makes owners desperate to employ anyone “with a heartbeat who can cook”. In one of the group interviews, respondents suggested that chefs are employed on the basis of their reputation as a chef, and that “no one cares if the chef is a bully as long as there’s food on the tables and customers in the restaurant”. The problem of bullying in the kitchen environment was not thought to be a major problem in most large restaurants, as they had appropriate hiring methods and strong management that would never tolerate bullying behaviour. However, the relationship between the size of an organisation and bullying may be reversed in the hotel subsector, as the focus group felt that there were more problems in large hotels — small businesses are more of “a family” and could deal with potential problems through direct communication.

Part-time and casual workers, who make up a large proportion of the hospitality sector, are often looked down on by permanent and professional staff. In banqueting, some 90% of staff are casual and they are often considered as “slave labour”. Other hot spots for bullying included the gaming area in casinos. Customers were perceived to be the source here, and negative behaviour often came repeatedly from a single customer or from multiple sources towards cashiers and others (perhaps complaining about the same issue, for example, the level of payout from gaming machines).

One focus group noted that groups of staff may bully individuals who take time off work or are on long-term rehabilitation programs, as this creates pressure for the staff who have to cover for them. Another issue may be ethnicity, where a minority ethnicity may take over a particular area and exclude anyone from another ethnicity (that is, they try to keep that work area as an area belonging to their ethnicity). Finally, staff being bullied by customers who had been drinking was perceived as a major source of intimidation, and was often directed at staff who refuse to serve “piss heads”. One respondent noted that “if you are 21 years old and trying to tell people who have been drinking a lot that they are not going to be served, you are going to feel very intimidated”.

Perceived risk factors for workplace bullying

The risk factors for workplace bullying in the hospitality sector can only be inferred from the comments of respondents and are noted here as a guide for further empirical study. The various themes identified from the analysis relate to industry, organisational/situational, cultural, group, and interpersonal factors. A summary of the perceived risk factors is shown in Table 1. It should be noted that these potential risk factors interact to produce conditions in which bullying may occur.

It is interesting to note that organisational and industry-level risk factors were mentioned more often than interpersonal factors. However, it is likely that many of these situational or contextual factors act as latent conditions for interpersonal bullying. Hence, factors such as an industry culture that is accepting of bullying under certain conditions, an absence of strong leadership to address workplace bullying, poor hiring and other HR practices, and work organisation issues (such as work intensification due to workflow or staffing issues) can interact to create the conditions whereby interpersonal bullying behaviour can occur relatively unchecked.

TABLE 1
Perceived risk factors for bullying in the hospitality industry

<i>Risk factor</i>	<i>Level</i>	<i>Explanation</i>
Culture that accepts a level of bullying from chefs and management	Cultural/contextual	<ul style="list-style-type: none"> Bullying is believed to be in the nature of the industry/normalised.
Failure of senior management to address bullying	Organisational	<ul style="list-style-type: none"> Management has not recognised or come to terms with the problem of bullying, which may be viewed as acceptable in terms of getting results.
Failure to recognise bullying as a problem — pre-contemplative industry	Industry	<ul style="list-style-type: none"> Bullying is not recognised as a problem at the industry level. This reduces the likelihood of developing initiatives to increase awareness and policies and practices for its management.
Work pressure	Industry/organisational	<ul style="list-style-type: none"> High levels of pressure in the kitchen environment appear to increase the likelihood of bullying. Pressure is due to staff shortages and seasonal work pressures.
Physical kitchen environment	Industry/organisational	<ul style="list-style-type: none"> The heat, cramped conditions and hard floors all contribute to stress/strain and increase the bullying risk.
Kitchen tasks	Industry/organisational	<ul style="list-style-type: none"> The pressurised nature of work and multi-tasking increase the bullying risk.
Poor hiring practices	Organisational	<ul style="list-style-type: none"> Small restaurants may fail to check on the background of chefs and employ bullies.
Poor HR practices	Organisational	<ul style="list-style-type: none"> Owner-operators of small businesses may have poor knowledge of good HR practices and may not know how to manage bullying problems. Large organisations may not have effective policies and practices.
Staff shortages	Industry	<ul style="list-style-type: none"> Low unemployment means a shortage of talent. Chefs are hired on the basis of their reputation as a cook, and their behaviour towards staff is not a concern.
Staffing planning	Organisational	<ul style="list-style-type: none"> Levels of staffing are kept to a minimum (no cover for sickness, etc). This creates pressure and frustration among staff, and can lead to bullying of absentee member/s. Young and inexperienced individuals often have responsibility for dealing with drinkers, or cashiers with gamblers.
Lack of support for bullied staff	Organisational	<ul style="list-style-type: none"> Some organisations do not have adequate systems for managing bullying and supporting targets.
Ethnicity-based patch protection	Group	<ul style="list-style-type: none"> Individuals may be bullied to restrict entry to a job area where a single ethnicity dominates.
Attitudes towards part-time and casual staff	Organisational/group	<ul style="list-style-type: none"> Professional, permanent and full-time staff can treat casual staff as "slave" labour or second-class citizens.
Alcohol	Interpersonal	<ul style="list-style-type: none"> Staff may be intimidated and bullied by customers whom they refuse to serve.

Health sector

Perceived extent and nature of bullying

Respondents from all parts of the health sector indicated that high levels of bullying occur, and that bullying was “endemic” (particularly in large organisations) and “an everyday occurrence”. Bullying was perceived to be fairly widespread within the DHBs. However, the extent of the bullying problem is difficult to gauge at present, since the reporting systems in the DHBs and other sectors have not captured the relevant information. It was suggested that a move to an electronic format for reporting may lead to the perception that it is now safe to report bullying and harassment.

Bullying appears to be more widespread in the health sector than in hospitality (where a limited number of hot spots were identified). The health sector is less accepting of bullying than in hospitality, as people working in this sector are more aware of their rights and are more likely to challenge bullying behaviour than in the past. However, bullying in the health sector was perceived to occur at all levels of the organisation, from senior managers to lower-level staff, between clinicians at different levels of the hierarchy, and between peers. Additionally, the problem of “organisational bullying” or “institutional bullying” (involving poor treatment from management through policies relating to issues such as staffing, responsibilities and resourcing generally) was highlighted.

As with hospitality, it is likely that a lot of the behaviours reported as examples of bullying do not involve systematic repeated harm towards targets, but are more related to people reacting (inappropriately) under pressure. Cases of “chronic” bullying, involving the long-term systematic bullying of one or more individuals by a perpetrator, appear less common, although several such cases involving stress leave were reported by respondents.

Respondents in the residential/aged care sector indicated that bullying was a significant problem, particularly for workers who were bullied by nurses, patients, relatives and doctors. The autocratic nature of the working relationship between doctors, nurses

and carers was identified as a key factor in the experience of bullying. Indeed, it was argued that people in the residential care sector may be good clinicians but they are not always effective in managing people. Respondents believed that carers and nurses from overseas were more likely to be bullied due to their lower status, as was observed in the hospitality industry. An example given was Filipino nurses who “won’t ask questions of others’ behaviour and won’t speak up”. Part-time and contingent workers across the health sector appear to be subject to bullying from full-time and permanent staff.

While respondents felt that the major bullying problem was perpetrated against nursing staff specifically, the literature suggests that junior doctors are also victimised by bullies.^{32,33} In nursing, manager-to-nurse and consultant/doctor-to-nurse is the main direction of bullying, although peer-to-peer bullying was perceived to be an area of concern. For example, nurse-to-nurse bullying can take subtle forms, and can involve behaviour such as not helping a colleague with a lift or unfairly denying someone training. One respondent noted that there were “always one or two resident bullies”, and these are often individuals who have been in the organisation for a long time and like to stir things up. Another respondent asserted that “old fashioned” charge nurses yell at everyone, and people eventually change their behaviour to avoid being shouted at. In the health sector, this is perceived to be bullying, although often nothing is done about the problem. A clear illustration of the nature of bullying in this sector was provided by one respondent who indicated that it was common for doctors to get away with yelling at nurses and other staff due to the power that they hold over their targets. A specific example given was in the operating theatre, where targets cannot escape the situation and are highly concerned that, if they answer back the surgeon who is in the throes of a tantrum, the surgeon may become upset and walk out or make an error.

In the area of primary health care, bullying was considered to be a potential problem for workers

who have to go into people's houses — although this might be more accurately described as the risk of acute violence or aggressive behaviour/harassment rather than a bullying risk.

Residential care staff and general nursing staff were also deemed to be at risk from harassment and bullying involving clients and relatives, including pressure from patients who have certain expectations of health professionals, but where nurses and others are constrained by the available resources (particularly time factors) to meet these expectations.

Perceived risk factors for workplace bullying

A summary of the perceived risk factors for workplace bullying in the health sector is shown in Table 2, and the key factors of leadership and hierarchy are discussed in further detail below.

Leadership quality was perceived as a risk factor by the majority of respondents (including a strong consensus among the group interview participants). The common view was that bullying would not be challenged and made unacceptable unless there was strong leadership to direct the culture away from such practices. One senior nursing participant noted that, even when policies against bullying are in place, they will be ineffective if leaders (including nursing managers and others) do not challenge the bullying behaviour and create an environment where bullying is unacceptable. A common response was that clinically and technically proficient individuals often get promoted to management, yet there is no guarantee that they will have the necessary leadership or people skills to undertake the job effectively. For individuals rising up through the system, there are often poor role models who see bullying as acceptable or legitimate behaviour, and for managers and senior clinicians, there is often no coaching or alternative models of leadership. These views were countered to some extent by the view that younger staff less readily accept bullying and are more likely to resist adopting bullying behaviour. For this to occur, however, the necessary support and mentoring will need to be in place — but this is

not available for many. A number of respondents felt that there was a need to emphasise *leadership* over *management* in the development of senior people, and there is a nationwide DHB initiative to achieve this in the future.

Most respondents believed that the hierarchical nature of the health sector was a key factor in creating the ideal conditions for bullying to occur. Autocratic relationships appear to be the norm for many organisations — including those run by DHBs. Senior managers, consultants and clinicians were among those seen as being in a strong position to bully individuals with less power, especially those who had significant concerns about their job security and where bullied individuals were unsupported by their managers.³³ Some respondents saw the rotational aspect of many of the jobs in the health sector as undermining the ability of groups to form alliances and to resist poor treatment from managers and senior clinicians. Countering these arguments, it was noted that groups of nurses are now “standing together” in some DHBs against bullying doctors. In addition, doctors are more aware of the need to look after staff because of staff shortages. Lower-level staff tended to experience bullying from their supervisors, nurses, doctors and employers in the residential care sector. As with hospitality, ethnic minorities and part-time/contingent workers often experience bullying as they are seen by some as second-class citizens in the workplace and easy targets for aggressive behaviour.

Discussion

For both the health and hospitality sectors, bullying was consistently recognised as a significant issue. For the health sector, bullying was reported to be fairly widespread across the subsectors (in line with past research^{27,32,33}), while in hospitality, bullying was associated with a number of “hot spots” (notably, the kitchen). The type of behaviour identified as bullying in each of the sectors was varied, and the question arose as to whether certain types of aggressive behaviour can be considered to correspond with established definitions and models.^{3,7}

TABLE 2
Perceived risk factors for bullying in the health sector

<i>Risk factor</i>	<i>Level</i>	<i>Explanation</i>
Quality of leadership	Cultural/contextual/ organisational	<ul style="list-style-type: none"> • Poor leadership creates conditions where bullying is accepted and not challenged. • Clinical and technical basis for promotion (such people are not always good leaders or managers). • Lack of leadership coaching. • Lack of alternative leadership models. • Poor succession management. • Poor role models for future leaders/managers.
Hierarchical nature of the industry	Organisational/cultural	<ul style="list-style-type: none"> • Autocratic relationships across the system. • Fear for jobs and low political power means that bullying is not challenged. • Tendency to blame the lowest worker (those with the greatest distance from policymakers/top management). • Politically weakened staff due to rotation, etc.
Communication failures	Organisational	<ul style="list-style-type: none"> • Failure to provide adequate communication structures.
Poor or absent reporting of bullying (inadequate reporting system)	Industry	<ul style="list-style-type: none"> • Low awareness of the extent and nature of the bullying problem due to the failure to collect records. • There are barriers to using current reporting systems, including job security fears, fear of reporting to managers, etc. • Political resistance to mandatory reporting by managers and nurses.
Lack of support for management and staff	Organisational	<ul style="list-style-type: none"> • Failure to provide support from contact persons. • High turnover and lack of continuity/rotation. • Denial of professional support for managers. • Management lack of mentoring and support.
Working in isolation	Industry/organisational	<ul style="list-style-type: none"> • Primary health and residential care workers are exposed to the risk of unstable clients, etc. • Working remotely (in homes, etc).
Work pressure and lack of resources	Industry/organisational	<ul style="list-style-type: none"> • The high level of pressure on nurses and all clinical staff leads to stress and bullying. • Low staffing levels. • Bullying from management around staffing. • Prioritising profits over quality and health. • High turnover — nurses and doctors are leaving and being replaced by overseas and less qualified staff.
Failure of DHBs to address the bullying problem	Contextual/industry	<ul style="list-style-type: none"> • Lack of leadership in policymaking from the Ministry of Health. • Piecemeal approach of individual DHBs to policy. • Lack of awareness of the extent and nature of the problem by senior management.
Organisations as the bully	Organisational	<ul style="list-style-type: none"> • Staff are powerless to resist senior management. • Undermining of clinical staff by management.
Aggressive behaviour from clients and relatives	Interpersonal	<ul style="list-style-type: none"> • Expectations of clients and relatives. • Working in isolation.
Attitudes towards "weaker" individuals	Interpersonal/group	<ul style="list-style-type: none"> • Victims are seen as weak and deserving of bullying. • Low-level and ethnic minorities are easy targets.

A good example of this is the aggressive and abusive behaviour of chefs that is directed towards kitchen hands and waitresses/front-of-house staff in the hospitality sector. Respondents' descriptions and experience of this type of behaviour suggest that the aggression and abuse is short-lived, linked strongly to periods of work intensification, and not particularly targeted at any one individual. It is also very public, rather than the more covert nature of much bullying.²² It is suggested that further research into this relationship across other industry sectors could help to advance theory in this area.

A large number of risk factors for bullying were identified, the majority of which were related to the social organisation of work. The most frequently mentioned issues were those of hierarchy, resourcing and leadership — particularly the absence of strong leadership to create the conditions in which bullying is not acceptable behaviour. Leadership also played a role in supporting bullying targets and creating a healthy work culture. The problem of staff being promoted on the basis of technical and clinical skills alone was a strong theme in the health sector, and it was noted that coaching managers was an important factor in the prevention of bullying. From this perspective, prevention is likely to be most effective where it addresses primary risk factors that influence bullying risk, rather than focusing purely at an interpersonal level. This finding warrants further investigation, with the aim of advancing theory in the area of workplace bullying causation and prevention.

General resourcing and staffing issues were high on the list of risk factors for workplace bullying. A range of contextual and situational factors were identified as contributing to these problems, and respondents argued that they affected their ability to do their job effectively, contributed to poor morale and subsequent bullying, and reduced the likelihood of strong leadership and effective support for staff.

Further important factors related to the HR and OHS practices of organisations in both sectors. The lack of appropriate monitoring and reporting of workplace bullying has led to a lack of information

about the extent and nature of the problem, and this reduces the likelihood of preventive action to address bullying. This is an important area for further study. The use of appropriate recruitment practices to increase the likelihood of screening out bullies at the hiring stage is another important HR issue. Staff shortages and an overwhelming focus on task-related competencies also compound the problem. Effective workplace bullying policies may not be in place in many organisations across the two sectors, while many organisations fail to adequately distinguish between harassment, bullying and physical violence.

Conclusion

The findings from this study have provided a strong baseline for understanding how workplace bullying is perceived by key informants from the health and hospitality sectors in New Zealand. An important limitation of this qualitative study is the relatively small number of respondents and a lack of input from employees. As a result, the findings cannot be considered as representing an industry perspective. However, further research is planned to examine the extent and nature of workplace bullying involving a large sample of employees and managers from a number of New Zealand industry sectors, and to examine the impact of bullying on individuals and on organisational productivity. The research also aims to identify effective initiatives and interventions that are currently in place to manage the problem of workplace bullying.

References

1. Einarsen, S. The nature and causes of bullying at work. *International Journal of Manpower* 1999, 20(1/2): 16.
2. Leymann, H. Mobbing and psychological terror at workplaces. *Violence Vict* 1990, 5(2): 119-126.
3. Keashly, L and Jagatic, K. By any other name: American perspectives on workplace bullying. In Einarsen, S, Hoel, H, Zapf, D and Cooper, C (eds). *Bullying and emotional abuse in the workplace: international perspectives in research and practice*. London: Taylor & Francis, 2003, pp 31-61.
4. Namie, G. The challenge of workplace bullying. *Employment Relations Today* 2007, 34(2): 43-51.

5. Rayner, C and Keashly, L. Bullying at work: a perspective from Britain and North America. In Fox, S and Spector, P (eds). *Counterproductive work behaviors: investigations of actors and targets*. Washington: American Psychological Association, 2005, pp 271-296.
6. Rayner, C, Hoel, H and Cooper, C. *Workplace bullying: what we know, who is to blame, and what can we do?* London: Taylor & Francis, 2002.
7. Einarsen, S, Hoel, H, Zapf, D and Cooper, C. The concept of bullying at work: the European tradition. In Einarsen, S, Hoel, H, Zapf, D and Cooper, C (eds). *Bullying and emotional abuse in the workplace: international perspectives in research and practice*. London: Taylor & Francis, 2003, pp 3-30.
8. Lutgen-Sandvik, P, Tracy, S and Alberts, J. Burned by bullying in the American workplace: prevalence, perception, degree and impact. *Journal of Management Studies* 2007, 44(6): 837-862.
9. Mikkelsen, E and Einarsen, S. Bullying in Danish work-life: prevalence and health correlates. *European Journal of Work & Organizational Psychology* 2001, 10(4): 393-413.
10. McCarthy, P and Barker, M. Workplace bullying risk audit. *J Occup Health Safety — Aust NZ* 2000, 16(5): 409-417.
11. McCarthy, P, Sheehan, M, Barker, M and Henderson, M. Ethical investment and workplace bullying: consonances and dissonances. *International Journal of Management and Decision Making* 2003, 4(1): 11-23.
12. Leymann, H and Gustafsson, A. Mobbing at work and the development of post-traumatic stress disorders. *European Journal of Work & Organizational Psychology* 1996, 5(2): 251.
13. Groeblichhoff, D and Becker, M. A case study of mobbing and the clinical treatment of mobbing victims. *European Journal of Work & Organizational Psychology* 1996, 5(2): 277.
14. Hogh, A, Henriksson, M and Burr, H. A 5-year follow-up study of aggression at work and psychological health. *Int J Behav Med* 2005, 12(4): 256-265.
15. Matthiesen, S and Einarsen, S. MMPI-2 configurations among victims of bullying at work. *European Journal of Work & Organizational Psychology* 2001, 10(4): 467-484.
16. O'Connell, P, Calvert, E and Watson, D. *Bullying in the workplace: survey reports, 2007. Report to The Department of Enterprise Trade and Employment*. Dublin: The Economic and Social Research Institute, 2007.
17. Cassitto, M, Fattorini, E, Gilioli, R, Rengo, C and Gonik, V. *Raising awareness of psychological harassment at work*. Geneva: World Health Organization, 2004.
18. Hauge, L, Skogstad, A and Einarsen, S. Relationships between stressful work environments and bullying: results of a large representative study. *Work & Stress* 2007, 21(3): 220-242.
19. McCarthy, P and Mayhew, C. *Safeguarding the organization against violence and bullying*. Basingstoke: Palgrave MacMillan, 2004.
20. Needham, A. *Workplace bullying: the costly business secret*. Auckland: Penguin Books, 2003.
21. Keashly, L and Harvey, S. Emotional abuse in the workplace. In Fox, S and Spector, P (eds). *Counterproductive work behaviors: investigations of actors and targets*. Washington: American Psychological Association, 2005, pp 201-236.
22. Rayner, C and Cooper, C. Workplace bullying. In Kelloway, K, Barling, J and Hurrell, J (Jr) (eds). *Handbook of workplace violence*. Sage: Thousand Oaks, 2006, pp 121-145.
23. Liefoghe, A and MacKenzie Davey, K. Accounts of workplace bullying: the role of the organization. *European Journal of Work & Organizational Psychology* 2001, 10(4): 375-392.
24. Di Martino, V, Hoel, H and Cooper, C. *Preventing violence and harassment in the workplace*. Dublin: European Foundation for the Improvement of Living and Working Conditions, 2003.
25. Salin, D. Prevalence and forms of bullying among business professionals: a comparison of two different strategies for measuring bullying. *European Journal of Work & Organizational Psychology* 2001, 10(4): 425-441.
26. Niedhammer, I, David, S and Degioanni, S. Economic activities and occupations at high risk for workplace bullying: results from a large-scale cross-sectional survey in the general working population in France. *Int Arch Occup Environ Health* 2007, 80(4): 346-353.
27. Rutherford, A and Rissel, C. A survey of workplace bullying in a health sector organisation. *Aust Health Rev* 2004, 28(1): 65-72.
28. Neidl, K. Mobbing and well-being: economic and personnel development implications. *European Journal of Work & Organizational Psychology* 1996, 5(2): 239-249.
29. Power, K, Dyson, G and Wozniak, E. Bullying among Scottish young offenders: inmates' self-reported attitudes and behaviour. *Journal of Community and Applied Social Psychology* 1998, 7(3): 209-218.
30. Lewis, D. Workplace bullying — interim findings of a study in further and higher education in Wales. *International Journal of Manpower* 1999, 20(1/2): 106.
31. Quine, L. Workplace bullying in NHS community trust: staff questionnaire survey. *BMJ* 1999, 318: 228-232.
32. Foster, B, Mackie, B and Barnett, N. Bullying in the health sector: a study of bullying of nursing students. *New Zealand Journal of Employment Relations* 2004, 29(2): 67-83.
33. Scott, J, Blanshard, C and Child, S. Workplace bullying of junior doctors: a cross-sectional questionnaire survey. *NZ Med J* 2008, 121(1282): 10-15.
34. Crawford, N. Bullying at work: a psychoanalytic perspective. *Journal of Community and Applied Social Psychology* 1998, 7(3): 219-225.



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