Peer-to-peer bullying in nursing: Interventions at individual and organizational levels

Tanya L. Joyce

University of Hartford

Abstract

Workplace bullying has become epidemic in health care organizations across the United States. Healthcare workers suffer significant physical and psychological effects at the hands of bullying. These consequences lead to high nursing turnover and poor patient care. Organizations suffer as well through fiscal losses and losses related to decreased performance, productivity, absenteeism and turnover. Although there is ample research on negative workplace behaviors, there has been no advancement on effective interventions to decrease bullying between nurses. This paper provides a thorough literature review on workplace bullying and peer-to-peer bulling in nursing, possible antecedents and negative outcomes that manifest because of bullying behavior. Following the literature review, practical interventions using emotional intelligence (EI) and Dialectical Behavioral Therapy (DBT) coaching for remediation of those who bully and to support those targeted by bullying along with a modified zero-tolerance policy are introduced. The foundation has been laid for further empiric research on the effectiveness of these concepts as interventions for peer-to-peer bullying between nurses.

Key words: antecedents, bullying, dialectical behavioral therapy, emotional intelligence, hazing, healthcare, horizontal hostility, individual outcomes, interventions, lateral hostility, lateral violence, mobbing, nursing, and organizational outcomes.

Table of Contents

Introduction……..5

Workplace Bullying…….7

History and Definition of Workplace Bullying……...7

Workplace Bullying in Nursing…….12

Theories of workplace bullying in nursing……13

Incidence and Prevalence of Workplace Bullying…….15

Consequences of Workplace Bullying……...16

Individual Consequences……...16

Organizational Consequences……20

Antecedents to Bullying Behavior…….21

Target characteristics…….21

Perpetrator characteristics…….....22

Organizational factors……24

Ineffective Organizational Response to Workplace Bullying……...28

Emotional Intelligence in Response to Peer-to-Peer Bullying……..31

History and Definition of Emotional Intelligence…….31

Conceptualization of Emotional Intelligence in Workplace Bullying……...32

Positive individual and organizational effects of emotional intelligence……..34

Dialectical Behavioral Therapy Skills and Emotional Intelligence……...35

History of Dialectical Behavioral Therapy……35

Components of Dialectical Behavior Therapy……...36

Clinical uses of Dialectical Behavior Therapy……..37

Non-clinical Uses of Dialectical Behavioral Therapy……...38

Summary of Literature Review……..38

Recommended Organizational Policy and Individual Interventions…….40

Organizational Assessment……40

Healthy Workplace Policy Development……...……42

Individual Intervention for Perpetrators…….45

Individual Intervention for Target…….48

Discussion and Future Research……50

References……..53

Appendix A – Elements of a Respectful Workplace Policy……..61

Appendix B – Individualized DBT Skills Coaching – Perpetrator……62

Appendix C – Individualized DBT Skills Coaching – Target……...63

Peer-to-peer bullying in nursing: Interventions at individual and organizational levels

Nursing, as a profession, has a long-standing history of peer-to-peer bullying among coworkers and has been the subject of research over the past four decades (Hutton & Gates, 2008). Bullying, also referred to as negative acts, is a counterproductive work behavior characterized by deviant intent by a perpetrator toward a targeted individual or group (Hutton & Gates, 2008; O'Boyle, Forsyth, Banks, & McDaniel, 2012). Peer-to-peer bullying occurs between nurses in the same employment level (Bambi et al., 2014). Many terms have been used to define peer-to-peer bullying, including mobbing, hazing, negative acts and horizontal or lateral aggression. Regardless of the term used, bullying by any name causes significant negative consequences to individuals and organizations and, as a result, significant consequences to patient care. Targets of bullying suffer psychological, social, physical, financial and work-related harm (Bortoluzzi, Caporale & Palese, 2013). Organizations that allow bullying to continue incur financial and productivity losses as well as loss of reputation and ability to recruit high quality employees (Carter et al., 2013; Hutton & Gates, 2008). Although the individual and organizational costs of bullying are well documented, the nursing profession continues to foster a culture mired in bullying.

Bullying between nurses is multifaceted and many factors leading to bullying behavior reside at both individual and organizational levels. Understanding the possible correlations between these factors and negative behaviors may lead to effective interventions to reduce workplace bullying. At the individual level, personality traits of the perpetrator are contributing features of bullying behaviors. Perpetrators of workplace bullying share characteristic traits of the “dark triad” (narcissism, Machiavellianism and psychopathy) and exhibit lower abilities in EI (O'Boyle et al., 2012; Piotrowski, 2016). Thus, offering training to perpetrators of workplace bullying in EI may be one viable method to decrease bullying at the source (Bibi & Karim, 2013). The symptoms of bullying that affect targets are often debilitating and influence their

ability to work to their potential. Using DBT concepts may provide an effective strategy to increase EI in perpetrators and at the same time support targets (Namie & Namie, 2009b; Oade, 2018). Furthermore, the organizational culture directly affects bullying at work and is impacted by policy and procedure (Duffy, 2009; Ferris, 2009). Unfortunately, most organizations have either weak or non-existent policy related to workplace bullying that provides a rich environment for bullying behaviors and this needs to change (Namie & Namie, 2009b). Without interventions at multiple organizational levels, healthcare organizations will continue to breed negative work environments and foster workplace bullying.

This paper includes a thorough literature review of workplace bullying, peer-to-peer bullying in healthcare, consequences at individual and organizational levels, factors that influence bullying and interventions at both individual and organizational levels. The personality traits of perpetrators and targets and organizational factors as antecedents of workplace bullying as well as the lasting psychophysical effects that targets endure are examined. Unfortunately, research lacks empirically tested interventions that effectively decrease bullying. Retaining strong workers who may exhibit behavioral problems by intervening with bullying behavior and developing problematic employees instead of termination may be most beneficial to the organization. Therefor, possible interventions such as EI training, DBT concepts and policy and procedure interventions used to mitigate workplace bullying are reviewed. To close the gap in research, interventions increasing the EI of perpetrators and supporting targets using DBT skills at the individual level will be recommended in addition to effective policy and procedure change at the organizational level. This paper aims to provide interventions that retain skilled nurses by developing positive behaviors and decreasing workplace bullying, which may be more beneficial for organizations rather than merely resorting to termination.

Mutual respect for employees of organizations is paramount in this paper and with a goal to maintain the dignity of all parties involved in incidents of workplace bullying. The intention of

the proposed interventions in this review is to maintain and develop strong employees who are committed to the goals of the organization. Therefore, the descriptions of the participants of bullying behavior for this paper have been chosen carefully. The term "target" is used to describe the employee that is subjected to the negative behavior instead of "victim" to depict the intentional use of negative actions by another. The term "bully" elicits images of one employee being bigger, stronger or more powerful than the targeted employee, which incorrectly illustrates the true dynamics of bullying behavior and the peer-status of the target (Duffy, 2009). The intent of this policy is not to demonize the employee exhibiting bullying behavior, but to focus on the intent and purpose of his or her actions (Namie & Namie, 2019). Therefore, the term "perpetrator" is used instead of the label "bully."

Workplace Bullying

History and Definition of Workplace Bullying

Bullying behaviors in the workplace have been studied over the past 40 years beginning with R.L. Krebs' focus on non-respect and incivility and Carol Brodsky's research on harassment as a preventable workplace injury in the 1970s (Hutton & Gates, 2008; Kolbeck, 2012). Interest headed by Heinze Leyman bolstered the study of workplace bullying in Europe in the 1980s until a research boom in the 1990s emerged in both Europe and America (Kolbeck, 2012; Namie & Namie, 2009b). There is now a considerable amount of research on workplace bullying that includes: bullying at multiple levels, bullying by supervisors/managers (abusive supervision), bullying between coworkers and informal authority figures, both top-down and bottom-up behaviors, antecedents and consequences and theory propositions. Today, workplace bullying is considered a global epidemic and is a concern for national and international healthcare organizations around the world (Burton, 2010). Although workplace bullying occurs in all industry, it is noted that the nursing professional has higher incidents of bullying than other

sectors both in the United States and abroad (American Nurses Association, 2015; Einarsen, 2013; Hutchinson, 2010; Johnson & Rea 2009).

Considered a form of counterproductive workplace behavior (CWB), workplace bullying includes the negative behaviors associated with abuse and sabotage as described in the "five facets" of CWB (Bibi, 2013, p. 318). In fact, Meglich-Sespico, Faley and Knapp (2007) noted that workplace bullying is an "insidious form of CWB that results in significant costs" for employees and organizations (p. 31). In much of the research, incivility and bullying are studied as the same phenomenon. Although incivility is often a precursor, there is a distinct difference from bullying. Whereas incivility is "low intensity, deviant behavior" that is a "generalized disregard to others," bullying is persistent and intentional toward a target or targets (Hutton & Gates 2008, p. 169; Law, Dollard, Tuckey, & Dormann, 2011; Namie & Namie, 2009b; Trépanier, Fernet & Austin, 2015; Van Heugten, 2009; Vessey, Demarco, Gaffney & Budin, 2009; Wilson & Nagy, 2017). Uncivil behavior in the work environment often results in an "incivility spiral" that further leads to bullying and, at times, physical aggression (Hutchinson et al., 2010; Laschinger & Nosko, 2013, p. 254). Unfortunately, employers often disregard bullying behavior in error as isolated incivility instead of patterns of bullying behavior (Meglich-Sespico, 2007). Not only is bullying manifested by a single perpetrator, mobbing also occurs when more than one person perpetrates negative behavior toward a coworker. Mobbing has been noted to include negative acts by a group toward a single target with the intent to remove the target from the unit or organization (Sperry, 2009). Sperry (2009) defined mobbing as "the nonsexual harassment of a coworker by a group of other members of an organization for the purpose of removing the targeted individual from the organization or at least a particular unit" by means of direct termination or constructive termination (p. 191).

Wendt and Bartoli (2017) noted that bullying is about power and labeled bullying as "abusive, cruel and unfair" (p. 131). In fact many researchers extensively discuss power as a

determining component for bullying behavior. The perpetrator uses power to bully coworkers while systematically removing power from the target (Law et al., 2011; Oade, 2018; Strandmark & Rahm, 2014; Wilson & Nagy, 2017). To encompass the phenomenon fully, this paper uses a working definition for bullying of "*intentional* verbal and non-verbal conduct by one or more individuals against one or more individuals *over a period of time* that continuously and systematically intimidates, shows hostility, threatens, offends, humiliates or insults a coworker; interferes with a coworker's performance; or has an adverse impact on a coworker's mental or physical well-being" (Hutton & Gates, 2008, p. 169).

Operationalization of bullying behavior includes intensity, frequency, intent to harm, perpetrator power over a target for a distinct period that causes negative outcomes (Namie & Namie, 2009b; Tehrani, 2012; Wilson & Nagy, 2017). Bullying is the perpetration of intentional unwanted negative behavior that is purposeful, deliberate and continual (Meglich-Sespico et al., 2007; Joint Commission, 2016). Some authors classify bullying behaviors as being either direct or indirect actions (Wendt & Bartoli, 2017; Einarsen, Hoel, & Notelaers, 2009). Whereas direct bullying includes overt, face-to-face actions such as ridicule, accusations and shouting, indirect bullying includes gossip, maligning and withholding and can be difficult to ascertain (Wendt & Baratoli, 2017). Although the target experience is unique, the methods used by perpetrators of bullying consistently utilize similar negative acts. Regardless of the tactics in play, bullying causes harm and hostile workplace behaviors are the foundation to workplace bullying (Duffy, 2009).

Although workplace bullying is operationalized by the behaviors exhibited by perpetrators, defining bullying is less about the specific behaviors and more about the persistence of those behaviors (Eienarsen et al., 2009). Meglich-Sespico et al. (2007) added that bullying is a "persistent torment intended to wear down a target" (p. 32). Bullying is considered an escalation of an instigating interaction or confrontation that leads to repeated and regular negative acts.

When bullying behavior persists, the target finds his or herself in an inferior position where they are unable to protect and defend themselves (Van Heugten, 2009). Besides intended maliciousness, bullying behavior toward a target occurs over an extended period. Although the common standard to define bullying is a period of six months or more, such precise allocation of time measures may not be beneficial to operationalizing bullying. Ferris (2009) stated that "in the context of work, such behaviors should be determined unacceptable and address long before 6 months" (p. 171). Additionally, many targets have reported being bullied for up to two to eight years (Meglich-Sespico et al., 2007; Namie & Namie, 2009b).

Bullying involves deliberate behavior exhibited by the perpetrator and deliberateness is difficult to substantiate (Van Huegten, 2009). A leading factor in unsubstantiated bullying is that intentional negative acts often occur out of the sight of management making the behavior virtually untraceable (Meglich-Sespico et al., 2007). Additionally, Meglich-Sespico et al. (2007) highlighted that many targets are uncertain about the reality of bullying episodes and negative acts may be misunderstood as merely isolated incidents of uncivil behavior. Compounding the issue is that perpetrators will often cloak their actions in "plausible deniability" and/or blame the incident on the target's misperceptions (Meglich-Sespico et al., 2007, p.35). Leadership further compounds the issue by inaccurately ascribing incidents of bullying as being isolated episodes of incivility or conflict (Meglich-Sespico et al., 2007). When incidents of bullying go unnoticed or unacknowledged, the affects of bullying on the individual and the organization are exponentially exacerbated.

To be clear, neither incivility nor general conflict between coworkers of an equal status is a form of bullying because they lack the constructs specific to bullying (Duffy, 2009; Van Heugten, 2009; Wilson & Nagy, 2017). Bullying is not an interpersonal disagreement, a representation of different working styles, constructive feedback or unintentional, incidental interpersonal acts (Miglich-Sepsico et al., 2007;Oade, 2018). Additionally, peer-to-peer bullying

does not include bullying by managers or leaders in differing levels of the organization (Bambi et al., 2014). Aggressive acts may appear to be incidents of bullying, both they often are more characteristic of the aggressor's inability to handle emotions rather than intent to harm or remove power from the target (Oade, 2018). Moreover, constructive conflict cannot be misconstrued as bullying. Conflict in the workplace is normal and can be a positive force in generating ideas and solving problems (Duffy, 2009) Bullying, by definition, does not include discrimination or harassment of people under Federal protection (age, race, religion, national origin, sex, pregnancy, citizenship, familial status, disability or veteran status) or incidents of sexual harassment that require organizations to protect employees (Namie & Namie, 2009b). To date, there are no laws protecting workers from bullying at either the State of Federal levels and labor unions will not protect employees unless bullying is specifically itemized in the labor contract (Joint Commission, 2016; Namie & Namie, 2009b).

Workplace Bullying in Nursing

Evidence shows that there are higher levels of workplace bullying in the helping professions of teaching, social work and nursing (Justo, Andretta & Abs, 2018; Van Heugten, 2009). Bullying behaviors that occur in healthcare are indeed a national problem (Vessy et al, 2009). The Joint Commission reports that over 50% of American nurses have been verbally abused in the past 12 months (Burton, 2010). Peer-to-peer bullying in nursing may be manifested as early as nursing school and perpetuated through competition at all levels of nursing (Douglas, 2014). It is well known that 'nurses eat their own' when describing the bullying that occurs in all clinical environments and nursing specialties (Douglas, 2014; Joint Commission, 2016). Nursing is shrouded in a "culture of silence" where negative acts are neither acknowledged nor reported creating a prime breeding ground for bullying (American Nurses Association, 2015; Laschinger & Nosko, 2013; Vessey et al., 2009, p. 300). In the culture of silence, low-grade bullying goes unnoticed and/or is not acknowledged (Vessey et al., 2009)

Nurses often feel that bullying is merely part of the job and the profession or, worse yet, a rite of passage (Van Heugten, 2009; Joint Commission, 2016). This concept is further compounded in nursing work environments, which create unique forms of incivility and bullying that are distinctive to the nursing profession (Blackstock et al., 2014).

Theories of workplace bullying in nursing. With the high prevalence of peer-to-peer bullying in the nursing profession, researchers have utilized several theories to understand why nurses engage in bullying behavior. Understanding the possible causes of bullying between nurses may lead to effective interventions to resolve the problem. Although not exclusive to healthcare, several theories have frequently been identified as antecedents, including oppression theory, task and time theory and workplace victimization theory (Bambi et al., 2014; Brown & Middaugh, 2009; Rodwell et al., 2013; Sheriden-Loes, 2008). Oppression theory is the most cited theory of bullying in nursing and hypothesizes that health care professionals are oppressed through managers and superiors, physicians, work schedules and the organizational hierarchal structures found in hospitals (Sheridon-Loes, 2008, Van Heugten, 2009). Oppression occurs often in helping and feminized professions where employees who feel subjugated use dominance to overcome others (Van Heugten, 2009). Thobanen (2011) described nursing as being an oppressed discipline "because nurses lack autonomy, accountability and control" and that when they "feel inferior and powerless they behave aggressively toward coworkers or subordinates to relive tension" (p. 477). Furthermore, nurses who feel oppressed lash out laterally as a safe means of relieving employee's feelings of low self-esteem and low self-confidence (Bambi et al, 2014, Van Heugten, 2009, Wilson & Nagy, 2017). The workplace environment can be seen as 'emotionally, spiritually and psychologically toxic caused by oppressive management styles, organizational instability and competition' (Sheriden-Loes, 2008, p. 399). Oppression also occurs in relation to deprivation of rights and privileges, generational and hierarchal abuses, low intraprofessional esteem, cliques and cycles of aggression (Bambi et al., 2014; Law et al., 2011;

Van Heugten, 2009). Sheriden-Loes (2008) described a "submissive-aggressive syndrome" that fits within oppression theory; which includes lack of autonomy, control, and self-esteem (submission) of which nurses respond by overpowering others (aggression) (p. 399).

Although oppression theory is one of the most frequently cited theories in workplace bullying of nurses, other theories may also explain the phenomenon. For instance, the job demands resource theory may explain negative acts that are elicited by a sense of injustice with a perceived imbalance between the effort nurses put into their work and the rewards that they receive, which is worsened when they compare the resources received by others (Burton, 2010; Namie & Namie, 2009b). The job demands-resources theory may explain workplace bullying in the nursing profession where job demand is high, and resources are often low (Law et al., 2011). When nurses are vying for resources such as support, rewards, justice and acknowledgement, competition heightens, and the environment is primed for bullying (Law et al., 2011). In workplace victimization theory, targets of bullying attribute blame toward either one's self or the organization resulting in either the internal manifestation of psychophysical symptoms or the external manifestation of dissatisfaction with work and the organization (Rodwell et al., 2013). Rodwell's et al. (2013) findings supported that employees felt safer to target other coworkers rather than confronting issues directly, which can lead to a repetitive cycle of victimization and retaliation (Rodwell et al., 2013). Time and task theory centers on stress induced by work tasks, the time allowed to perform tasks and rules governing how a task is performed (Sheridan-Leos, 2008). Additional theory may include circuits of power related to Leopold Kohr's power theory of aggression, which would explain why senior nurses frequently are perpetrators of incivility and bullying toward those just starting in the health care field (Hutchinson et al., 2010; Rodwell et al., 2013). Given the many possible theoretical reasons that nurses encounter peer-to-peer bullying, the incidence and prevalence of workplace bullying should not be surprising.

Incidence and Prevalence of Workplace Bullying

The already high prevalence of bullying around the world and the United States is noted to be increasing (Oade, 2017). Incidents of bullying reported in research vary widely depending on the operational definition, constructs and assessment measures (Wilson & Nagy, 2017). Meglich-Sespico et al. (2007) reported results of a United States survey showing that over half of the U.S. workforce reported being subjected to abusive behavior at work and other reports show workplace bullying at levels as high as 86% internationally (Burton, 2010, Laschinger & Nosko; Vessey et al., 2009). Surveys that utilized operationalization of bullying behavior of one negative act per week consistently show bullying to be around 50% (Wendt & Bartoli, 2017; Wilson & Nagy, 2017, p.125). Both Namie and Namie (2019) and the World Health Organization find that women are more commonly subject to workplace bullying than men (Burton, 2010). Coworkers are known to be the most frequently targets of bullying and are also the most frequent perpetrators, 55.2% and 39.2% respectively (Namie & Namie, 2009a). There is a common belief that workplace bullying is an epidemic and nursing is not immune (Burton, 2010; Joint Commission, 2016; Laschinger & Nosko, 2013, Namie & Namie, 2019; Oade, 2009).

Giorgi et al. (2013) empirically studied the difference between rates of bullying when strictly operationalized by standardized questionnaires versus a self-labeling method. Self-labeling includes providing a definition of bullying to the target and asking them to report the extent that they have been subjected to negative behaviors that fit the definition (Giorgi et al., 2013). The researchers' study supported that the target's perspective may better constitute bullying behavior, negative outcomes and persistence rather than a list of operationalized behaviors (Giorgo et al., 2013). Rodwell, Demir and Steane (2013) and the Joint Commission (2016) agreed and recommended using target perception as part of operationalizing workplace bullying. It may be beneficial to measure bullying as operationalized by the target's perception of bullying, like the pain assessment in health care. With that mindset, bullying is what the target

perceives it to be. The incidence of bullying increases when self-labeling is used and operationalized in numbers of bullying acts over a period (Giorgi et al, 2013). When objective measures are used to operationalize bullying, it sends a message to the target that their experience must be validated by a third party when it is the subjective experience that leads to psychological and physical effects (Einarsen et al., 2009).

Consequences of Workplace Bullying

Individual consequences. After a clear understanding of bullying between nurses and the prevalence to which it occurs, it is imperative to recognize the damage that workplace bullying can extort on individuals and organizations. Extensive study has been conducted on the impact of bullying at the individual level and the results are not surprising (e.g., Namie & Namie, 2009b). Namie and Namie (2009b) concluded that workplace bullying significantly threatens employee well-being. Focused and unrelenting bullying is a substantial threat to the target who suffers loss of psychological integrity, safety and incur health consequences, which has manifestations like targets of domestic violence (Namie & Namie, 2009b). Trépanier et al. (2015) noted that workplace bullying is now one of the most detrimental stressors that employees face during work. In what Law et al. (2011) coined as a "slow accident," workplace bullying can create psychological injury and physical health problems over long periods of time (p. 1782). The injury often goes unnoticed by the organization but is no less detrimental than physical injuries that receive immediate attention and remedy.

Exposure to workplace bullying can be considered a workplace hazard or unsafe condition (Law et al., 2011). As shown in Figure 1, symptoms correlated with bullying include psychological dysfunction, physical illness, somatic complaints and work-related symptoms. The researchers' results show a direct correlation between bullying and medically validated illness (Bambi et al., 2014; Carter et al. 2013; Hutchinson et al., 2010; Hutton & Gates, 2008; Nicholson & Griffin, 2015; Rodwell, et al., 2013; Sheriden-Loes, 2008). In fact, Carter et al. (2013) found

that 25-36% of survey respondents exhibited symptoms of psychological distress related to negative acts and noted that direct bullying incurred the greatest distress (p. 8). Similarly, Bambi et al. (2014) reported that 69% of survey respondents suffered psychological affects of bullying and 39% of those who had experienced bullying were continuing to have psychophysical symptoms at the time of the survey. However, unlike physical injury, psychological harm is not protected under the federal Occupational Safety and Health Administration (OSHA) (Law et al., 2011). In fact, OSHAs general duty clause that covers "non-specific hazards" does not protect employees from psychological harm or bullying (Meglich-Sepico et al., 2007; American Nurses Association, 2015). Likewise, targets also are unlikely to win workers compensation claims or legal cases in court (Meglic-Sespico et al., 2007).

Figure 1. Individual Impact of Workplace Bullying

Psychological symptoms: Anxiety, depression, helplessness, despair, reduced self-esteem, powerlessness, anxiety, sleep disorders, flashbacks/PTSD, stress, shame/guilt, sense of alienation/remoteness, substance abuse, emotional exhaustion and, at worst, suicidal ideation

Physical symptoms: Heart palpitations, cardiovascular disease/symptoms, heart attack, hypertension, hyperventilation, psychosomatic complaints, musculoskeletal complaints, frequent headaches, decreased immune system, frequent illness, weight gain or loss and gastrointestinal disorders.

Work symptoms: Apathy, poor morale, lack of enthusiasm, burnout, isolation and withdrawal, forgetfulness, increased absenteeism, presenteeism, decreased job satisfaction, decreased confidence, intent to leave job or health care field, financial losses and at worst the inability to work.

Adapted from Carter et al., 2013; Ferris, 2009; Namie & Namie, 2009b; Nicholson & Griffin, 2015; Rodwell et al., 2013; Sheriden-Loes, 2008.

Evidence of post-traumatic stress disorder (PTSD) related to workplace bullying has also been documented over the past two decades with between 60% and 70% of targets having diagnosable levels of post-traumatic stress symptoms by some measures (Tehrani, 2012). However, the symptoms of PTSD are often overlooked. The more a target is exposed to bullying, the higher the symptoms of PTSD (Laschinger & Nosko, 2013). Workplace bullying has been correlated to the 'PTSD triad' that includes hyper arousal, re-experiencing the bullying events and avoidance of stimuli that will cause the target to relive the experience despite not having an immediate physical threat (Laschinger & Nosko, 2013, p.254; Van Heuten, 2009). Nurses that have been bullied have higher rates of diagnosable anxiety, depression and PTSD and suffer lasting effects, including memory problems, nervousness, social isolation, hostility, withdrawal and avoidance (Laschinger & Nosko, 2013; Namie & Namie, 2009b). The harmful effects of bullying accumulate and become emotionally burdensome (American Nurses Association, 2015). Additionally, suicidal ideation and completed suicide may be a very real responses to workplace bullying (Wendt & Bartoli, 2018; Namie & Namie, 2019). In response to workplace bullying, many targets turn their shame and humiliation inward and there is a high rate of suicide occurring within six months of being bullied (Duffy, 2009; Namie & Namie; 2009a; Vessey et al., 2009). Severe psychophysical symptoms can also lead to financial loss and loss of the ability to work (Hutchinson et al., 2010; Nicholson & Griffin, 2015).

Negative acts are intended to intimidate the target and may also create disruption of the target's perception of a safe environment. Hutton and Gates (2008) correlate bullying with the erosion of feeling safe in one's employment, which is compounded when managers and the organization side with the perpetrator and participate in labeling the target as the source of problem (Duffy, 2009, Namie & Namie, 2009b; Van Heugten, 2009). This occurs when leadership buys into the perception of the perpetrator. Some employers have gone so far as to extensively investigate both the current event and the target's entire work history for evidence

that the target is indeed the problem to create a case after the fact (Duffy, 2009; Namie & Namie, 2009b, 2019). The effect of leadership's involvement may lead to organizational mobbing that segregates the target and often leads to expulsion of the target by either direct or constructive termination (Duffy, 2009; Namie & Namie, 2009b, 2019; Meglich-Sespico et al., 2007). Unfortunately, bullying of the expelled target often continues after their exit from the organization, which is further demonstration that the behavior is deliberate with the intent to harm (Duffy, 2009).

Although the psychosocial effects of negative acts are a "severe and critical life event for those targeted," workplace bullying does not merely affect the target (Hutchinson et al., 2010, p. 174). Carter et al. (2013) noted that witnesses to workplace bullying incur similar negative effects of bullying to those who are targeted and witnessing bullying can cause almost as much distress as being the direct target of bullying. Additionally, bystanders need to process the event and decide how they are going to react (Oade, 2018; Wilson & Nagy, 2017). Hutchinson et al. (2010) also found that as the target's stress, anxiety and anger mount, their families can suffer increased stress as well. Van Heugten (2009) reported that the effect of incivility and bullying on the family leads to less attention for their spouse and children. The overall personal effect of individual personal and professional consequences from workplace bullying is often a significant change in the target's "world view" (Van Heugten, 2009, p. 645). When a target experiences bullying over an extended period and there are impacts both at home and work, their world view changes to seeing others as self-serving and distrustful; those affected can also lose the idealized views that helping professions uphold high ethical standards for those in their care and their employees (Van Heugten, 2009). Lastly, Vessey et al. (2009) stated that quality-nursing care requires a collaborative environment and positive relationships with other nurses, providers, patients and families. Several authors highlighted that the cumulative effects of bullying on the target are a threat to the care and well-being of patients (e.g. American Nurses Association,

2015). Bullying has been correlated to higher incidents of medication errors, falls and adverse reactions and lead to poorer patient outcomes including death (American Nurses Association, 2015; Burton, 2010; Laschinger & Nosko, 2013).

Organizational consequences. Given the extensive consequences individual employees experience from bullying, the problems that organizations sustain are not surprising. Normalization of workplace bullying can create toxic workplaces that sustain high rates of absenteeism, turnover and productivity losses (Carter et al, 2013; Duffy, 2009; Hutton & Gates, 2008; Namie & Namie, 2009b; Oade, 2018). When employees suffer under bullying behaviors, the organization faces increased use of sick leave due to physical and psychological health concerns and emotional strain (Namie & Namie, 2009b, 2019; Wilson & Nagy, 2017). Targets and those who witness acts of bullying show lower morale, lower job satisfaction, poor interpersonal relationships and reduced commitment to the organization that further create a negative atmosphere and may lead to poor performance (Wilson & Nagy, 2017). Oade (2018) noted that the target's standard of performance decreases when the energy needed for work is turned inward to cope with the behaviors and the effects of bullying. Furthermore, the work team suffers as the power differential shifts and team members are required to choose allegiance (Oade, 2018). Varying studies show that the financial costs of bullying of a single target can cost the organization between $30,000 and $100,000 or up to one and a half times the employee's salary (Meglich-Sespico, 2007; Namie & Namie, 2009b). These numbers reflect over 5% of the annual organizational operating budget (Hutchinson et al., 2010, 174). Bambi et al. (2014) found that 11% of targets request department transfers and 13% leave health care work altogether because of incivility and bullying.

Organizations also suffer hidden costs related to incivility and bullying (Hutchinson et al., 2010). Organizations may incur losses in productivity when targets of bullying withdraw and lose initiative to perform to their ability either to avoid the perpetrator or because of self-doubt

(Wilson & Nagy, 2017) Ferris (2009) noted a phenomenon referred to as "presenteeism" where employees are physically present at work but have lowered productivity or perform below expected standards of work (p. 174). The cost of presenteeism is difficult to assess and may incur costs of 7-10 times the amount of absenteeism (Ferris, 2009).

When employees become less engaged, less committed and dissatisfied with employment health care organizations suffer (Vessey et al., 2009). Negative acts affect how employees view work and the organization. The cycle of negativity can create a vortex of negative feelings and in turn leads to decreased employee retention (Hutton & Gates, 2008). Employee dissatisfaction often becomes public knowledge leading to poor reputation and further difficulty hiring (Duffy, 2009; Namie & Namie, 2009b; Sheriden-Loes, 2008). Poor retention and difficulty hiring new employees creates organizational loss of expertise. This loss of human capital and expertise carries over to the health care system when workers leave the healthcare industry for employment in other industries (Duffy, 2009; Hutchinson et al., 2010; Laschinger & Nosko, 2013). Loss of expertise may be an even greater loss to health care organizations than employee turnover (Hutchinson et al., 2010). Understanding what peer-to-peer bullying is and how it affects individuals and organizations has left unanswered questions as to why individuals use bullying behavior in the workplace.

Antecedents to Bullying Behavior

Target characteristics. Understanding the antecedents to bullying behavior is an integral step in developing solutions to this phenomenon. To comprehend what causes peer-to-peer bullying, there have been many studies related to factors that may predicate negative behaviors at the individual level. Some research has indicated that the personality traits of targets are a contributing factor to workplace bullying, including targets showing higher levels of conscientiousness and neuroticism and lower levels of extraversion (Sperry, 2009; Wilson & Nagy, 2017). However, other authors equated such reports as a method to blame the victim and

recommended resisting the fundamental attribution error in blaming the target for the concerted effort of the perpetrator (Namie & Namie, 2009b; Van Heugten, 2009). Meglich-Sespico et al. (2007) implore organizations to be mindful that targets do not instigate the negative behavior bestowed upon them and should not be blamed for incidents of bullying. Blaming the target for negative acts inflicted upon them is often propagated by the bullies themselves and is then accepted as the organizational view (Van Heugten, 2009). When this happens, the target may be labeled as difficult, or worse, mentally unstable (Duffy, 2009). After prolonged experiences with bullying, targets may indeed begin to exhibit the behaviors they are accused of, including hyper-vigilance, paranoia and hyper-reactivity (Namie & Namie, 2009b). Although not thought to be a direct cause of bullying, there are traits of the target that may trigger the perpetrator to feel threatened and defensive on the job, which leads the perpetrator to use bullying as an ego defense mechanism (Namie & Namie, 2009b; Wilson & Nagy, 2017). Targets are often found to be high in conscientiousness and are hard workers who excel in their organizations. These factors can cause jealousy in the perpetrator and may lead to bullying behavior (American Nurses Association, 2015). In fact, in a study on the reason's perpetrators bully others, 56% of respondents reported that they did so because the target had superior skill or competence and 49% reported that they did so because the target exhibited positive social skills that include being well liked, being nice and having a positive attitude (Namie & Namie, 2009b). A target's work orientation may also be predictive of bullying.

Perpetrator characteristics. There is considerably more evidence of personality being a component of those who perpetrate negative behaviors onto others than there is on personality traits of targets. Several articles show that perpetrators of bullying score lower in conscientiousness and agreeableness and higher in neuroticism and extroversion (O'Boyle, Forsythe, Banks & McDonald, 2012, Namie & Namie, 2009b; Piotrowski, 2017; Sperry, 2009, Wilson & Nagy, 2017; Wendt & Bartoli, 2017) Piotrowski (2017) has studied "adult bully

syndrome" where perpetrators of bullying exhibit psychological characteristics of narcissism, arrogance, insecurity and aggression to persevere their self-image and ego (p. 94). Studies relating CWB and perpetrators of bullying to the dark triad of personality disorders show a link between bullying behavior and narcissism, Machiavellianism and psychopathy (O'Boyle et al., 2012; Piotrowski, 2016; Wendt & Bertoli, 2017). These personality traits are known to include feelings of inadequacy; lower self-esteem, status insecurity and anxiety that create a situation where perpetrators of bullying target others whom they feel threaten their ego (Van Heugten, 2009). Piotrowski (2017) also discussed an ineptitude profile of perpetrators where bullying behaviors are used to compensate for feelings of anxiety and incompetence. Perpetrators often envy the status and competence of others, which are motivators for bullying (Van Heugten, 2009).

People having traits within the dark triad are known to lack empathy and to act in a "callous, selfish and malevolent" manner during interpersonal interactions (O'Boyle et al., 2012, p. 557; Wendt & Bartoli, 2017). In fact, callousness and lack of empathy are consistently associated with bullying behavior (Wendt & Bartoli, 2017). Instead of following the rules of social exchange, those with dark triad traits use social exchange to benefit themselves by overlooking obligations to others, foregoing reciprocity, a lack of emotional commitment and an unfair value of cost/benefit equity (O'Boyle et al., 2012). Narcissism holds a sense of entitlement and belief that the rules of interpersonal engagement do not apply to them, whereas those exhibiting Machiavellianism believe that others are a means to an end for their self-serving needs (O'Boyle et al., 2012). Wendt and Bertoli (2017) empirically studied psychopathy and adult bullying and found that the core traits of psychopathy, absence of fear and inability to respect others, are directly related to bullying behavior. Psychopathy possibly includes as many as three million American employees who may fit the clinical criteria to be classified as psychopathic (O'Boyle et al., 2012). In fact, many perpetrators of bullying self-report traits of psychopathy,

such as viewing hostility positively, using manipulation and aggression for problem solving, lack of concern for others, using power and control over targets and holding a level of indifference and grandiosity (Wendt & Bertoli, 2017).

Although bullying behavior may fit the criteria of personality behaviors, there is often an aversion to using such strong terms such as narcissism and, especially, psychopathy to characterize perpetrators of bullying. These terms are often used to describe extreme behaviors that lead to criminal offenses or significant social consequences (O'Boyle et al., 2012). However, narcissism and psychopathy can be diagnosable disorders, or a set of traits held by those who bully their coworkers (Laschinger & Nosko, 2013; O'Boyle et al, 2012; Piotrowski, 2016). Furthermore, narcissistic traits are the most common of the dark triad associated with perpetrators of bullying (O'Boyle et al., 2012). As personality traits are relatively stable, many adult perpetrators may have exhibited bullying behavior as children as well (Wendt & Bertoli, 2017). Bullying behaviors may "age out" as a person matures; however, some perpetrators may exhibit more sophisticated methods replacing old acts of bullying that they used as children (Wendt & Bertoli, 2017, p. 142). Additionally, Wendt and Bertoli (2017) state that age may strengthen the effects of narcissism and psychopathy leading to greater severity of bullying behavior as the individual gets older.

Organizational factors. Although the individual causes of workplace bullying are astounding, bullying behavior cannot take place without the intentional or unintentional support of the organization (Namie & Namie, 2009b). Focusing on individual causes for workplace bullying is not enough and doing so negates any responsibility of the organization (Duffy, 2009). Although bullying has been mostly regarded as individual acts of behavior, Hutchinson et al. (2010) described a more deeply seeded causation in the organization itself. There are significant concerns by the American Nurses Association, an organization that promotes dignity and respect for both patients and those who work in health care settings, about the organizational factors that

increase the propensity for workplace bullying (American Nurses Association, 2015). The World Health Organization also voices concerns about organizational culture, attitudes, values, beliefs and practices that lead to bullying behavior at an organizational level and stated that organizations that do not address workplace bullying are, in fact, promoting it (Burton, 2010). Organizations that revere procedural expertise, individualistic competition and achievement, often found in healthcare organizations, foster the dynamics that breed workplace bullying (Duffy, 2009, Vessey et al., 2009). In these organizations, bullying may a sign of strength and resilience and employees will secretly support and condone negative behavior (Vessey et al., 2009). When bullying is allowed to continue, negative behaviors become organizationally institutionalized and can be almost impossible to eradicate (Law et al., 2011).

Hutchinson et al. (2010) studied the impact of organizational cultures vs. individual behaviors as they impact bullying. As depicted in 2, Hutchinson et al. (2010) developed a model of bullying that included "informal alliances, organizational tolerance and reward and the misuse of legitimate process and procedures" that reside at the organizational level (p. 174). An unseen but potent facilitator of bullying is informal alliances – a hierarchy of individuals outside of the formal organization structure – that increase the opportunities for employees to participate in negative behaviors and create cultural norms that tolerate, socialize and reward bullying behavior (Hutchinson et al., 2010, 2012). In these informal alliances, one member of the group often serves as the informal leader and may exert petty tyranny. Petty tyranny is an informal, malevolent form of informal leadership and exertion of power, legitimate or perceived, in an informal alliance that often causes mobbing behavior toward other coworkers (Pinder, 2008). Informal alliances and petty tyranny often occur because of authoritative and rigid work environments as found in nursing (Pinder, 2008). Petty tyranny is not to be confused with interactional injustice, which is carried out by a superior (Pinder, 2008). Furthermore, Ferris (2009) discussed micropolitical behavior that utilized organizational tolerance of bullying to

enhance an individual's own interests over that of the organization by building coalitions, such as plotting against targets for their own advancement. Coupled with organizational tolerance, bullying tends to increase when employees misuse authority and processes, including policy and procedures (Hutchinson et al., 2010). The systematic use of bullying behaviors then becomes normalized and bullying becomes part of the organizational culture (Hutchinson et al., 2010).

Figure 2. Model of Bullying

Hutchinson's et al. (2010) model of bullying depicting how organizational factors may lead to bullying and the individual consequences that may occur (p. 176).

Strandmark and Rahm (2014) agreed that informal leaders, alienation and alliance-building within the organization create an atmosphere ripe for bullying. Informal alliances create an in-group versus out-group situation that may lead to mobbing behaviors and further promote bullying (Sperry, 2009). Informal alliances may indeed be the common denominator for both

organizational tolerance and reward and misuse of legitimate process and procedures. When organizational elements strongly support negative work environments, moral and good people may engage in the perpetration of negative acts (Sperry, 2009). Hutchinson et al. (2010) concluded that organizational factors have more bearing on bullying than do individual factors and that current organizational responses to bullying based on the individual alone are ineffective in treating the epidemic of bullying.

An organizational climate that supports workplace bullying also decreases the probability that victims of bullying will report incidents. Targets of bullying feel that their experiences will be discounted and that valid reports will go unaddressed by leadership and administration (Hutchinson et al, 2010; Vessey et al., 2009). Research has supported that there is significant underreporting of negative acts by nurses (Vessey et al., 2009). In fact, Carter et al. (2013) found only 3-14% of victims report bullying to superiors. Target responses indicted that fear of being blamed, being incompetent and not wanting to be viewed as acting petty or being a troublemaker are the greatest barriers to reporting incidents of bullying (Carter et al., 2013). Furthermore, organizational factors, such as failure to sanction bullying, cause targets to believe that nothing will be done about incidents and that reporting may cause the situation to worsen (Carter et al., 2013). Targets have a lack of confidence that the organization will take the issue seriously and fear retaliation if they report bullying behavior, which is a common occurrence of perpetrator conduct (Vessey et al., 2009). Consequences after reporting incidents of bullying can include either work retaliation or social retaliation (Meblich-Sespico et al., 2007) Social retaliation is most frequent and work retaliation is most often accompanied by social retaliation (Meglich-Sespico et al., 2007). Instead of reporting incidents, targets avoid and withdraw or show aggression to fellow coworkers. When negative acts are unchecked at the organizational level, a repetitive, patterned and escalated culture of bullying evolves. Psychological hazards in the

organization related to bullying stem from lack of policies and procedure that ensure the dignity and safety of all employees (Burton, 2010).

Ineffective Organizational Response to Workplace Bullying

Before organizations attempt to incorporate anti-bullying interventions, it is important to understand what research has shown to be ineffective. Organizations have not been completely unresponsive to bullying, but current organizational response continues to be ineffective. Whether because of poor understanding of workplace bullying or lack of initiative to manage bullying, many organizations have chosen to enact poor policy and procedure in hopes of appearing proactive (Namie & Namie, 2009b, 2019). Anti-harassment and antiviolence policies are narrowly defined in terms of legal language and do not include workplace bullying (Namie & Namie, 2009b). When organizations do not have adequate anti-bullying policy in place, direct management is left unsure how to handle bullying appropriately, which leads to ineffective attempts to solve the problem (Laschinger & Nosko, 2013). Namie and Namie (2009b) asserted that "although the existence of anti-bullying policies will not, by themselves, eliminate bullying, carefully crafted policies will help prevent bullying and provide mechanisms for addressing it when it does" (p. 243). Therefore, it is imperative that anti-bullying policy be enacted within an organization that upholds the mission and values against bullying behavior. However, zero-tolerance policy has not been effective because it is difficult to enforce, and many employers are often unwilling to commit to a systematic solution for resolving workplace bullying (Namie & Namie, 2009b). Additionally, it is implausible to assume that the organization would immediately terminate perpetrators of bullying, which would incur an impractical loss of personnel.

One of the most common procedures organizations use to handle bullying is through mediation between the perpetrator and the target most often hosted by their immediate supervisor (Namie & Namie, 2009b). In fact, mediation is often the first remedy chosen for acts of bullying

although it has also been long known to be ineffective (Namie & Namie, 2009b; Van Heugten, 2009). Incorporating mediation as a method to dispel bullying holds the inaccurate belief that bullying is a form of individual conflict where coworkers "need to work it out" (Namie & Namie, 2009b, p. 211). Namie and Namie (2009b) further recommended that mediation should never be used for acts of bullying and not be used for incidents that involve a power differential between the parties, which is always the case between perpetrators and targets. Using mediation has shown to not only be ineffective, but also ignores the target's need for acknowledgement and a sense of organizational justice (Namie & Namie, 2009b). Workplace bullying is not a form of interpersonal conflict and using mediation as a tool can also lead to re-victimization of the target at the organizational level (Namie & Namie, 2009b, Van Heugten, 2009). Organizations that believe that targets merely need to stand up for themselves are missing the mark and are unduly perpetuating an environment conducive to unbridled workplace bullying (Laschinger & Nosko, 2013; Oade, 2018).

Use of mediation is not the only unsuccessful method used for incidents of workplace bullying. Organizations use several other procedures at the individual level that have also proven ineffective (Oade, 2018). For example, organizations may attempt to discourage perpetrators by providing a written or verbal warning to stop unwanted negative behaviors in the belief that the behavior will end. Although the perpetrator may understand that he or she is being reprimanded, they may not fully understand what behavior is unacceptable or have the tools to correct their behavior (Oade, 2018). Another frequent response used by administration is to remove either the perpetrator or the target from the current work unit to another unit (Oade, 2018). Changing the perpetrators environment will not organically alter their behavior and my instead lead him or her to believe that they are receiving special treatment (Oade, 2018). Bullying behavior is not triggered by the environment in which the perpetrator works but is instead a phenomenon of intentional behavior. Moving the perpetrator to another work unit is merely shuffling the

problem around the organization (Oade, 2018). Furthermore, moving the target to another work unit may be viewed as punishment for reporting and may further decrease reporting incidents of bullying (Oade, 2018).

Targets often find themselves with nowhere to go when they experience episodes of bullying. Many organizations have employee assistance programs (EAP) available to their employees. However, EAPs have shown to be ill-equipped to handle bullying complaints and lack the expertise to identify bullying when it's occurring (Meglich-Sespico et al., 2007). Those who provide services through EAPs may miss the symptoms of bullying and inaccurately attribute them to medical illness and/or psychosomatic complaints (Meglich-Sespico et al., 2007). This leaves the targets feeling like they are being treated for the symptoms rather than the root cause of their problems. Additionally, there is often no recourse for targets from their human resource department. Ferris (2009) discussed the role of human resources departments and their inability to facilitate solutions for bullying behavior. The author describes human resource personnel in terms of "wolf in sheep's clothing" where the intent of their existence is cloaked in providing assistance to employees, but their real value is now in managing employees to meet organizational expectations instead of looking after employee welfare (Ferris, 2009). When employees report bullying, the human resources department either turns targets away, are reluctant to consider negative acts as bullying even when meeting criteria and fail to see the extent of bullying within the organization (Ferris, 2009). Unable to meet their needs through EAP and human resources, targets feel more frustrated and less confident in their organization.

With the lack of effective strategies to mitigate peer-to-peer bullying in healthcare, there should be no surprise that nurses continue to suffer. When organizations fall short in offering solutions to workplace bullying, targeted individuals and managers may feel that they have no recourse when bullying occurs (American Nurses Association, 2015; Ferris, 2009; Namie & Namie, 2009b). Finding and using effective methods to control workplace bullying is imperative

to create an organizational culture that deters negative acts, allows managers to handle bullying and provides applicable solutions when bullying does occur. Increasing EI by utilizing DBTconcepts may be useful in managing workplace bullying.

Emotional Intelligence in Response to Peer-to-Peer Bullying in Nursing

The nursing profession is highly regarded for caring for the health and welfare of communities. However, the care that nurses provide to society is not often received within their places of employment. Duffy (2009) describes organizations as either high caring or low caring, which encompasses the quality of social relationships within the organization. In low care organizations, employees are poorly supported as is true in hierarchal, authoritative and procedurally based professions such as nursing (Duffy, 2009; Law et al., 2012; Vessey et al, 2009). In contrast, high care organizations foster nurturing, commitment and safety of their employees (Duffy, 2009). High care organizations utilize appropriate anti-bullying policy and interventions that protect the dignity and respect for all employees (Duffy, 2009). One method to move an organization from a low caring environment to a high caring environment may be providing training in EI to the employees.

History and Definition of Emotional Intelligence

EI was termed by Salovey and Mayer (1990) as "a set of emotional and social skills that influence the way we perceive and express ourselves, develop and maintain social relationships, cope with challenges, and use emotional information in an effective and meaningful way." Stein and Book (2011) further highlight that EI allows individuals to use internal and external emotional information to maneuver through social and political aspects of work life. Those with higher EI are better able to understand their strengths and weaknesses and use their emotional knowledge to foster positive relationships within their work environment. Although EI has become more popular recently, Charles Darwin studied emotions and human survival as early as the 1870s (Stein & Book, 2011). Research again emerged in the early 21st century with Edward

Thorndike's "social intelligence" in the 1920s, followed with R.W. Leeper's idea of "emotional thought" in the 1940s and Albert Ellis' Rational Emotive Behavioral Therapy in 1955 (as cited in Stein & Book, 2011, p. 14 – 15). Several decades later, Howard Gardner began studying differing intelligences including "intra-psychic abilities and personal intelligence" and the term "emotional quotient" was coined by Reuven Bar-On in the 1980s (as cited in Stein & Book, 2011, p. 15). Finally, in 1990, Mayer and Salovey studied what is now known as EI and developed with David Caruso the Mayer-Salovey-Caruso Emotional Intelligence Test that is now commonly used to empirically assess emotional abilities (Stein & Book, 2011). Unlike cognitive intelligence, EI can be predictive of success and, fortunately, can be developed through training and practice (Stein & Book, 2011).

Conceptualization of Emotional Intelligence in Workplace Bullying

As described, perpetrators of workplace bullying may express characteristics of low EI and may benefit from developing better emotional skills. EI can be viewed on a continuum of high to low emotional skill and includes self-perception, self-expression, interpersonal, decision-making, stress management and happiness (Stein & Book, 2011). Stein and Book (2011) described self-perception as the "inner self" where one is aware of feelings, feels strong and capable and has confidence in the pursuit of goals (p. 51). Those with low self-perception abilities often lack emotional self-awareness and self-regard, which may result in bullying behaviors to protect and defend perpetrator's ego (Piotrowski, 2016). Of all the EI abilities, self-awareness is the foundation to build all other aspects of EI and should be developed for successful personal and professional outcomes (Stein & Book, 2011). EI self-expression consists of the abilities to appropriately express emotion and develop assertive behavior. While merely expressing our emotions (verbally and non-verbally) is part of the equation, doing so in a manner that fosters our needs and is respectful to other people is essential to behaving assertively (Stein & Book, 2011).

Perpetrators of workplace bullying may fall short on the continuum of appropriately expressing their emotions and negatively affect their ability to maintain positive interpersonal relationships (Wilson & Nagy, 2017). Interpersonal skills are at the pinnacle of both social and professional relationships. People high in interpersonal skills are able to interact and relate to other people in meaningful ways, which allows them to be well-functioning members of a team (Stein & Book, 2011). The interpersonal realm of EI includes the abilities to form interpersonal relationships, use empathy and show social responsibility in both personal and professional life, which may be quite poor in perpetrators who exhibit behaviors of the dark triad (O'Boyle et al., 2012; Piotrowski, 2016; Stein and Book, 2011). Those who lack positive interpersonal skills may resort to negative behaviors and knowingly or unknowingly perpetrate workplace bullying. Additionally, perpetrators may have difficulty with reality testing, problem solving and impulse control and exhibit poor decision-making ability. People who can to use emotions to understand problems, factually understand situations and manage impulses in a systematic manner to make the best choice (Stein & Book, 2011).

Emotionally intelligent people are also better able to manage stress related to the oppressing and demanding work that nurses perform. Using stress management by maintaining flexibility and optimism, people can tolerate stressful situations in constructive and productive ways and may lessen the need to lash out at coworkers (Stein & Book, 2011). Happiness is most recent realm of EI and, in definition, is the "ability to be satisfied with your life, enjoy yourself and others and to have fun" by combining "self-satisfaction, general contentment and the ability to enjoy life" (Stein & Book, 2011, p. 219). It may be assumed that happiness and high EI are negatively correlated to negative acts and that improvement of EI will decrease perpetration of workplace bullying (Law et al., 2011; Oade, 2018).

Positive Individual and Organizational Effects of Emotional Intelligence

There is significant research on the positive effects of high EI that includes better social and work relationships and greater resilience (Stein & Book, 2011). Schutte and Loi (2014) related higher EI to the ability to flourish both personally and professionally. Kotsou et al. (2011) described higher EI in association to improved mental and physical health and relationships as well as lower stress and increase feelings of well-being. Organizationally, people with higher EI show higher levels of group involvement and organizational citizenship, better performance and higher job commitment (Kotsou et al., 2018). The opposite is true for those having low EI. Low EI has been linked to mental health problems such as depression, anxiety, negative affectivity and attention deficit disorder (Megias et al., 2007; Piotrowski, 2016). As Kotsou et al. (2015) explained, all diagnosis under axis I and axis II disorders, such as the dark triad of personality traits, include a level of emotional dysregulation and encompass lower levels of EI. Lower EI has also been related to higher levels of interpersonal problems and those with lower EI are more likely to engage in CWB, including incivility, aggression and bullying (Kotsou et al., 2018; Law et al., 2011).

Although the problems associated with low EI may seem daunting, EI can be learned, practiced and increased (Stein & Book, 2011; Kotsou et al., 2011). In an empiric study of adult EI, Katsou et al. (2011) determined that EI is readily enhanced in what they call “emotional plasticity” (p. 827). Our use of emotions and personality characteristic involving emotions can be changed over time. Javaras et al. (2019) stated, “personality is not immutable but is dynamic and changing and mean levels of personality traits can change over time (p. 13). Changes in EI can occur through both individual and group interventions using concepts in cognitive and behavioral therapies (Stein & Book, 2011). Using the concepts of EI may be a method to managing workplace bullying and is an integral element in the practical application of this paper. DBT has

been shown to improve emotionally intelligent behavior and may be an ideal way to develop EI as an intervention to workplace bullying.

Dialectical Behavioral Therapy Skills and Emotional Intelligence

History of Dialectical Behavioral Therapy

DBT has been used to increase EI in both clinical and non-clinical environments and may be a method to intervene in workplace bullying. Marsha Linehan's study of DBT was seeded by her own struggles with mental illness and psychiatric hospitalization as a teen in the early 1960s (Carey, 2011). Linehan, diagnosed as schizophrenic, described her struggle with emotional dysregulation and inability to stop her destructive behaviors, including suicidal attempts and self-injurious behavior (Carey, 2011). Linehan also described the ineffective therapies she endured at the time – seclusion, electroconvulsive therapy, and strong psychotropic medications (Carey, 2011). As a consequence of her experiences, Linehan's intention was to help others who were suffering as she had (Carey, 2011). Linehan's academic study and career focused on severely suicidal women and later borderline personality disorder (Carey, 2011; Flynn, 2014). In the 1970s, cognitive behavioral programs where highly used as therapy for suicidal clients, but Linehan found that treating suicidal clients lacked humanistic characteristics that these fragile clients required (Flynn, 2014). To provide support to these clients, Linehan then focused on purely humanistic therapy that provided the validation that vulnerable clients needed. Unfortunately, this approach was deficient in the structural methods required for the clients to make the changes required to move into mental health (Flynn, 2014). Throughout the research on suicidal women, and later borderline personality disorder, Linehan combined concepts from cognitive behavioral therapy, validation therapy, the use of meditative prayer and 35 years of Zen practice to treat clients with severe emotional regulation dysfunction (Flynn, 2014; Frazier, 2014, Linehan, 2015).

Components of Dialectical Behavior Therapy

DBT is closely related to EI and may be an ideal way to increase emotional competency and decrease workplace bullying behavior. DBT is an intensive therapy that includes weekly individual therapy sessions combined with weekly group skills instruction (Linehan, 2017). The focus of DBT is behavioral and emotional regulation as the clients move through four learning modules – mindfulness, interpersonal effectiveness, distress tolerance and emotional regulation (Linehan, 2017). Mindfulness is central to the program, is the concept that starts the therapeutic intervention and is revisited at each individual session and group skills class. Mindfulness training increases self and social awareness and supports EI through-self management, interpersonal relationships and decision-making (Justo et al., 2018). Distress tolerance is accomplished through reality testing and radical acceptance of the client's situation by a realistic appraisal of their situation. Distress tolerance is related to EI concepts of self-regulation, social awareness and decision-making skills (Justo et al., 2018).

As noted, DBT is a therapy that works toward regulating an individual's emotions and the emotional regulation module is essential with assisting the client in perceiving and moderating the emotions in an individual's self and those exhibited by others, which reduces emotional vulnerability (Justo et al., 2018). DBT teaches empirically tested methods to increase interpersonal effectiveness through behavior modification and increased ability in communication (Justo et al., 2018). Interpersonal effectiveness is vital to effectively reaching individual goals in a social context using EI themes of social awareness, relational skills and effective decision-making. Not only are clients validated during DBT, they are also taught validation methods to nurture themselves as well as positive social relationships (Linehan 2015 & 2017). Javaras et al. (2019) discussed the use of DBT as a method to increase client flexibility of thoughts, emotions and situations. There is empiric evidence that the use of DBT increases

physical and psychological well-being, mood, interpersonal abilities and coping skills while decreasing maladaptive behavior (Justo et al., 2018; Moore et al., 2018)

Clinical Uses of Dialectical Behavioral Therapy

Since 1993, DBT has been the primary treatment for borderline personality disorder (Linehan, 2017). The hallmark of borderline personality disorder is emotional dysregulation, which is shared by other clinical and non-clinical problems (Moore et al., 2018). Other clinical uses for DBT include symptoms of depression and anxiety, post-traumatic disorder, substance abuse, disturbances of cognition, self injurious behavior, interpersonal problems, impulsivity and attention deficit disorder, weight management, personality disorders, aggression and anger management (Frazier and Vela, 2014; Javara, Williams & Baskin-Sommers, 2019, Linehan, 2017). Javara et al. (2019) described DBT as a "third wave therapy" for behavioral modification combining cognitive, behavioral and emotional techniques. DBT shifts the client toward acceptance and commitment and uses techniques to help clients better respond to thoughts and emotions by "focusing on the context and function of behaviors, thoughts and emotions rather than their content" (Javaras et al., 2019, p. 15). Moore et al. (2018) discussed that DBT uses learning theory to recognize what causes and reinforces dysfunctional behavior while helping the client adapt more functional behaviors and skills. Given the many therapeutic uses, DBT has become a popular form of therapy over the past 20 years.

Non-Clinical Uses of Dialectical Behavioral Therapy

Although DBT was developed and researched for the treatment of clients with emotional dysregulation, the skills have been shown to be effective in non-clinical environments as well. New editions of Linehan's (2015; 2017) DBT manual and skills training publications noted the application of DBT skills for non-clinical uses and issues that are not related to a clinical diagnosis, such as in schools and for corporate use. In fact, she states "businesses will find DBT skills useful in creating better work environments" (Linehan, 2015, p. vii). Justo et al. (2018)

studied and supported the effectiveness of DBT used with teachers to decrease stress and burnout, increase health promotion and increase effectiveness in the classroom. (Justo et al., 2018). Moore et al. (2018) discussed a broader use of DBT and studied the effects of skills training with non-violent jail inmates without a mental health diagnosis. Their study supported DBT as an effective method in improving interpersonal skills in this population. Although there is no empiric research on the effects of DBT skills as an intervention with workplace bullying, the success of DBT in the many clinical and non-clinical settings may lead to effective use to support the targets of peer-to-peer bullying and reduce negative behaviors exhibited by perpetrators of negative acts. More research is needed on the application of DBT to this context to determine if this is a potentially useful strategy to reduce the incidence of workplace bullying.

Summary of Literature Review

Having been studied for the past four decades, peer-to-peer bullying is not a new phenomenon. Not only has bullying been shown to be an epidemic problem for but is recognized internationally as well. As the problem continues, workplace bullying is increasing in incidence and prevalence. Nurses that are targeted endure unique forms of bullying related to their work, environment, organizational structure and professional culture. Additionally, research has supported that character traits and personality are integral factors in workplace bullying (Piotrowski, 2016; Wilson & Nagy, 2017). Those with dark triad traits are more likely to be perpetrators of workplace bullying, as are those with low self-esteem and professional insecurity (Piotrowski, 2016; Van Heugten, 2009). Targets suffer psychological, physical, social and professional consequences at the hands of the perpetrators of bullying (Carter et al., 2013). Organizations are not immune to the effects of workplace bullying and incur financial losses through impaired productivity, absenteeism, presenteeism and turnover as well as damage to organizational reputation (Ferris, 2009).

Despite the organizational consequences, peer-to-peer bullying is largely ignored or, as revealed in research, organizations continue to utilize ineffective interventions (Namie & Namie, 2009b; Law et al., 2011). Organizations have been largely unsuccessful in reducing workplace bullying either because of lack of awareness or lack of concern. For instance, mediation continues to be the most frequently used intervention for workplace bullying despite being ineffective and potentially cause more harm to the target (Namie & Namie, 2009b). Interventions at the organizational level are often aimed at zero-tolerance policy, which is difficult to enforce and does not include the root causes of bullying at the individual level. Even the best zero-tolerance policy will fall short of solving the problem if it does not include individual remediation for perpetrators and support for targets. It is essential that organizations combine a well-written zero-tolerance policy that focuses on developing appropriate behavior for the perpetrator and support for the target. Although it is unlikely that workplace bullying will be fully eradicated, peer-to-peer bullying may be more effectively managed when organizations focus on both organizational policy and individual level interventions (Namie & Namie, 2009).

As reviewed, the personal consequences of bullying on nurses are extensive and possibly debilitating (Hutchinson et al., 2010; Namie & Namie, 2009b). Nurses suffer not only the actions of the perpetrator, but also may be targeted again by organizational deficiency in managing bullying. Additionally, organizations suffer both tangible and hidden costs because of bullying, which include financial loss, productivity loss and loss of human expertise (Hutchinson et al., 2010). It is evident that research on more effective interventions for workplace bullying is needed for both the welfare of nurses and healthcare organizations (American Nurses Association, 2015; Hutchinson et al., 2010). Possible interventions include an emphasis on training focused on the importance of EI and even the application of a DBT intervention to address bullying behavior. Specifically, EI has become an important area of study in psychology and specifically organizational psychology. EI is essential to individual well-bing and

professional success (Stein & Book; 2011). In fact, those with high EI have been shown to perform better in their jobs than those with low EI. High EI is also related to positive interpersonal relationships and improved decision-making ability, which perpetrators of bullying may lack (Wilson & Nagy, 2017). One successful method of increasing EI in individuals may be the use of DBT skills that focus on improving emotional competence through behavioral and cognitive skills. Research in the use of DBT showed an increase in skills that are related to EI and these same interventions may even reduce behaviors exhibited by individuals who perpetrate bullying (Moore et al., 2018). Additionally, using validation and acceptance-based techniques may be effective in acknowledging and supporting targets of peer-to-peer bullying. DBT has the potential to be a legitimate method to increase EI in perpetrators and support targets, especially when combined with a modified zero-tolerance policy against bullying to effectively manage peer-to-peer bullying in nursing.

Recommended Organizational Policy and Individual Interventions

Organizational Assessment

The World Health Organization takes a hard stand on workplace bullying and stated that the organizational work environment should protect employees against psychosocial hazards just as is expected with physical hazards (Burton, 2010). They recommended that organizations recognize, assess and control psychosocial hazards at the source if possible or modify the behavior (Burton, 2010). Effective anti-bullying policy and procedure may reduce employee suffering and organizational costs related to bullying (Meglich-Sespico et al., 2007). It is important that organizations make respectful workplaces a core value and to maintain surveillance of bullying incidence within the organization (Meglich-Sespico et al, 2007). The primary intervention for workplace bullying is acknowledging and assessing the problem (American Nurses Association, 2015).

Seeking advice from a consulting organizational psychologist can be vital to organizations that are working toward healthy and respectful workplaces. One way that the organizational psychologist can make an impact in organizations with peer-to-peer bullying would be to provide awareness of workplace bullying through empirical assessment measures to determine the types and extent of bullying in the organization (American Nurses Association, 2015; Ferris, 2009). To facilitate the first phase of the intervention, the organizational psychologist should conduct a thorough assessment of bullying through an organization-wide survey of bullying followed by semi-structured interviews of randomly selected employees. For example, the Negative Acts Questionnaire-Revised (NAQ-R,) a 22-item questionnaire of behaviors common to workplace bullying, is one of the most common surveys used to determine bullying behavior in organizations and has shown high reliability and validity (Einarsen, et al., 2009). The organizational psychologist should administer the NAQ-R to employees with an incentive for each work unit that has a response rate of 75% or higher, thus encouraging high participation among organizational employees. After statistical analysis of NAQ-R results, the organizational psychologist should conduct randomized, semi-structured interviews with a goal of interviewing a representative sample of the employees to produce a picture of the nature of bullying in the organization. Semi-structured interviews can provide perceptions of workplace bullying and rich illustrations of the problem (Ferris, 2009). The results of the data should be provided to the chief executive officer and senior leadership to define the problem and construct organization specific interventions. It is imperative that senior leadership drive the change toward a respectful workplace culture (Ferris, 2009; Namie & Namie, 2009b).

Healthy Workplace Policy Development

Healthcare organizations must set the expectation for nurses to promote healthy relationships in their workplace (American Nurses Association, 2015). Additionally, the American Nurses Association's (2015) code of ethics holds nurses accountable to use and model

professional behavior that is civil and respectful. After assessing bullying in the organization, a carefully constructed respectful workplace policy should be implemented. The intention of the policy is to create an organizational culture of civility and decrease bullying behaviors. As previously discussed, any interventions proposed without adequate policy will be less likely to be effective (Namie & Namie, 2009b). Namie and Namie (2009b) contended that responsive organizations view bullying as an organizational problem and provide prescriptive policy and procedure to effectively manage workplace bullying. Organizational policy should make a clear statement about the organizations values, what behavior is and is not acceptable and how employees are expected to work within the organization and its culture. Organizations that take a stern stance on bullying are more likely to be perceived as credible and fair (Namie & Namie, 2009).

To facilitate the change to a respectful workplace culture, the organization's bullying policy should be simple and easy to understand as well as readily available to employees in hardcopy and found on the organizational intranet (Ferris, 2009; Oade, 2018). A healthy workplace policy should include the mission and values of the organization as they relate to a respectful workplace and guide the expectations for employee conduct (Ferris, 2009). The policy should emphasize a work environment that is free from psychological harm, provide a clear definition of bullying behaviors, highlight the effects of workplace bullying, clearly state the consequences of peer-to-peer bullying and describe expectations of both the perpetrator and the organization (Law et al., 2011; Namie & Namie, 2009b; Oade, 2018; Van Heugten, 2009).

Based on previous research showing flaws in zero-tolerance approaches, the Respectful Workplace Policy should include a modification of zero-tolerance that provides a more humanistic approach to workplace bullying (Ferris, 2007). The modified zero-tolerance serves as a top-down intervention that is most effective when enforced by senior leadership through development and implementation (Ferris, 2007; Namie & Namie, 2009b). Important

modifications should include the responsibility of the organization and the perpetrator of bullying, remedial and corrective action for those who perpetrate bullying and support for the targeted employee (See Appendix A; Namie & Namie, 2009b). The policy should elicit a sense of confidence and safety for the target, which may increase the likelihood of targets to report incidents of bullying (Meglish-Sespico, 2007). Although even the best policy may not completely eradiate workplace bullying, a well-written policy will provide a process to handle bullying when it does occur (Duffy, 2009; Namie & Namie, 2009b).

Underreporting has been problematic for resolving workplace bullying (Carter et al., 2013). The respectful workplace policy should not only encourage reporting but should also create an effective means for targets to report incidents of bullying. The policy should include informal and formal methods that are easily accessible for reporting (Ferris, 2009). The initiation of a complaint should be in the form of an intranet-based application where the target can begin the process in a confidential manner. To provide non-biased investigation of bullying complaints, the organization should utilize a respectful workplace committee to serve as bullying ombudsmen that includes members of the organization who are invested in a respectful culture (Meglich-Sespico et al., 2007; Oade, 2018). Members of the respectful workplace committee should be chosen from applications submitted by employees representing different organizational departments and business units. Having a group of employees with diverse jobs and backgrounds may be beneficial in leading an organizational change. Leadership and human resources should not be included in the respectful workplace committee to eliminate a conflict of interest and increase the target's confidence in the process (Ferris, 2009). The members of the committee should be trained by the organizational psychologist to use sound methods of identifying and investigating workplace bullying. The investigation of bullying complaints should be the sole responsibility of the respectful workplace committee and the investigation should adhere to the definition and behaviors central to the Respectful Workplace Policy. All complaints of bullying

and the parties involved should remain confidential until the respectful workplace committee substantiates the complaint. If the complaint of bullying is substantiated, the perpetrator's immediate manager should be notified and provided a copy of the individual interventions and performance plan. Additionally, a copy of the respectful workplace committee's report should be placed in the employment file of the perpetrator.

When a complaint is initiated, the committee should assign a designated target support liaison within 24 hours of the complaint. Target support liaisons are members of the organization who have applied and been selected by the Respectful Workplace Committee to serve as an unbiased third party and are trained in supportive techniques provided by the consulting organizational psychologist (Namie & Namie, 2009b; Oade, 2018). Namie and Namie (2009b) noted that peers can be trained as experts in identifying and investigating bullying and may be trained to support targets. The organizational psychologist should provide training to one support liaison per work unit to allow for adequate availability of liaisons. Having support liaisons throughout the organization should facilitate assigning non-biased support outside of the target's work unit and is intended to reinforce confidentiality (Tehrani, 2012). There also may be incidents where both parties in the incident identify as the target of bullying and each may require a support liaison, which is facilitated by a larger pool of available liaisons. Additionally, an adequate number of individuals trained to support targets to reduce emotional strain from providing support (Tehrani, 2012). The target support liaison serves to provide emotional support solely to the target and to aid the target in maneuvering through the reporting and investigation process (Tehrani, 2012). The support liaison's focus is on the target rather than the organization and their responsibilities include acknowledging, validating and advocating the target's perspective of the experience (Tehrani, 2012). Providing target support is essential in creating an emotionally safe work environment.

Individual Intervention for Perpetrators

Effective policy is essential for perpetrators to realize that the organization is serious about eradicating bullying behaviors and, because all employees are expected to follow the Respectful Workplace Policy, the perpetrator may not feel singled out or feel special (Namie & Namie, 2009b). The Respectful Workplace Policy prescribes detailed remedial actions for the perpetrator of bullying and holds them accountable for confirmed policy violations. Namie and Namie (2009b) and Thobanen (2011) strongly recommend that anti-bullying policy include innovative remedies that include interventions up to termination. The Respectful Workplace Policy describes the options to employees who have substantiated complaints of bullying – consent to participate in the intervention program (including psychometric assessment) or immediate termination. The goal of interventions for the perpetrator should be to clarify expectations and immediate behavioral changes. Namie and Namie (2009b) remarked that the start of a behavioral intervention is the first time that the perpetrator hears that the needs of the organization surpass their personal agenda. For employees who chose to proceed with the intervention, they should be assured that the costs of the intervention will be covered by their employer. Additionally, sessions with the organizational psychologist and DBT coach will occur during the workday and be compensated at their normal rate of pay.

It is recommend that after receiving signed consent, the intervention for the perpetrator should proceed with a psychometric assessment by the organizational psychologist using a traditional personality measure, the Trait Emotional Intelligence Questionnaire-SF (TEIQue-SF) and the Trait Emotional Intelligence Questionnaire-360-SF (TEIQue-360-SF) (Kostou et al., 2011). A generalize personality assessment could also be used to assist the perpetrator in understanding their dominant personality traits and allow the organizational psychologist to create an individual intervention plan, which is be formally referred to as an Individual Employee Development plan. The perpetrator should be given assurance that the personality

assessment will not become part of their employment record, will be used only for employee development and guarantee strict confidentiality. The TEIQue-SF is a 30 item, Likert-style assessment measure completed by the perpetrator of bullying to self-report their level of EI (Kostou, 2011). The TEIQue-SF has been found to be a reliable and valid for measuring EI (Kotsou, 2011). However, perpetrators may be motivated to favorably present themselves to the organization, answers they provide on the self-report measure may represent a social desirability response bias. Therefore, the TEIQue-360-SF should be administered to the immediate managers of the perpetrator. The TEIQue-360-SF is a reliable and valid measure for informant reports of the perpetrator's global EI (Kotsou, 2011). Administering both the TEIQue-SF and the TEIQue-360-SF may provide a well-rounded view of the perpetrator's EI ability and may shed light on any gaps between the perceptions of the perpetrator and their displayed emotional abilities. With the results of assessments, the organizational psychologist should devise an individual intervention and performance planning. As highlighted by the American Nurses Association (2015) it is important that the performance plan be specific in what actions the perpetrator must take and a timeline for doing so.

After the psychometric assessment, the organizational psychologist should create an individual employee development plan for the perpetrator. The individualized intervention should include coaching with a professional certified in DBT skills training. Namie and Namie (2009b) reported that coaching interventions develop interpersonal, emotional and career development skills on an individual basis and that much of the coaching provided is to "restructure the perpetrators work reality" (p. 212). DBT for mental health disorders occurs over a one-year program with a licensed that includes a weekly therapy session and a weekly group skills class (Linehan, 2017). Unlike DBT for clinical use, Frazier and Vela (2014) found that DBT skills training in non-clinical environments does not require a licensed therapist but can be taught by professionals certified in skills instruction. Moore et al. (2018) researched the use of

abbreviated DBT skills training and found that programs as short as eight weeks rather than 12 months can be effective in modifying behavior. The coaching program for perpetrators should ideally include eight weekly sessions with the DBT coach and, as recommended by Frazier and Vela (2014), should require the employee to study and practice DBT skills using homework sheets between coaching session (Appendix B for a sample abbreviated DBT skills plan for perpetrators). Additionally, weekly attendance should be required for continued employment. Certification can be obtained with training through Behavioral Tech, an organization founded by Linehan (2017a). The organization should provide training and certification through Behavioral Tech to professional employees who are invested in creating a respectful workplace. It is recommended that the DBT coaches work closely with the organizational psychologist and strictly follow the employee's individual employee development plan. A post-intervention assessment of EI should be completed at the end of the eight-week course and compared with the pre-intervention assessment.

The Individual Employee Development Plan should be provided to the perpetrator's immediate manager and include a performance plan for the manger to follow. Performance monitoring for the perpetrators of bullying is an essential component of the Respectful Workplace Policy and the Individual Employee Development Plan (American Nurses Association, 2015; Namie & Namie, 2009b). The performance plan should follow the definition of bullying and the description of bullying behaviors as documented in the Respectful Workplace Policy. The immediate manager works closely with employees and can monitor the behaviors of the perpetrator through the course of his or her work. The manager must be required to hold the perpetrator accountable for the behavior that they express at work and to report any continuation of bullying to the organizational psychologist (Oade, 2018). If necessary, additional coaching sessions may be required. Continuation of bullying should result in termination. Regularly evaluating the perpetrator's work behavior is an important means of maintaining high standards

of conduct (American Nurses Association, 2015). The bully's manager should complete a performance appraisal that focuses on bullying behaviors on a quarterly basis for a period of one year after the completion of coaching.

Individual Intervention for Target

Interventions for employees targeted by bullying are designed to treat the specific injuries that occur with bullying, to regain belief in themselves and an enthusiasm for work and to protect themselves from further attack (Meglich-Sespico et al., 2007; Oade, 2018). Support to those targeted by bullying must be underscored by individual interventions that are intended to provide if being bullied and the emotional consequences. The psychological harm suffered by targets should be viewed as an organizational responsibility and supportive services should be provided as an option to targets (Namie & Namie, 2009b). Support services should be held in strict confidentiality and not be made part of the employment record.

It is recommended that the first line of support to those affected by bullying should be provided by a target support liaison. At a minimum, the target support liaison should check in with the target on a regular basis to make certain that the bullying has stopped and that there is no retaliation against the target (American Nurses Association, 2015). The assigned target support liaison is designed to emotionally support the target and should work with the affected employee to rebuild a sense of safety and trust. Namie and Namie (2009) note that mere acknowledgement of the experience assists individuals in reducing stress caused by the bullying event, loss of power and loss of control over their work life. Many targets may feel adequate support through their relationship with the target support liaison. However, many may require more in-depth supportive measure.

Employees who have suffered significant emotional harm beyond the abilities of the target support liaison should be offered individual coaching sessions with a certified DBT skills coach. If the target chooses DBT coaching, it is important that the target be encouraged to

complete the entire six-week coaching sessions. The DBT coach should use the concepts of DBT to help the target manage and reduce the lingering effects of workplace bullying. Coaching should include measures to debrief the target and include an individualized DBT skill plan to assist the employee with grieving the perceived losses, accepting the bullying experience and moving toward healthy coping (See Appendix C for a sample abbreviated DBT skills plan for targets). In addition to validating the experience of the target, training in mindfulness skills is central to the coaching process. Targets should be taught DBT skills that generate mindfulness in the present moment to reduce psychological symptoms of bullying. Targets may be unable to organize and regulate their emotions related to the bullying event. DBT skills of emotional regulation and distress tolerance are intended to help the targeted employee correctly identify and manage the distressing emotions related to their experience. These include skills that can be used when feeling distressed to reduce physical responses to emotions that frequently accompany fear, anxiety and anger. Lastly, coaching DBT skills that increase interpersonal effectiveness to allow the target to regain their personal power and control over their work situation.

Targets of bullying may exhibit symptoms of diagnosable depression, anxiety and PTSD, which are beyond the scope of the organizational psychologist. Mental health restoration at this level is imperative and targets may require psychological support beyond that available by the organization. Targets with this level of psychological harm may require the care of licensed therapist who has knowledge of and experience in treating exposure to workplace bullying. The organization should encourage individual therapy with the psychologist of the targets choice or the organization should refer the employee to appropriate therapists. Therapy of this nature may be covered under insurance for those who are enrolled in the organization's health plan. Financial assistance must be available for copay charges and for those not covered under the employee health insurance.

Discussion and Future Research

The purpose of this review is to inform the reader of the epidemic phenomenon of peer-to-peer workplace bullying between nurses and to provide a possible solution to this worldwide problem. Although there is ample literature defining workplace bullying, discussing consequences to individuals and organizations and theorizing possible causes, there is a research gap in effective interventions aimed to reduce bullying. Despite intervention attempts at either the organizational or individual level, peer-to-peer nursing is on the rise and needs to be stopped (Hutchinson et al., 2010; Namie & Namie, 2009b). This paper offers possible interventions at both individual and organizational levels, including a modified zero-tolerance policy and procedure and interventions for remediation of perpetrator behavior and to emotionally support the target. It is noted that the use of DBT in the organizational setting and for the use in workplace bullying has not been researched or empirically tested. Although the interventions are based on existing literature, the concepts are in their infancy and will require further examination. Limitations of the interventions include the cost of devising a complex system using an external consulting organizational consultant, training employees for the Respectful Workplace Committee and as Target Support Liaisons as well as individual assessments and coaching sessions. However, with the exorbitant cost of bullying that organizations face, the benefits of implementing interventions such as described here may outweigh the costs in the end (Carter et al, 2013; Namie & Namie, 2009b; Oade, 2018). Another limitation noted is the amount time it would take to assess, plan and implement the project as well as ongoing management of the program and training after the implementation is fully functioning. Immediate improvement would be quite optimistic and there may be a honeymoon period of improvement initially. However, organizations that are dedicated to creating an environment free of workplace bullying will be invested not only in the implementation, but also with leading employees toward a lasting cultural change (Ferris, 2009, Joint Commission, 2016). Lastly, any intervention must be

researched using empiric methods. It is recommended that scientific research be conducted on the effective use of DBT for developing EI in the organizational setting, remediation of perpetrators and the support of target separately and, eventually, together with a modified zero-tolerance policy as presented here.

Although this paper is confined to the narrow scope of peer-to-peer bullying between nurses, there are innumerous areas of research on the topic of workplace bullying. For instance, this literature touches upon organizations who are unaware or do not acknowledge the acts of bullying occurring in their work environment (Namie & Namie, 2009b). Without awareness or motivation to change the organizational culture, any intervention would likely fail. An important area of study would be how to create awareness within the organization that would drive a need for change. This paper purposely did not discuss leadership effects on bullying between nurses because this area of research is extensive, beyond the scope of this review and deserves its own focus. Research using EI and DBT to develop managers who can manage bullying at the department level may be especially impactful. Abusive supervision by management is also absent from this paper and may require a separate area of study. There is a different dynamic with top-down bullying behavior because of the large differential in real power between the manager and the subordinate (Bortoluzzi et al., 2013; Hutchinson & Hurley, 2012). Studying EI and DBT training on this population would be intriguing. As noted, bullying in nursing often begin during nurses training and there is literature regarding bullying between faculty nursing instructors (Sheriden-Loes, 2008). An interesting area of research would be bullying behaviors in these populations along with interventions that may decrease bullying at the level of the nursing profession. Finally, there is an age gap beginning to emerge in the nursing profession as those in the Baby Boomer generation remain employed and nurses in the Millennial generation are entering the nursing field. With the older generation often working within a strict hierarchal orientation and the Millennial generation needing fairness and justice, there may be dynamics

between the two that could lead to intergenerational bullying in nursing (Rodwell et al., 2013). Interesting questions for the melding of these two generations would include the incidence of bullying by more senior nurses and how Millennial nurses handle these situations. It is obvious that the problem of peer-to-peer bullying in the nursing profession is not only unique, but also vast (Blackstock et al., 2014, Joint Commission, 2016). Each area of study brings new information, ideas and possible solutions to problem of workplace bullying in nursing. With continued research on potential cause and possible interventions, bullying in healthcare may become a thing of the past.

References

American Nurses Association. (2015). Incivility, bullying, and workplace violence. Retrieved March 30, 2019, from https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/incivility-bullying-and-workplace-violence/

Bambi, S,. Becattini, G., Giusti, G. D., Mezzetti, A., Guazzini, A., & Lumini, E. (2014). Lateral hostilities among nurses employed in intensive care units, emergency departments, operating rooms, and emergency medical services. *Dimensions of Critical Care Nursing*, *33*(6), 347-354. Doi:10.1097/dcc0000000000000077

Bibi, Z., Karim, J., & Din, S. U. (2014). Workplace incivility and counterproductive work behavior: Moderating role of emotional intelligence. *Pakistan Journal of Psychological Research, 28*(2), 317-334. Retrieved from https://www.researchgate.net/publication/261879555_Workplace_Incivility_and_Counterproductive_Work_Behavior_Moderating_Role_of_Emotional_Intelligence_Siraj_ud_Din

Blackstock, S., Harlos, K., Macleod, M.L., & Hardy, C.L. (2014) The impact of organizational factors on horizontal bullying and turnover intentions in the nursing workplace. *Journal of Nursing Management, 23*(8), 1106-1114.

Bortoluzzi, G., Caporale, L., & Palese, A, (2013). Does participative leadership reduce the onset of mobbing risk among nurse working teams? *Journal of Nursing Management, 22*(5), 643-652.

Brown, L., & Middaugh, D. (2009). Nurse hazing: A Costly reality. *Nursing management, 18*(5), 305-307

Burton, J. (2010). WHO healthy workplace framework and model: Background and supporting literature and practices. Retrieved March 30, 2019, from http://www.revistavirtualpro.com/biblioteca/entornos-laborales-saludables-fundamentos-y-modelo-de-la-oms-contextualizacion-practicas-y-literatura-de-apoyo-ingles-

Carter, M., Thompson, N., Crampton, P., Morrow, G., Buford, B., Gray, C., & Illing, J. (2013). Workplace bullying in the UK NSH: A questionnaire and interview study on prevalence, Impact and barriers to reporting. BMJ Open, 3(6). Doi:10.1136/bmjopen-2013-002628

Carey, B. (2011). Expert on Mental Illness Reveals Her Own Struggle. Retrieved April 13, 2019, from http://archive.nytimes.com/www.nytimes.com/2011/06/23/health/23lives.html

Douglas, K. (2014). Nurse eat their own: Bullying and horizontal violence takes its toll. *Australian Nursing and Midwifery Journal, 21*(8), 20-24. https://search.informit.com.au/documentSummary;dn=119111768888280;res=IELHEA ISSN: 2202-7114.

Duffy, M. (2009). Preventing workplace mobbing and bullying with effective organizational consultation, policies, and legislation. *Consulting Psychology Journal: Practice and Research, 61*(3), 242-262. doi:10.1037/a0016578

Einarsen, S., Hoel, H., & Notelaers, G. (2009). Measuring exposure to bullying and harassment at work: Validity, factor structure and psychometric properties of the Negative Acts Questionnaire-Revised. *Work & Stress, 23*(1), 24-44. doi:10.1080/02678370902815673

Ferris, P. A. (2009). The role of the consulting psychologist in the prevention, detection, and correction of bullying and mobbing in the workplace. *Consulting Psychology Journal: Practice and Research, 61*(3), 169-189. doi:10.1037/a0016783

Flynn, D. (2014). *Marsha Linehan - Interview* [Video file]. Retrieved April 13, 2019, from https://www.youtube.com/watch?v=fR7Oi0cyoVo

Frazier, S. N., & Vela, J. (2014). Dialectical behavior therapy for the treatment of anger and aggressive behavior: A review. *Aggression and Violent Behavior, 19*(2), 156-163. doi:10.1016/j.avb.2014.02.001

Giorgi, G., Ando, M., Arenas, A., Shoss, M. K., & Leon-Perez, J. M. (2013). Exploring personal and organizational determinants of workplace bullying and its prevalence in a Japanese sample. *Psychology of Violence, 3*(2), 185-197. doi:10.1037/a0028049

Hutchinson, M., & Hurley. J. (2012). Exploring leadership capability and emotional intelligence as moderators of workplace bullying. *Journal of Nursing Management, 21*(3), 553-562.

Hutchinson, M., Wilkes, L., Jackson, D., & Vickers, M. H. (2010). Integrating individual, work group and organizational factors: testing a multidimensional model of bullying in the nursing workplace. Journal of Nursing Management, *18*(2). 173-181. doi:10.1111/j.1365-2834.2009.01035.x

Hutton, S., & Gates, D. (2008). Workplace incivility and productivity losses among direct care staff. *American Association of Occupational Health Nurses Journal, 56*(4), 168-175.

Javaras, K. N., Williams, M., & Baskin-Sommers, A. R. (2019). Psychological interventions potentially useful for increasing conscientiousness. *Personality Disorders: Theory, Research, and Treatment, 10*(1), 13-24. doi:10.1037/per0000267

Johnson, S. L., & Rea, R. E. (2009). Workplace bullying concerns for nurse leaders. *Journal of Nursing Administration, 39*(2), 84-90. https://www.researchgate.net/profile/Susan_Johnson19/publication/23974699_Workplace_Bullying_Concerns_for_Nurse_Leaders/links/56f3fdd408ae38d7109f62f6.pd

Joint Commission. (2016). Bullying has no place in healthcare. Retrieved March 30, 2019, from https://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_24_June_2016.pdf

Justo, A. R., Andretta, I., & Abs, D. (2018). Dialectical behavioral therapy skills training as a social-emotional development program for teachers. *Practice Innovations, 3*(3), 168-181. doi:10.1037/pri0000071

www.pjprnip.edu.pk/pjpr/index.php/pjpr/article/download/329/327

Karim, J., Bibi, Z., Rehman, S. U., & Khan, M. S. (2015). Emotional intelligence and perceived work-related outcomes: Mediating role of workplace incivility victimization. *Pakistan Journal of Psychological Research, 30*(1).

Kolbeck, D. (2012). *Workplace bullying: Trauma spectrum symptoms in a community population of registered nurses* (Doctoral dissertation, Alliant International University, California School of Forensic Studies, Fresno, 2012) (pp. 1-152). Ann Arbor, MI: ProQuest.

Kotsou, I., Nelis, D., Grégoire, J., & Mikolajczak, M. (2011). Emotional plasticity: Conditions and effects of improving emotional competence in adulthood. *Journal of Applied Psychology, 96*(4), 827-839. doi:10.1037/a0023047

Law, R., Dollard, M. F., Tuckey, M. R., & Dormann, C. (2011). Psychosocial safety climate as a lead indicator of workplace bullying and harassment, job resources, psychological health and employee engagement. *Accident Analysis & Prevention, 43*(5), 1782-1793. doi:10.1016/j.aap.2011.04.010

Laschinger, H. K., & Nosko, A. (2013). Exposure to workplace bullying and post-traumatic stress disorder symptomology: The role of protective psychological resources. *Journal of Nursing Management, 23*(2), 252-262. doi:10.1111/jonm.12122

Linehan, M. (2015). *DBT skills training handouts and worksheets* (2nd ed.). New York, NY: The Guilford Press. doi:ISBN: 978-1-57230-781-0

Linehan, M. (2017). Behavioral Tech – Training, Continuing Education in Dialectical Behavior Therapy (DBT). Retrieved April 17, 2019, from https://behavioraltech.org/

Linehan, M. (2017). *DBT Skills Training Manual* (2nd ed.). New York, NY: The Guilford Press. ISBN: 978-1-4625-1699-5

Meglich-Sespico, P., Faley, R. H., & Knapp, D. E. (2007). Relief and Redress for Targets of all Workplace bullying. *Employee Responsibilities and Rights Journal, 19*(1), 31-43. doi:10.1007/s10672-006-9030-y

Megías, A., Gómez-Leal, R., Gutiérrez-Cobo, M. J., Cabello, R., & Fernández-Berrocal, P. (2018). The relationship between aggression and ability emotional intelligence: The role of negative affect. *Psychiatry Research, 270*, 1074-1081. doi:10.1016/j.psychres.2018.05.027

Moore, K. E., Folk, J. B., Boren, E. A., Tangney, J. P., Fischer, S., & Schrader, S. W. (2018). Pilot study of a brief dialectical behavior therapy skills group for jail inmates. *Psychological Services, 15*(1), 98-108. doi:10.1037/ser0000105

Namie, G., & Namie, R. F. (2009)(a). *The bully at work what you can do to stop the hurt and reclaim your dignity on the job*. Naperville, IL: Sourcebooks.

Namie, G., & Namie, R. (2009)(b). U.S. Workplace bullying: Some basic considerations and consultation interventions. *Consulting Psychology Journal: Practice and Research, 61*(3), 202-219. doi:10.1037/a0016670

Namie, G., & Namie, R. (2019). Workplace Bullying Institute. Retrieved March 23, 2019, from https://www.workplacebullying.org/individuals/problem/who-gets-targeted/

Nicholson, T., & Griffin, B. (2015). Here today but not gone tomorrow: Incivility affects after-work and next day recovery. *American Psychological Association, 20*(2), 218-225. Doi:10.1037.a0038376

Oade, A. (2018). Responding to an incident of bullying at work: An opportunity to create a zero-tolerance culture. *The Psychologist-Manager Journal, 21*(1), 75-83. doi:10.1037/mgr0000065

Occupational Health and Safety Administration. (n.d.) Workplace violence in healthcare: Understanding the challenge. Retrieved March 30, 2019, from https://www.osha.gov/Publications/OSHA3826.pdf

O'Boyle, E. H., Jr., Forsyth, D. R., Banks, G. C., & McDaniel, M. A. (2012). A meta-analysis of the dark triad and work behavior: A social exchange perspective. *Journal of Applied Psychology, 97*(3), 557-579. doi:10.1037/a0025697

Pinder, Craig C. *Work Motivation in Organizational Behavior*. 2nd ed., Psychology Press, 2008.

Piotrowski, C. (2016). Adult bully syndrome: An integrative conceptualization based on personality disorders framework. *Psychology and Education - An Interdisciplinary Journal, 53*, 91-98.

Rodwell, J., Demir, D., & Steane, P. (2013). Psychological and organizational impact of bullying over and above negative affectivity: A survey of two nursing contexts. International Journal of Nursing Practice, *19*. 241-248. Doi:10.1111/ijn.12065

Salovey, P., & Mayer, J. D. (1990). Emotional Intelligence. *Imagination, Cognition and Personality, 9*(3), 185-211. doi:https://doi.org/10.2190/DUGG-P24E-52WK-6CDG

Schutte, N. S., & Loi, N. M. (2014). Connections between emotional intelligence and workplace flourishing. *Personality and Individual Differences, 66*, 134-139. doi:10.1016/j.paid.2014.03.031

Sheriden-Loes, N. (2008). Understanding lateral violence in nursing. *Clinical Journal of Oncology Nursing, 12*(3), 399-403. Doi:10.1188/08.cjon.399-403

Sperry, L. (2009). Mobbing and bullying: The influence of individual, work group, and organizational dynamics on abusive workplace behavior. *Consulting Psychology Journal: Practice and Research, 61*(3), 190-201. doi:10.1037/a0016938

Stein, S., & Book, H. E. (2011). *The EQ edge: Emotional intelligence and your success*. Hoboken, NJ: Wiley.

Strandmark, M., & Rahm, G. (2014). Development, implementation and evaluation of a process to prevent and combat workplace bullying. *Scandinavian Journal of Public Health, 42*, 66-73. doi:10.1177/1403494814549494

Szczygiel, D. D., & Mikolajczak, M. (2018). Emotional Intelligence Buffers the Effects of Negative Emotions on Job Burnout in Nursing. *Frontiers in Psychology, 9*, 1-10. doi:10.3389/fpsyg.2018.02649

Tehrani, N. (2012). *Workplace Bullying: Symptoms and Solutions*. New York, NY: Routledge. ISBN: 978-0-415-61708-6

Thobaben, M. (2011). Bullying in the nursing profession. *Home Health Care Management and Practice, 23*(6), 477-479. doi:10.1177/108482231413556

Trépanier, S., Fernet, C., & Austin, S. (2015). A longitudinal investigation of workplace bullying, basic need satisfaction, and employee functioning. *Journal of Occupational Health Psychology, 20*(1), 105-116. doi:10.1037/a0037726

Vessey, J. A., Demarco, R. F., Gaffney, D. A., & Budin, W. C. (2009). Bullying of staff registered nurses in the workplace: A preliminary study for developing personal and organizational strategies for the transformation of hostile to healthy workplace environments. *Journal of Professional Nursing, 25*(5), 299-306. doi:10.1016/j.profnurs.2009.01.022

Van Heugten, K. (2009). Bullying of social workers: Outcomes of a grounded study into impacts and interventions. *British Journal of Social Work, 40*(2), 638-655. doi:10.1093/bjsw/bcp003

Wendt, G. W., & Bartoli, A. P. (2017). Adult bullying and primary and secondary psychopathic traits: Insights from a community sample. *Journal of Aggression, Maltreatment & Trauma, 27*(2), 131-146. doi:10.1080/10926771.2017.1387836

Wilson, C. J., & Nagy, M. S. (2017). The effects of personality on workplace bullying. *The Psychologist-Manager Journal*, *20*(3), 123-147.

Appendix A – Elements of a Respectful Workplace Policy

1. Purpose of the Respectful Workplace Policy

2. Definition of respectful workplace in relation to the organizational mission and values

3. Statement of desired respectful workplace behavior

4. Definition of Bullying - "The verbal or non-verbal conduct by one or more individuals against one or more individuals over a period of time that continuously and systematically intimidates, shows hostility, threatens, offends, humiliates or insults a coworker; interferes with a coworker's performance; or has an adverse impact on a coworker's mental or physical well-being" (Hutton & Gates, 2009, p. 169).

5. Explanation of terms:

a. Target – the employee experiencing bullying behavior exhibited from a coworker

b. Perpetrator – the employee exhibiting behaviors of bullying

c. Negative acts

d. Behaviors consistent with bullying include, but are not limited to:

- Non-verbal cues: gestures, sighing, eyebrow shifting, rolling eyes, making faces
- Verbal: snide, rude, demeaning, shouting or yelling, insulting/offensive remarks, untrue allegations, threats of violence, name-calling
- Actions: targeted anger, withholding info, humiliation, ridicule, malicious intent, physical intimidation, failure to respect privacy, unwanted and excessive teasing/sarcasm/jokes
- Passive-aggressive behavior: failing to resolve conflict directly, complaining, and ignoring/excluding, discounting opinions
- Broken confidence: gossip, rumors, sharing private information
- Work-related: repetitive reminders of errors, purposeful sabotage, unmanageable workloads, poor or overextended work assignments, excessive monitoring, hiding

supplies, refusing to help, unjust evaluation, scapegoating & blaming, employment sabotage, encouraging target to leave job, lack of cooperation

- In-group infighting: maligning, cliques and retaliation

6. Description of the personal and organizational costs of bullying
7. Description of formal and informal methods of reporting incidents of bullying
8. Description of target support liaison assignment and resources for targets and witnesses
9. Description of the investigation process, time frames and reporting of findings
10. Description of support services for the target of bullying behavior
    a. Consultation with organizational psychologist
    b. Referral to a licensed clinical therapist knowledgeable in workplace bullying
    c. Redress of costs associated to external counseling services
11. Description of perpetrator accountability and sanctions
    a. Formal written statement of offense to be included in the personnel file
    b. Required remedial DBT session with trained personnel
    c. Signed behavioral contracts, performance planning and quarterly performance evaluation
    d. Refusal to participate in remediation or change in behavior will result in termination
    e. Other possible consequences including suspension and report to professional governing body
12. Description of organizational responsibility
    a. Adhering to mission and values
    b. Respectful workplace education during orientation and quarterly
    c. Yearly assessment of organizational bullying
    d. Yearly evaluation and revision of the Respectful Workplace Policy
13. Statement of confidentiality for both parties

14. Anti-retaliation statement

    a. Protect for targets that report bullying

    b. Reverse bullying of the perpetrator

15. Appeals process for both the target and the perpetrator

16. Continued assessment of bullying in the organization

17. Education for employees during orientation and quarterly

18. Use of psychometric data to evaluate the policy and procedure

(Adapted from American Nurses Association, 2015; Duffy, 2009; Ferris, 2009; Namie & Namie, 2009b; Thobaben, 2011)

Appendix B – Individualized DBT Skills Coaching – Perpetrator

For remedial intervention of bullying behavior by perpetrators, this sample of an abbreviated DBT skills plan is recommended as a coaching intervention. The coaching plan is intended to be individualized using DBT skills appropriate for the needs of the employee and begins with an initial assessment of personality and EI. To validate the effectiveness of the coaching plan, a post-intervention assessment of EI and an employee evaluation will be utilized.

Session 1 – Pre-intervention assessment (1.5 hours)

a. Review of intervention requirements, discussion of employee development and consent signing

b. Pre-intervention assessment using general personality assessment and TEIQue-SF

c. Discussion of assessment results and proposed DBT coaching plan

Session 2 – Mindfulness (1 hour)

a. Discussion of professional and personal self-defeating behaviors

b. Explanation of mindfulness

c. Wise mind discussion – what and how skills; rational, emotional and wise minds

d. Discussion of values fit with organizational values

e. Pros/cons tool

f. d. End of session mindfulness practice

Session 3 – Emotional regulation (1 hour)

a. Review of homework

b. Mindfulness of emotions and Model of emotions

c. Identification of individual specific problem emotions related to bullying behavior

d. Use of the ABCDE chart (Stein & Book, 2011).

e. End of session mindfulness practice

Session 4 –Distress Tolerance (1 hour)

a. Review of homework

b. Individual stressors related to acts of bullying

c. IMPROVE the moment, ACCEPTS, TIP and STOP skills

d. End of session mindfulness practice

Session 5 – Interpersonal Effectiveness (1 hour)

a. Review of homework

b. Discussion of the individual and organizational effects of bullying

c. DEAR MAN skills

d. GIVE FAST skills

e. End of session mindfulness practice

Session 6 & 7 – Review of DBT skills and individual behaviors (1 hour)

a. Review of homework

b. Discussion of individual behaviors

c. Individual skills reinforcement

d. End of session mindfulness practice

Session 8 – Post intervention assessment

a. Assessment using general personality assessment and TEIQue-SF

b. Discussion of results and the intervention program

c. Evaluation of the program by the perpetrator

(Adapted from Linehan, 2015; Moore et al., 2018)

Appendix C – Individualized DBT Skills Coaching – Target

For supporting targets of workplace bullying, this sample of an abbreviated DBT skills plan is recommended as a coaching intervention. The coaching plan is intended to be individualized using DBT skills appropriate for the needs of the employee and begins with an initial assessment of the negative acts that the target has experienced. To validate the effectiveness of the coaching plan, a post-intervention assessment of EI and an employee evaluation should be administered.

Session 1 – Pre Assessment, debrief and Mindfulness (1.5 hours)

a. Pre-intervention assessment using the NAQ-R

b. Active listening and acknowledgment of the target's experience as self-report of bullying

c. Explanation and instruction of mindfulness practice

d. Self-validation and loving kindness instruction

Session 2 – Emotional Regulation (1 hour)

a. Review homework

b. Mindfulness of emotions

c. Model of emotions

d. End of session mindfulness practice

Session 3 – Emotional Regulation (1 hour)

a. Review of homework

b. Problem solving and opposite action

c. Cope ahead skill

d. End of session mindfulness practice

Session 4 –Distress Tolerance (1 hour)

a. Review of homework

b. IMPROVE the moment

c. ACCEPTS, TIP and STOP skills

d. End of session mindfulness practice

Session 5 – Distress Tolerance (1 hour)

a. Review of homework

b. Radical acceptance

c. Reality acceptance skills

d. End of session mindfulness practice

Session 6 – Interpersonal Effectiveness and Post Assessment (1.5 hours)

a. Review of diary card and homework

b. DEAR MAN skills

c. GIVE FAST skills

d. Post intervention assessment using the NAQ-R

e. Discussion of the intervention and evaluation form completed by the target

e. End of session mindfulness practice

(Adapted from Linehan, 2015; Moore et al., 2018)