A systematic review: Antecedents of workplace bullying in the health sector in Australia and New Zealand

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Attestation of Authorship

“I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.”

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ABSTRACT

This study sought to determine the antecedents (or causes) of workplace bullying in the health sectors of Australia and New Zealand that lead to employee job-related and health related outcomes; It also sought to determine the consequences of workplace bullying in the health sectors of Australia and New Zealand on job-related outcomes and/ or employee health and well-being. The dissertation utilised a systematic literature review using "workplace bullying in the health sectors of Australia and New Zealand" as a search term. Six databases were used in this research: Web of Science, ABI/Inform, Scopus, CINAHL PsycInfo (Ovid) and Medline. From 202,7497 research articles found, 50 research articles were utilised in the analysis. These were analysed and categorised into five themes through content analysis. The five themes were psychological stress, horizontal bullying, intention to turnover, retention and ethnicity themes. Findings from this dissertation showed that negative work environments reflecting bad work systems and horizontal bullying are the main antecedents of bullying. The health consequences of bullying include psychological stress, burnout, strain, emotional abuse and stress which affect job-related outcomes such a high number of clinical errors, a high rate of intention to leave and/ or turnover rate and low productivity within the organisation. This study demonstrated the need for more research on linking the different levels and settings in an organisation with management and bullying. It was also found that more research is needed on government legislations and polices that address workplace bullying with the aim of encouraging organisations to abide by these legislations and laws to minimise workplace bullying. Such research would also provide information and knowledge to policy makers and government agencies Overall, the findings illustrated the importance of creating organisational practices, accompanied with the right programs, strategies and policies at the organisation-level to address and minimise bullying incidents.

CHAPTER ONE: INTRODUCTION

This chapter provides an introduction to the dissertation topic – a systematic literature review of the antecedents and consequences of workplace bullying in the health sectors of Australia and New Zealand (1985-2015). Within this chapter, there is first a brief discussion on the researches that have been performed in the past to justify the relevance of this study. Next, the research objectives are deliberated. Then, the research designed is discussed. The last section briefly describes how this research paper is organized.

1.1. Background

Over the last 20 years, there has been an increase in the body of international research showing evidence that workplace bullying has a strongly negative effect in the workplace (Blackwood & Bentley, 2013). Internationally, there has been increasing concern about workplace bullying and the consequences of this not only in terms of employee health but also organisationally and financially (Blackwood & Bentley, 2013). Blackwood and Bentley (2013) point out that existing literature on working place bullying in the health sector has made a significant contribution to enhancing knowledge on workplace bullying. It has been found that bullying within the health sector undermines the professionalism of employees and the quality of their work, leading to poor employee relationships, burnout, emotional abuse and psychological stress (Trepanier, Fernet, Austin & Boudrias, (2016). Such consequences also significantly affect employees' work commitment towards the organisation resulting in low productivity (Farrell & Shafiei, 2012). Researchers have identified the three most important factors of workplace bullying: prevalence, antecedents and outcomes (Samnani & Singh, 2012). These three factors link bullies with victims and provide reasons and consequences of such behaviour. Researchers have identified bullying within the workplace as a huge stress factor within the organisation accompanied with negative consequences for both individuals and organisations (Eirnarsen & Raknes, 1997; Mathiesen & Hellesoy, 1996; Vartia, 2001, Niedl, 1996, O'Moore, Seigne, McGuire & Smith 1998). For example, the consequences of workplace bullying include a high turnover rate in the nursing field and an overall shortage of nurses (Farrell et al., 2006).

1.2. Purpose of the Study

The objective of this study is to investigate and systematically find answers to two research questions: 1) What are the antecedents (or causes) of workplace bullying in the health sectors of Australia and New Zealand that lead to employee job-related and health related outcomes; 2) What are the consequences of workplace bullying in the health sectors of Australia and New Zealand on job-related outcomes and/ or employee health and well-being.

1.3. Research Design

A systematic literature review is adopted in this research paper in order to answer the research questions. Excel is used to systematically organise the data into categories and themes. In order to categorise the data in this way, content analysis is regarded as the most appropriate method to use in analysing and describing the data.

1.4. Contributions

This systematic review research paper seeks to investigate the antecedents and consequences of workplace bullying in the health sectors of Australia and New Zealand by analysing published literatures from 1985-2015. The findings are expected to contribute to the research in this area by identifying the gaps found the process of analysis.

First, there is lack of knowledge and detail regarding workplace bullying costs per employee in diminished work performance and/ or any legal costs at the organisational level. This area of research is vital as it addresses the losses that companies and/ or sectors make or face in dealing with preventable costs. Findings would encourage leaders to create the right programs, policies and strategies that could minimise this issue and also prove that these bullying costs are preventable if management focus on developing preventative programs, policies and strategies.

Second, there is lack of knowledge and understanding on the antecedents and outcomes and/ or consequences of workplace bullying specifically in the healthcare sector as whole. While there is a great deal of research on nursing and the consequences of workplace bullying in this area, information is needed on the antecedents of workplace bullying focusing on the health sector as whole.

Third, it is clear that there is not enough updated information, knowledge and research on government legislations and policies that address workplace bullying in Australia and New Zealand. It is important that organisation are informed about these laws and regulations in the government and/ or state level in order for an organisation to in order that they can abide by the guidelines. It is also important that researchers in this area of study provide up-to-date knowledge. This knowledge is important as it can be used to encourage organisations to respond to current legislation by creating steps and developing programs or policies to address bullying in the workplace.

Fourth, managers and supervisors are not given enough training in dealing with the issue of workplace bullying. A possible avenue of research is the utilisation of the Negative Acts Questionnaire (NAQ) instrument developed by Einarsen and his colleagues (O'Driscoll et al., 2015) that could be used for theoretical development and determining the link between organisational structure and/ or individuals in positions of power and organisational culture.

Lastly, research has shown that horizontal bullying and power relations within the organisation are antecedents of bullying and can corrupt legitimate processes into authoritative gains. This is an important avenue of research. Although the literature has extensively examined the antecedents of workplace bullying, the methods used to uncover these relationships are not sufficient. For example, most of the empirical articles only utilise cross-sectional data and more longitudinal and process models are needed.

1.5. Organization of the dissertation

The remainder of the dissertation is structured as follows.

Chapter 2 provides a summary of what has been previously researched in this chosen area of study. It first introduces the current concept of workplace bullying in general. It then discusses the different definitions of workplace bullying and the specific definition that this study have chosen to adopt. It then explains why this chosen research topic is important. Following this is a discussion on the different researches on workplace bullying in the health sector in general followed by a focus on the health sectors of Australia and New Zealand. The chapter concludes by discussing the research gaps identified in the process of analysing this research paper.

Chapter 3 outlines the processes undertaken to identify the available and relevant literatures regarding workplace bullying in the health sectors of Australia and New Zealand. It then explains the epistemological position of this study and the systematic processes used to analyse and categorise the data collected. Finally, the chapter explains the reliability and validity processes used.

Chapter 4 presents and discusses the findings of this study. Fifty papers were obtained and included in this systematic review study. These 50 papers were analysed, organised and categorised into five themes through content analysis. These themes were ethnicity, retention, intention to turnover, horizontal bullying and psychological stress.

Chapter 5 presents the main conclusion of this research paper, then discusses the practical implications of this systematic research study as well as the limitations encountered. The chapter concludes with future recommendations for research.

The research question of this dissertations is to first, investigate and systematically find answers as to what are the antecedents (or causes) of workplace bullying in the health sector in Australia and New Zealand that leads to employee job-related and health related

outcomes. Second, investigate and systematically answer as to what are the consequences of workplace bullying in the health sector in Australia and New Zealand on job-related outcomes and or employee health and well-being.

CHAPTER TWO: LITERATURE REVIEW

2.1. Introduction

This chapter begins by introducing the current concept of workplace bullying. It then discusses the definition of workplace bullying adopted by this research. A review of the literature associated with workplace bullying in the health sectors of Australia and New Zealand is then presented along with a discussion on the antecedents and consequences of workplace bullying within the health sectors of Australia and New Zealand and why this study is important. The chapter concludes with a summary of the gaps identified in the process of analysing this research paper.

2.2. Workplace bullying

Over recent decades, the literature has shown increasing recognition of workplace bullying. The concept of workplace bullying first gained prominence in the 1980s (Mikkelsen & Einarsen, 2002) and has subsequently emerged as an important field of research in management studies (Samnani & Singh, 2012). An increasing number of academic studies have identified the harmful effects of workplace bullying not only on individuals but also on organisations (Einarsen, 1999). According to Cortina (2008), different types of negative acts such as workplace bullying have significantly negative consequences for individuals, groups and organisations as a whole. Researches have focused on three important factors in workplace bullying: prevalence, antecedents and outcomes (Samnani & Singh, 2012). These three factors link the bully to the victims and give the causes, reasons and consequences of bullying behaviour. Research has shown bullying to be a stress factor within organisations accompanied by negative consequences for individuals and the organisations (Eirnarsen & Raknes, 1997; Mathiesen & Hellesoy, 1996; Vartia, 2001; Niedl, 1996; O'Moore, Seigne, McGuire & Smith 1998). A few of the negative health effects of bullying that have been reported by victims are psychological stress, depression, anxiety and emotional exhaustion (Heugten, 2012; Einarsen & Raknes, 1997). These negative health effects coupled with organisational consequences have resulted in a number of researches on the antecedents of workplace bullying (Demir & Rodwell, 2012; Samnani & Singh, 2012; Rodwell & Demir, 2012). The focus of these researches has been on the sources and causes of workplace bullying,

which once identified, could be targeted to minimise the problem. However, ultimately the power lies with the organisation, the leadership and the managers to address the issue and advocate for solutions. Developing the right strategies and policies or processes and procedures within the organisation that address workplace bullying has been shown within the literature to have a positive effect on employees and/ or victims, to improve job satisfaction and to set a strategic direction for the organisation (Meloni & Autin, 2011; Hills, Joyce & Humphreys, 2013). These sources of workplace bullying are generally internal and/ or within the organisation (Demir & Rodwell, 2012). There are also a number of researches on workplace bullying that have found the antecedents of workplace bullying to be aggression and negative acts in the workplace. This focus on the antecedents of bullying in the workplace relates to how leadership or managers manage the organisation. The literature has shown that horizontal bullying is an antecedent of workplace bullying based on the systems, procedures and processes being controlled by management (Hutchinson & Jackson, 2015; Demir & Rodwell, 2012; Hutchinson & Jackson, 2015; Hutchinson, Vickers, Wilkes & Jackso, 2009). The literature further elaborates that with power control, bullying is entrenched into the system which leaves the victims powerless and vulnerable (Hutchinson & Jackson, 2015). This is clearly a significant disadvantage for the organisation. Workplace bullying significantly affects the organisation by creating low job satisfaction, high negative affectivity, a high rate of absenteeism, low productivity and a high turnover rate. Nevertheless, workplace bullying has been identified by researchers to be a phenomenon of global proportions that needs to be considered by managers across the world (Einarsen, Hoel, Zapf & Cooper, 2011).

The following section provides definitions of workplace bullying that this research will be adopting and further discusses workplace bullying in the health sectors of Australia and New Zealand including the antecedents and consequences of this concept.

2.2.1. Definitions

Research on bulling in the workplace provides no clear definitions of bullying (Eirnarsen, 2000; Hoel & Cooper, 2000; Hoel, Cooper & Faragher, 2001; Hoel, Rayner & Cooper, 1999; Leymann, 1996; Mikkelsen & Einarsen, 2001; Hoel & Cooper, 2002; Zapf & Einarsen, 2001). The concept of workplace bullying is often regarded as workplace harassment (Brodsky, 1976) or workplace abuse (Keashly, 1998). This phenomenon was described for the first time in 1984 by Heinz Leymann, a Swedish researcher, as "mobbing" or "psychological terror" (Leymann, 1996). Leymann (1996) later defined workplace bullying as hostile and unethical communication that often occurs systematically (at least once a week) over a long period of time (at least six months). Eirnarsen, Hoel, Zapf and Cooper's (2003) proposed a slightly different definition of workplace bullying, one which is widely used in the literature as it proposes a less strict adherence to frequency and duration. Generally, researchers have applied two different methods to measure and evaluate the occurrence of workplace bullying. Method one is the "subjective method" referring to whether the respondents feel exposed to being bullied at work (Einarsen, 2000). The second method is the "operational method" which measures the frequency at which the victims of bullying have been exposed to different types of bullying in the previous six months. However, this operational method is not regarded as a good measure of bullying as it less likely to prompt the victim's cognitive and emotional processing (Mikkelsen & Einarsen, 2001).According to Agervold and Mikkelsen (2004, p. 336), bullying is "typically defined as a series of negative acts aimed at a single person or small number of people, performed with relatively high frequency over a prolonged period of time". Researchers generally agree that an imbalance in power or strength is the main characteristic of bullying in regards to the relationship between the victim and the bully (Einarsen, 2000; Hoel, Rayner & Cooper, 1999; Niedl, 1996). With this imbalance of power, workplace bullying is fairly defined as "*the systematic mistreatment of a subordinate, a colleague, or a superior, which if continued and long lasting may cause severe social, psychological and psychosomatic problems in the target"* (Einarsen, Hoel, Zapf & Cooper, 2011, p. 4). In other words, bullying is a process that happens repeatedly over a period of time usually by someone in authority within the organisation and is normally referred to as horizontal-bullying.

Table 1 provides different definitions of workplace bullying that this research will be adopting.

Table 1: Table of Definitions

Concept	Definitions	Authors
Bullying	1) ‘’a social interaction in which the sender uses verbal and/or non-verbal communication that is characterized by negative and aggressive elements directed towards the receiver’s person or his or her work situation. The experience of being bullied correspondingly involves the receiver experiencing this verbal and/or non-verbal communication as negative and aggressive and as constituting a threat to his/her self-esteem, personality or professional competence’’.	1) Agervold & Mikkelsen, (2004)
	2) “repeated inappropriate behaviour, directed or indirect, whether verbal, physical or otherwise, conducted by one or more persons against other(s), which may be considered unreasonable and inappropriate workplace practice”.	2) Meloni, M. & Autin, M, (2011)
	3) “a situation where an individual persistently, over a period of time, perceives themselves as being on the receiving end of negative actions by one or several other persons”.	3) Hoel, H., Cooper C.L. & Faragher, B. (2001)
Horizontal bullying	1) “the oppressed group behaviours can occur when the powerless are submissive and silent in confrontation with authority, and consequently, fear and low self-esteem result that lead to anger and aggressive behaviours internally towards one’s own group member”.	1) Rodwell, J. & Demir, D. (2012)
	2) “the informal organisational alliances, organisational tolerance and reward of bullying, and misuse of organisational processes/procedures – on bullying among peers”.	2) Blackstock, S., Harlos, K., Macleod, M.L.P & Hardy, C.L. (2014)
	3) “bullying that is not only by the abuse of power by supervisors but it is also practiced by nurses who do not have formal authority”.	3) Katrinli, A., Atabay, G., Gunay, G & Cangarli, B.G. (2010).
Harassment	1) “repeated behaviour, other than behaviour that is sexual harassment, that is directed at an individual worker or group of workers; and is offensive, intimidating, humiliating or threatening, and is unwelcomed and unsolicited ; and a reasonable person would consider to be offensive, intimidating, humiliating or threatening for the individual worker or group of workers”.	1) Queensland Workplace Bullying Task Force, 2002, www.whs.qld.gov.au/taskforces/bullying/bullyingreport.pdf
	2) “a behaviour towards an individual or a group which is offensive, humiliating, intimidating or threatening; is unwelcome, unsolicited, usually unreciprocated, and a reasonable person would consider to be offensive, humiliating, intimidating or threatening”.	2) Meloni, M. & Autin, M, (2011)
Psychological distress	1) As the psychological or emotional suffering that is characterized by health-related consequences such as depression, anxiety disorders, headaches, skin	1) Heugten, K. (2012)

	problem, poor concentration, digestive problems and memory problems.	
	2) "is an intentional workplace behaviour that is abusive, often subtle or hidden and intensely harmful".	2) Hutchinson, M., Vickers, M.H., Jackson, D. & Wilkes, L. (2006)
	3) "the unrelenting, calculated and deliberate nature of bullying that can cause not only psychological harm, but also physical illness".	3) Kivimaki, M., Virtanen, M., Vartia, M., Elovainio, M., Vahtera, J & Keltikangas-Jarvinen, L. (2003)

For the purpose of this research paper the concept of bullying is defined as:

"a social interaction in which the sender uses verbal and/or non-verbal communication that is characterized by negative and aggressive elements directed towards the receiver's person or his or her work situation. The experience of being bullied correspondingly involves the receiver experiencing this verbal and/or non-verbal communication as negative and aggressive and as constituting a threat to his/her self-esteem, personality or professional competence" (Agervold & Mikkelsen, 2004, p. 2).

These actions are systematically targeted towards the victim(s) in a way that the victim(s) becomes stigmatized and victimized (Bjorkqvist, Osterman & Hjelt-Back, 1994; Leymann, 1996). The victim is in a position where she or he cannot defend herself or himself (Agervold et al., 2003). The requirement of this current bullying definition is to confirm that being bullied is an ongoing phenomenon of negative acts in which the victim is negatively affected and tends to have health or psychological issues as a result (Fox & Stallworth, 2010).

This study uses the definition of Agervold and Mikkelsen (2004) as it matches the need for the victims of workplace bullying to be in a situation where they are psychologically affected by the bullying, while the addition to the definition by Fox and Stallworth (2010) refers to the frequency and persistency of these negative acts. This definition of workplace bullying is not as harsh as the original definition of Brodsky (1976) that referred to workplace harassment and that of Lymann (1984) "mobbing" or "psychological terror".

2.2.2. Why is it important?

Workplace bullying is an important area of research for various reasons. In the modern world, people are required to work in order to survive, therefore organisations are required to cater to the different personalities and demographics of employees in order to establish a positive work environment and a successful organisation with a high job satisfaction level. Therefore, workplace bullying is an important area of study for the following two reasons:

i) Human costs

Studies have proven that targets or victims of workplace bullying experience significant negative health consequences such as a high level of burnout and emotional exhaustion (Dawson, Stasa, Roche, Homer & Duffield, 2014). Furthermore, studies have also linked workplace bullying to psychological stress and distress (Rodwell, Demir & Steane, 2012; Hegney, Plank & Parker, 2003; Rodwell & Demir, 2012) to the extent that some victims of workplace bullying have reported experiencing symptoms associated with post-traumatic stress disorder (PTSD) (Matthiesen & Einarsen, 2004). In order for an organisation to grow, it is important that employees' performance leads to productivity and a sense of high job satisfaction. In cases where employees are being bullied, performance and high job satisfaction are negatively affected and therefore there is no organisational growth. It is vital that the phenomenon of workplace bullying is addressed through polices in order to minimise the issue and maximise performance.

ii) Organisational cost

The human cost factor mentioned above has implications for the organisation as a whole. Employees who have experienced psychological or emotional distress and/ or burnout are likely to be absent from work (Askew, Schluter, Rego, Turner & Wilkinson, 2012). This leads to lower job satisfaction and a decrease in job performance and productivity. It has been reported that workplace bullying costs the US $14,000 USD per employee in lost work performance (Pearson & Porath, 2009). Other organisational costs include legal costs when victims of bullying take an employer to court. Dermer (2007) found that in Australian businesses, $30 billion a year had been lost on account of workplace bullying. Lost

productivity costs due to psychological depression in response to workplace bullying were estimated at $8 billion AUD per annum equating to $693 AUD million in preventable lost productivity costs compared to $36 USD - $53 USD in the US (McTernan, Dollard & LaMontagne, 2013). These are preventable costs if there are clear guidelines and processes accompanied by the right strategies and policies.

2.3. Workplace bullying in the health sector

Workplace bullying is a growing concern and is a major issue in the health sector internationally. Over last 20 years, there has been an increase in the body of international research showing evidence that workplace bullying pervades the workplace (Blackwood & Bentley, 2013). Blackwood and Bentley (2013) point out that the existing literature on working place bullying in the health sector has made a significant contribution to enhancing knowledge on workplace bullying. Research in this area has also meant the phenomenon of workplace bullying is of increasing interest to practitioners as well as academics (Blackwood, 2015).

The literature suggests that up to 40% of nurses have experienced workplace bullying (Hutchinson et al., 2010; Laschinger et al., 2010). Nurses are exposed to different forms of negative acts which undermine their professionalism and quality of work resulting in burnout, emotional trauma and psychological stress (Trepanier, Fernet, Austin & Boudrias, 2016). These outcomes have serious consequences for the health sector as an organisation and also in terms of how the victims of bully carry out their day-to-day duties, often resulting in an increased rate of clinical errors (Farrell, et al., 2006). These consequences have led to a high turnover rate and ultimately a shortage of nurses (Farrell et al., 2006).

It has been established in the literature that nurses are exposed to workplace bullying on an individual level including bullying, aggression, harassment, assault and so on (Meloni & Autin, 2011). However, the literature has also found that cases of violence are typically external (clients, customers) rather than internal (colleagues, supervisors, managers) (O'Driscoll et al., 2011). Further, the literature has identified that the antecedents of these negative acts amongst nurses are a negative work environment that enables bullying to occur (Trepanier et al., 2016) such as inadequate work systems, management and leadership. However, there is lack of research that links different work environments such as different units and health care establishments with workplace bullying (Trepanier et al., 2016). There is also a need for future studies to focus on the link between bullying and performance in terms of quality of service, and to establish the costs of bullying at the organisation level (Trepanier et al., 2016).

Healthcare is a huge sector made up of health professionals and administration staff. Within the healthcare sector, workers are often vulnerable to bullying, partly based on the fast-paced work environment but also reflective of the different levels of employment and the environment of practice (Cashmore, Indig, Hampton, Hegney & Jalaludin, 2012). Within the healthcare sector, bullying results in absenteeism and low morale, leading to a decrease in productivity and an increased risk of errors in delivery of health services (Roche, Diers & Catling-Paull, 2010; Farrell et al., 2006). The power structure of a healthcare organisation can lead to a negative environment which sets the ground for bullying to occur. Horizontal bullying has been identified as one of the main forms of bullying and an insidious phenomenon in the healthcare environment (Yildirim, 2009; Rutherford & Rissel, 2004).

The literature has mostly focused on the impact of bullying on nurses rather than on any other healthcare profession including clinical staff (Rodwell, et al., 2012). There is a need for future studies to focus on the healthcare sector as a whole on both the individual and organisational level (Cashmore et al., 2012). Identifying factors relating to horizontal bullying amongst the total healthcare sector would allow the development of specific preventative processes, procedures and programs within the sector.

2.4. Current legislations in Australia and New Zealand

New Zealand's Employment Relations Act 2000(ERA) and the Health and Safety in Employment Act 1992 (HSE Act) are legal avenues for investigating and determining which claims can be brought against organisations or individuals for any breach of duty while at work (Blackwood & Bentley, 2013). On the 4th of April 2016, the new Health and Safety at Work Act 2015 (HSWA) came into effect. The HSWA repeals the Health and Safety in Employment Act 1992 with immediate effect. The act (HSWA) shifts the attention from monitoring and recording the health and safety incidents to effectively and proactively identifying and managing risks for a safer work environment (http://www.worksafe.govt.nz/worksafe/about/legislation). There are a number of Acts and Regulations that is related to the functions of Worksafe New Zealand which addresses safe and health work environment. These acts and regulations include Health and Safety Work Act 2015 (HSWA), WorkSafe New Zealand Act 2013, Mines Rescue Act 2013, Crown Entities Act 2004, Hazardous Substances and New Organisms Act 1996 (HSNO), Electricity Act 1992 and Gas Act 1992

(http://www.worksafe.govt.nz/worksafe/about/legislation).

In the case of Australia, despite the different laws at state level, Australia's Fair Work Act 2009 (FW Act) that deals with health and safety legislation was enforced by the federal government and the state government, and in Victoria, the Crimes Act (1958) has recently criminalised bulling (Blackwood & Bentley, 2013). The Fair Work Act 2009 in Australia governs the relationship between the employee and employer's relationship. The act provides legal avenues for investigating and determining which claims can be brought against organisations or individuals for any breach of duty while at work (Blackwood & Bentley, 2013). It also provides a safety net on entitlements, enables flexible working arrangements and fairness at work that prevents any form of discrimination against employee (https://www.fairwork.gov.au/about-us/legislation).

2.5. Workplace bullying in the health sectors of Australia and New Zealand

The literature identifies several reasons why workplace bullying continues to occur in the health sector. These reasons include limited training and development in management skills to deal with the issue of bullying (Kelly, 2004; Hutchinson et al., 2015). Another reason is the lack of acknowledgement and appreciation of the different types of personalities and ethnic groups employed in the health sector, leading to internal conflicts, lack of strategies and policies that address the issue of bullying and hierarchical power relations that enable bullying to continuously occur, thus corrupting the system (Kelly, 2004; Hutchinson et al., 2015). Victims of bullying in the health sector in Australia and New Zealand have reported being bullied both horizontally (bullying from a supervisor or anyone in management or in upper level in terms of position) and laterally (from colleagues of the same level) despite bullying and harassment being prohibited in both countries (Australian Medical Association [AMA], 2009; Royal Australasian College of Surgeons [RACS] Expert Advisory Group, 2015; Worksafe New Zealand, 2014). Management and/ or leadership plays a vital role in making a positive work environment. They have the power to create prevention programs, policies and strategies to deal with the issue of workplace bullying and also to follow clear processes and procedures when dealing with bullying cases.

This study drew on previous researches on workplace bullying in the health sectors of Australia and New Zealand from 1985-2015. After meeting the selection, inclusion and exclusion criteria of this study, 50 researches were obtained of which the majority focused on the consequences of workplace bullying rather than the antecedents. Horizontal bullying was found to be a common antecedent to bullying (Hutchinson et al., 2015). Negative work environment such as work systems and horizontal bullying is seen to be the main antecedents of bullying accompanied by the health consequences of bullying such as psychological stress, burnout, strain, emotional abuse and stress which affects the job-related outcomes such high critical clinical error, high rate of intention to leave and/ or turnover rate and low productivity within the organisation. There needs to be an updated information and knowledge on legislations and polices addressing workplace bullying in the government level to drive organisations to abide with these legislations and laws to minimise this issue.

Australia and New Zealand share common legal ground but differ in terms of developing legal statutes that address workplace bullying (Blackwood & Bentley, 2013). Australia has shown a proactive approach by providing legislation at the federal level on occupational health and safety laws that address workplace bullying. New Zealand, on the other hand, has continued with the legal status quo instead of educating organisations and employees based on the Ministry of Business and Innovation's (MBIE) guidelines (Blackwood & Bentley, 2013). New Zealand's Employment Relations Act 2000 (ERA) and the Health and Safety in Employment Act 1992 (HSE Act) are legal avenues for investigating and determining claims of which claims can be brought against the organisations or individual for any breach of duty while at work (Blackwood & Bentley, 2013). Blackwood and Bentley (2013) point out that there is room for improvement in terms of addressing workplace bullying at the organisational and legislative level. Effective legislation means requiring organisations to develop policies and strategies and processes and procedures to minimise workplace bullying and make sure that future cases of workplace bullying are dealt with within the organisation (Very, 2008).

Most studies referred to in this research have focused their research on the consequences of workplace bullying in the health sectors of Australia and New Zealand. These studies have explored and identified variables such as demographic variables that include ethnicity, race, age and gender (Bhandhri, Xiao & Belan, 2015; Gardner, Bentley, Catley, Cooper-Thomas, O'Dirscoll & Trenberth, 2013), influence of internal autonomy (Rodwell & Demir, 2012; Hutchonson et al., 2010; Demir & Rodwell, 2012), leadership (Duddle & Boughton, 2007; Evans, Boxer & Sanber, 2008; Cooper-Thomas, Gardner, O'Driscoll, Catley, Bentley & Trenberth, 2013), negative work environment controlled by systems (Clendon & Walker, 2012) and power relations where power is used to corrupt legitimate processes and where allies of bullies are allowed to control processes and promotions (Hutchinson et al., 2009). Bullying in the health sectors of Australia and New Zealand have led to negative health and psychological consequences. Researchers focusing on the outcomes and/ or consequences of bullying have explored and identified variables such as psychological stress and psychological distress (Rodwell, Demir & Steane, 2012; Hegney, Plank & Parker, 2003; Rodwell & Demir, 2012), headaches, skin problems, poor concentration, digestive problems,

anxiety, memory problems and depression (Heugten, 2012, Einarsen & Raknes, 1997; Meloni & Autin, 2011; Farrell & Shafiei, 2012), and the intention to quit and a high turnover rate (Morisson, 2008; Bogossian, Winter-Chang & Tucket, 2014; Kidd & Finlayson, 2010; Belbin, Erwee & Wiesner, 2012; Dawson, Stasa, Roche, Homer & Duffield, 2014; Askew, Schluter, Dick, Rego, Turner & Wilkinson, 2012).

However, the focus of these studies has either been on nursing, new nursing graduates or doctors and nothing specifically on the health sector as a whole in Australia and New Zealand. Researchers have explored and identified that there is a high frequency of nurses being exposed to workplace bullying (Hills, Joyce & Humphreys, 2012) with a negative impact on health and the organisation as whole. Researchers have also focused on new graduate nurses and identified that their transition into the new workplace environment is negatively affected due to horizontal bullying and other negative acts (Evans, Boxer & Sanber, 2008; Duddle & Boughton, 2007; Bentley et al., 2009; Hutchinson et al., 2009; Hutchinson & Jackson, 2015; O'Driscoll et al., 2011), no clear guidelines in the system, leading to personal conflicts and confusion (McKenna, Smith & Coverdale, 2002; Evans et al., 2008), and a negative environment such as a controlled system and no support from new colleagues, supervisors and managers (Evans et al., 2008; McKenna et al., 2002; Clendon & Walker, 2012; Hayes, Douglas & Bonner, 2014; Gabriell, Jackson & Mannix, 2008; Duddle & Boughton, 2007). Researchers have also explored workplace bullying amongst doctors and identified that 70% of clinicians are reported to have experienced some form of negative act (Hills, Joyce & Humphreys, 2012). According to Hill, Joys and Humphreys (2013) this is a result of work systems and management that are power driven instead of focusing on staff and patients, thus causing a negative work environment. Bullied doctors are not satisfied with their role and the work environment which undermines their professional confidence and self-esteem, causing absenteeism and a high turnover rate (Askew, Schluter, Dick, Rego, Turner Wilkinson, 2012). Rodwell et al. (2012) were the first researchers in Australia to focus on workplace bullying amongst health-care administration staff and found they were not as vulnerable as nurses. However, there needs to be more research on the health sector as a

whole (Rodwell, Demir, Parris, Steane & Noblet, 2012) especially in Australia and New Zealand.

The following section discusses gaps in the literature identified in the process of researching for this paper and stresses the importance of focusing on the Australian and New Zealand context.

2.6. Research Gaps

After reviewing the literatures above, the following is a summary of identified gaps:

- There is enough information on the consequences and/ or outcomes of workplace bullying as it affects nurses in Australia and New Zealand but not enough on the antecedents.
- There is little recent research on effective legislation that addresses workplace bullying.
- There is a lack of knowledge on what the bullying costs are on the organisational level in the health sector.
- Horizontal bullying has been identified as one of the main forms of bullying and an insidious phenomenon in the health sector environment; however, there is lack of research in this area. Identifying factors relating to horizontal bullying amongst the healthcare sector would allow the development of specific preventative processes, procedures and programs within the sector.
- There is lack of research or information that explores bullying in the health sectors of Australia and New Zealand; specifically there is a lack of understanding of the antecedents and outcomes and/ or consequences of workplace bullying in these sectors.
- There is a very small proportion of literatures on the antecedents of workplace bullying in the health sector in Australia and New Zealand.

Therefore, the research questions of this dissertation firstly focus on what the antecedents of workplace bullying in the health sectors of Australia and New Zealand that lead to employee job-related outcomes and health-related outcomes. Secondly, investigates and systematically answer as to what are the consequences of workplace bullying that lead to employee job-related outcomes and health and well-being outcomes in the health sectors of Australia and New Zealand.

2.7. Conclusion

The impact of workplace bullying on employee health well-being is indisputable (Hodgins, MacCurtain & Mannix-McNamara, 2014). Empirical research has shown that workplace bullying is a major stress factor accompanied by negative outcomes which affect the health and well-being of the victims (Einarsen, Raknes, Matthiesen & Hellesoy, 1996; Bjorkqvist et al., 1994; Niedl, 1996; O'Moore, Seigne, McGuire & Smith, 1998; Niedl, 1996; Vartis, 2001; Einarsen & Raknes, 1997; Zapf, Knorz. & Kulla, 1996). This study is important because it specifically studies the antecedents and consequences of workplace bullying in the health sectors of Australia and New Zealand and addresses gaps in the literature that may be useful for future research. The research fills the gaps by focusing on the consequences of bullying and by suggesting the need for policies at the organisational level that ensure bullying cases in the health sector as whole are addressed. It is important to address these factors in order to inform and educate managers and practitioners that "encouraging prevention" is possible through legislation and also to encourage more research on the antecedents of workplace bullying in the health sectors of Australia and New Zealand.

CHAPTER THREE – RESEARCH METHODOLOGY AND METHODS

3.1. Introduction

This chapter outlines the processes undertaken to identify the available and relevant literatures regarding workplace bullying in the health sector in Australia and New Zealand (Australasia). It outlines the systematic processes used to analyse and categorise the data collected. It also explains the reliability and validity processes used. Then it explains the epistemological position of this study and method of analysis carried out to analyse the data.

3.2. Methodology

This study used excel to systematically organise the data into categories and themes. To be able to categorise the data collected into themes or categories, content analysis is the more appropriate method to use in analysing and describing the data.

3.2.1. Search strategy and databases

The literatures relating to workplace bullying in the health sector in Australia and New Zealand were identified through the library electronic databases over the 30-year period from 1985-2015; Web of Science (1985-2015), ABI-INFORM Complete (ProQuest) (1985-2015), Scopus (1985-2015), CINAHL (1985-2015), PsycInfo (Ovid) (1985-2015) and Medline (1985-2015). These databases represent well-established, multi-specific fields of academic study and hold a wide variety of peer-reviewed journals which are kept up to date. In order to obtain the maximum and most relevant literature, search key terms and phrases associated with the health sector, health organisations and workplace bullying in Australia and New Zealand were applied in the subject search. The term “antecedents” was taken out as it did not result in a great deal of literature. In this search strategy, the same search terms were applied to all the electronic databases used. A collection of six databases using the keywords “work*” (workplace being the environment) and “bully*” (bullying as the keyword focus) combined with the following keywords: “health sector” OR ‘health organisation”, “Australia” and “New Zealand”. The search for Australia and New Zealand was executed separately in order to maximise the amount of all the relevant literatures available. The electronic search of the keywords identified a total of 202,7497 publications. From a total of 202.7497 publications,

101,4833 were identified under “Australia” and 101,2664 publications were identified under “New Zealand”.

3.2.2. Study selection and eligibility criteria

After excluding duplicates, refining the electronic search into academic articles, journals, English language and studies specifically in the Australian and New Zealand health sector, a total of 6,754 articles were identified, which were all published research papers from the six databases searched. In order for articles to be included in this research paper, studies needed to meet six inclusion criteria: the articles or study had to (1) be written in English language, (2) focus specifically on workplace bullying, (3) be conducted in the health sector (includes nurses, new graduate nurses, doctors, hospital administration staff and any employee within the health sector), (4) include data from Australia and New Zealand, (5) report on empirical findings (as opposed to essays and editorials), and (6) refer to any type of workplace bullying (verbal, physical, emotional and psychological) and the antecedents of workplace bullying. In total, sixty-nine (69) published articles and journals were identified as having potential and full-text copies were obtained. All these were cited and reviewed by title and abstract. After reviewing to meet the inclusion criteria, fifty (50) publications (all in English) were confirmed as meeting the inclusion criteria of this research paper. The methodological quality of the 50 studies obtained were further assessed by two independent reviewers (Professor Stephen Teo [ST] and Dr. Marcus Ho [MH]). ST and MH determined whether the inclusion and exclusion criteria had been met and they also reviewed and checked the reference list of all the publications. Figure 1 shows the flowchart of the literature search.

Table 2 shows the confirmed total number of literatures that were identified in each database used: Web of Science identified fifteen (15) literatures that met inclusion criteria, ABI/Inform identified sixteen (16), Scopus identified four (4), CINAHL identified three (3), PsycInfo identified (5) and Medline identified eight (8). In total, fifty (50) literatures were included in this research paper.

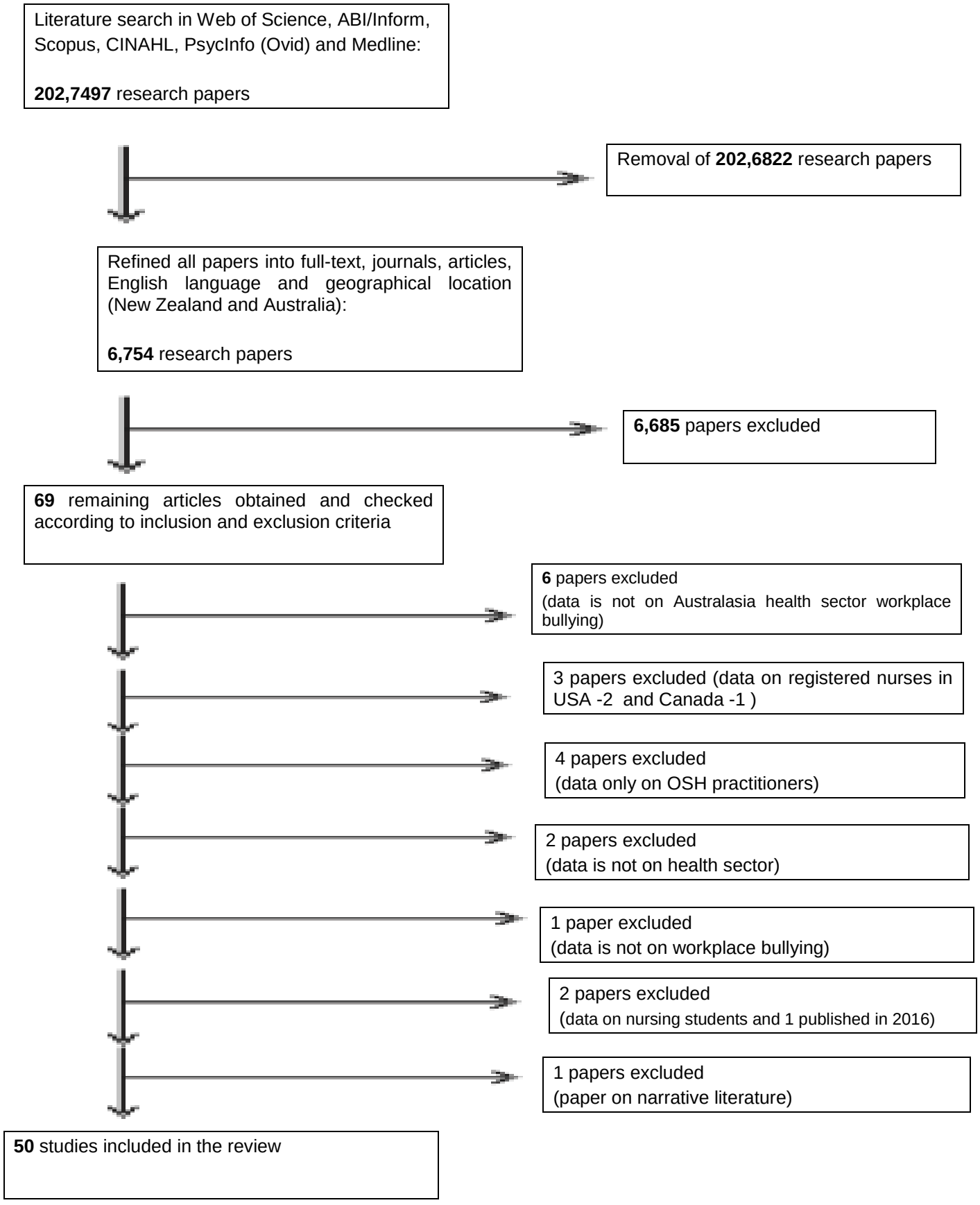

Fig.1: Flow diagram of strategy used to identify literature

Table 2: Number of Literatures Found in each Databases Used

DATABASE	**ARTICLES FOUND (full-text only)**	**ARTICLES FOUND (after refining into full-text, journals, articles, English language, location (Australia + NZ)**	**USEABLE (after reviewing - articles confirmed as meeting the inclusion criteria)**	**TOTAL USEABLE**
1) Web of Science	• Australia – 19,713 • NZ – 19712	• Australia – 1,716 • NZ – 289	• Australia – 12 • NZ – 3	Australia + NZ = 15
2) ABI/Info (Complete)	• Australia – 982,240 • NZ – 980,172	• Australia – 2,765 • NZ – 715	• Australia – 13 • NZ – 2	Australia + NZ = 15
3) Scopus	• Australia – 28 • NZ – 8	• Australia – 21 • NZ – 6	• Australia – 3 • NZ – 1	Australia + NZ = 4
4) CINAHL	• Australia – 2,886 • NZ – 2,883	• Australia – 328 • NZ – 328	• Australia – 2 • NZ – 1	Australia + NZ = 3
5) PsycInfo (Ovid)	• Australia – 129 • NZ – 52	• Australia – 129 • NZ – 52	• Australia – 3 • NZ – 2	Australia + NZ = 5
6) Medline	• Australia – 9,837 • NZ – 9,837	• Australia – 265 • NZ – 140	• Australia – 5 • NZ – 3	Australia + NZ = 8
TOTAL	• **Australia –101,4833** • **NZ = 101,2664** **= 202,7497**	• **Australia – 5,224** • **NZ = 1,530** **= 6, 754**	• **Australia – 38** • **NZ – 12** **= 50**	**= 50**

3.2.3. Quality assessment and extraction

Using the initial search strategy identified in section 3.2.1, 202,7497 papers were identified. These papers were then taken through the refining process where only full-text papers, scholarly journals, academic journals, articles – all in the English language and only from Australia and New Zealand – were accepted. During this process, 202,6822 papers were excluded and a total of 6,754 research papers were retained for further analysis. In further analysis, 6,685 papers were excluded and 69 retained. Most papers found at this assessment and extraction stage were essay reports and editorials (as opposed to empirical report papers) and studies that contained data of workplace bullying in the health sector overseas as opposed to data from within Australia and New Zealand. The high number of exclusions and extractions was due to the fact that five databases were used.

The remaining 69 research papers were obtained, checked and analysed according to inclusion and exclusion criteria (mentioned in **3**.2.2: Study selection and eligibility criteria). In this process, nineteen research papers were excluded for not meeting the inclusion and exclusion criteria. Six papers were excluded for not including any data on workplace bullying in the health sector. Four papers were excluded as they only had data on occupational health and safety practitioners in other organizations and not the health sector (an OHS-practitioner is a profession which comes under management and/ or human resource management). Three papers were excluded as they contained data on registered nurses in Canada (1 paper) and the United States of America (2 papers). Two papers were excluded as they contained workplace bullying data on other sectors and not the health sector. One (1) paper was excluded as it contained data on workplace bullying relating to student nurses as opposed to registered nurses. One paper was excluded due to the publishing year being in 2016. One paper was excluded because the data did not mention anything on workplace bullying and instead focused on health and safety policies. The final paper (1) was excluded as it was a narrative literature with no data on workplace bullying in the health sectors of Australia and New Zealand.

Following the inclusion and exclusion review, fifty research papers were included in this study of which the reference list of all the publications and key findings were reviewed and checked by ST and MH.

3.2.4. Content analysis

Content analysis is described as a method which analyses verbal, written or visual communication messages (Cole, 1998). When content analysis is used as a research method, it is characterised as a systematic and objective step or process in describing and quantifying a phenomena (Sandelowski, 1995; Downe-Wamboldt, 1992). It allows the researcher to understand more of the data. It also allows the identification of phenomenon in the data sources that can be included in the criteria. Results of content analysis are intended to be objective and replicable by another researcher (Bryman & Bell, 2007). This study uses certain words and themes that are explained and widely used in the data. According to Jose and Shang-Mei (2007), content analysis uses themes, concepts and certain words that are presented within the study which have been widely used in topics of environmental and social settings and responsibilities. While using the systematic approach, content analysis provides a greater range to enrich the textual themes. According to Elo and Kyngas (2007), content analysis is widely used in nursing studies and is regarded as a method which can either be used with qualitative or quantitative data and either in an deductive or inductive way. Qualitative content analysis is a common and widely used method in nursing studies (Elo & Kyngas, 2007). Elo and Kyngas (2007) also maintain that despite qualitative content analysis being used in nursing studies there have been few publications on how to apply the method. With this method of analysis, there is transparency, flexibility and ease of access and longitudinal analysis. In using content analysis, two concepts come into use: deductive content analysis and inductive content analysis. Deductive content analysis is used when there has been a previous study done and there is knowledge about the current analysis of the chosen topic (Elo & Kyngas, 2007). Inductive content analysis is used when there has been no previous study and no knowledge available on the topic of research chosen (Elo & Kyngas, 2007). Therefore, this current study uses deductive content analysis as there have been previous studies on this research topic.

In content analysis, there are both qualitative content analysis and quantitative content analysis methods that can be adopted in carrying out a research. According to Cole (1998), qualitative and quantitative content analysis have similar variants; however, they also have at least two differences: (1) the processes and procedures taken to produce codes for the data; and (2) the different uses that each method makes of the counts. In terms of the processes and procedures taken to produce data, qualitative content analysis uses the data collected to produce codes whereas quantitative content analysis uses search algorithms and/ or numerics and statistics that apply codes automatically. In the qualitative content analysis process, the data is interpreted and patterns are described whereas in quantitative content analysis, counts, codes and a summary of the data are presented in numerical results which according to Cole (1998), puts emphasis on the new contexts that are found in the coding and count process.

While the advantages of content analysis have been discussed above, there are also a few disadvantages in this this method. When using content analysis, there is an inability to answer 'why' questions. Content analysis can identify the peaks but cannot identify the reason. It also questions the authenticity and credibility of the documents. In saying this, one of the main disadvantages is that in some cases, data found is interpreted by the researcher. According to Robson (1993), all researchers have guidelines and aims to follow according to their research question of study, therefore they tend to choose the content they analyse. Critics have found that in the qualitative content analysis method, there is not enough detailed and specific statistical analysis to describe the result (Morgain, 1993). Sometimes mainstream content analysis rejects qualitative content analysis because it is not sufficiently quantitative and recent studies have also noted that it is not always sufficiently qualitative (Cole, 1998). There has also been debate regarding the analysis of hidden meanings found in documents because such analysis usually involves interpretation (Elo & Kyngas, 2007). For example, in quantitative content analysis it is difficult to analyse emotion, sighs, laughter and so on. However, despite these disadvantages and critiques, the content analysis method is the most appropriate method to use when carrying out a systematic review because with a wide range of studies and research previously done on the topic, the researcher is not only

able to understand the data but can also analyses verbal, written or visual communication messages (Cole, 1998) and use themes, concepts and certain words that are presented within the study to analyse the data. It gives the flexibility to research, analyse and interpret the data to answer the research questions and also systematically see researches that have been done in the past and compare them with the current research.

In this current study, content analysis is the more appropriate method to use in describing the data. As mentioned above, there are two different types of content analysis, however, this study adopts both qualitative and quantitative content analysis. It analyses any written data that is recorded on workplace bullying in the health sectors in Australia and New Zealand and journal articles must be within the inclusion criteria list. Publications of research papers on workplace bullying in the health sector in Australia and New Zealand have grown over the last 10-13 years which will be described in the result chapter (Chapter 4) of this study. Therefore, content analysis is suitable for this study as the next step taken was collecting data from previous researches on workplace bullying in the health sectors of Australia and New Zealand. According to Morgan (1993, p.118) from a "qualitative content analysis point of view, the exclusive emphasis on numerical summaries greatly limits what quantitative content analysis can do with qualitative data". In other words, when interpreting results, these analysts often use and search for words instead of searching for meaning (Morgan, 1993). Therefore, this systematic study includes data from both qualitative and quantitative studies on workplace bullying in the health sectors of Australia and New Zealand that are within the inclusion criteria (see 3.2.2.: Study selection and eligibility criteria).

3.2.5. Epistemology

Epistemology is the investigation of and perspective on the nature of knowledge. It asks the question, what is knowledge and how do we know what we know? Benjamin (1996b) argued that all research must be enclosed firmly in an epistemology and that no study or research exists in a theoretical vacuum. Crotty (1998) draws close attention to the three essential components of epistemological positions – subjectivism, objectivism and constructionism. Subjectivism concerns the epistemological position of the observer imposing a meaningful reality on the research object. Objectivism concerns the epistemological position that truth and reality exists outside the observer. Lastly, constructivism concerns the epistemological position that reality is constructed by the observer by giving meaning to what he/she observes (Crotty, 1998).

This dissertation works within the constructivist paradigm and incorporates the concept of a constructivist realist approach. Crotty (1998, p. 26) stated that "meaning is not discovered but constructed". Reality does not exist without a mind and meaningful realities can only be brought into existence through our engagement with these meaningful realities of our world. In this study, information and data on workplace bullying in the health sectors of Australia and New Zealand are collected, analysed and categorised to make meaning in order to answer the research questions. By discovering information through the data collected, this research paper is able to categorise the data into themes and issues to be identified (Mertens, 2005).

This study adopts the constructivist realist approach by gathering all the information and 'truths' about workplace bullying in the health sector in Australia and New Zealand that is out there and has been previously researched. Then it makes sense out of these 'truths' by analysing and categorising them ('truths') into themes. (Fig 2)

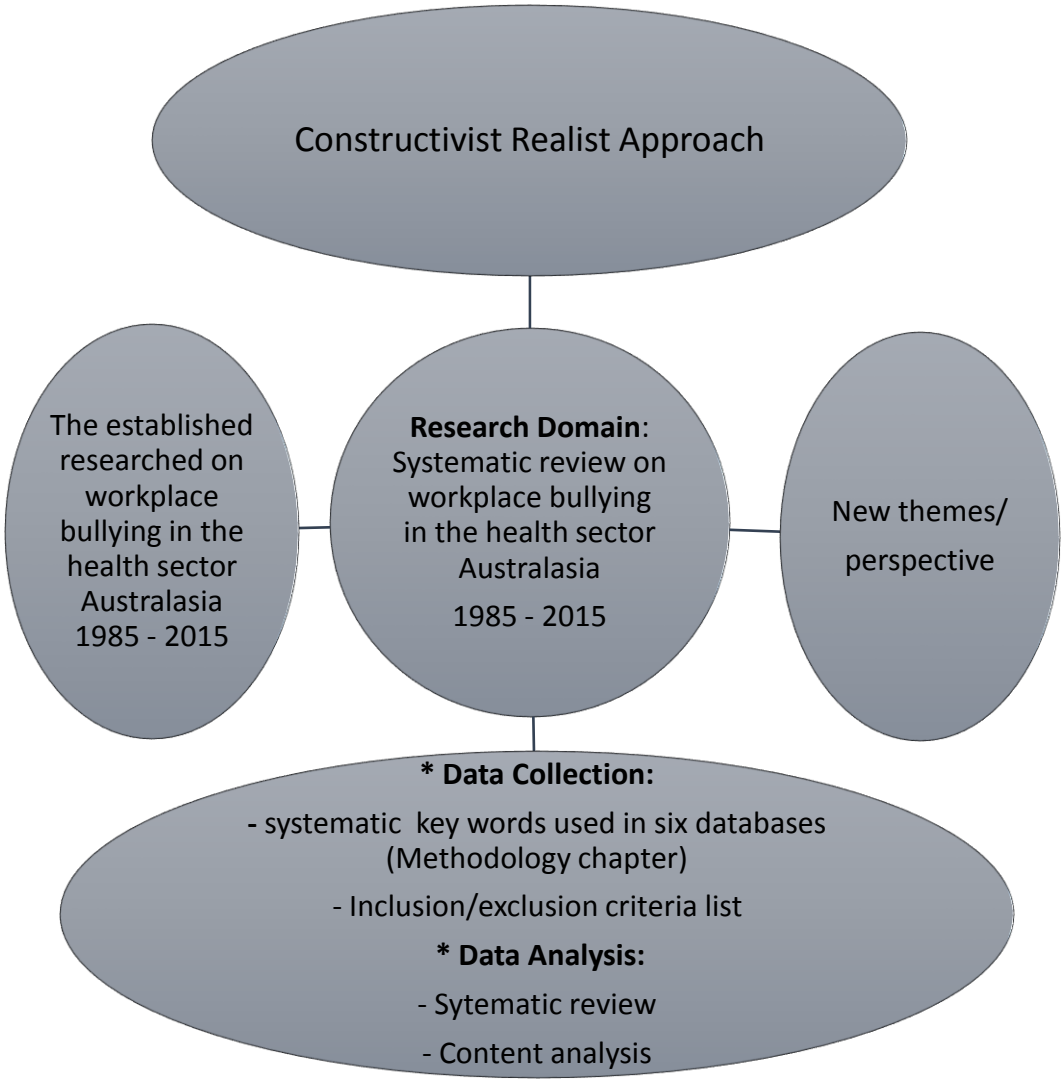

Fig.2: Epistemological flow diagram (Hindle, 2004)

3.3. Reliability and Validity

The reliability of this study is concerned with whether the results of the study can be replicated and the validity of this study is concerned with the integrity of the findings and conclusion of the study (Bryman & Bell, 2007). This section elaborates and discusses the steps taken in analysing and categorising the data found into themes. After going through the quality assessment and extraction process (3.2.3: Quality assessment and extraction), 50 articles were confirmed as eligible to be included in the criterion list. These articles were analysed and categorised into five themes: ethnicity, retention, intention to turnover, horizontal bullying and psychological stress. In order to categorise these themes, this study adopted the steps suggested by Miles and Huberman (1994) in "Strategy used to generate meaning"

The steps taken to categorise these findings into the following themes are as follows:

1) What goes with what? (Noting patterns and clusters) – The 50 articles were printed. Words and textual themes were found in the abstract sections and were used to determine and group the themes accordingly. At this stage, seven (7) themes were found: ethnicity, retention, intention to turnover, horizontal bullying, psychological stress, health and safety (OSH) and health and well-being. These original themes had the following total papers in the first stage of analysing and categorising: health and safety (OHS) = 1 research paper, health and well-being = 3 papers, ethnicity = 2 papers, retention = 5 papers, turnover intention = 6 papers, horizontal bullying = 9 papers and psychological stress = 24 research papers.
2) Integrating the diverse pieces of data – At this stage the data were being read through to make sure they were categorised under the right themes. Making metaphors at this stage was solely the author of this study's decision before the reference list of all the publications were reviewed and checked by ST and MH.
3) What's there? (Still analysing and counting) – Themes were checked over and over again. The 50 papers were moved around and themes analysed in detail. The health and safety (1 research paper) and health and well-being (3 research papers) themes were thoroughly analysed and research papers allocated to other themes were

moved. After analysing in detail, data from the two themes (health and safety & health and well-being) were regarded as better suited to the horizontal bullying (+1), intention to turnover (+1) and the psychological stress themes (+2). In addition to this analysis and categorising stage, 3 research papers were removed from psychological bullying and added to the horizontal bullying theme (see Table 3).

4) Sharpen our understanding – Journal articles were compared and partitioning variables were crucial. The content was analysed with the aim of matching the research question (Robson, 1993).
5) Seeing relationships abstractly – The 5 themes were confirmed and ready to be analysed further for the results chapter (Chapter 4).
6) Assemble a coherent understanding of the data – A logical chain of evidence was now visible.

In the process of categorising the papers into themes, the original 7 themes were cut down to 5 confirmed themes. During analysis, research papers were also removed from certain themes and added to other themes mainly because after reading through, they were found to be better suited to different theme allocations. Table 3 shows the stages in which articles were moved around to other themes and also the two themes that were removed because the articles under the two themes were better suited to the other 5 themes. Table 4 shows the total number of articles in each theme.

Table 3: Analysing and Categorising Theme Stages

Themes	Stage 1: Analysing/categorising	Stage 2: Analysing/categorising	Stage 3: Analysing/categorising	Total
Health and well-being	3	1 moved to intention to turnover	Theme removed	**0**
		1 moved to horizontal bullying		
		1 moved to psychological stress		
Health and safety (OHS)	1	moved to psychological stress	Theme removed	**0**
Ethnicity	2			**2**
Retention	5			**5**
Intention to turnover	6	1 + (added)		**7**
Horizontal bullying	9	1 + (added)	3 + (added)	**13**
Psychological stress	24	2 + (added)	3 moved to horrizontal bullying	**23**
Total	**50**			**50**

Table 4: Total number of confirmed research papers on each themes.

Themes	Number of research papers
Ethnicity	2
Retention	5
Intention to turnover	7
Horizontal bullying	13
Psychological stress	23
Total	**50**

The following themes will be addressed in detail in the next chapter (Chapter 4) of this study:

1) Psychological stress
2) Horizontal bullying
3) Intention to over
4) Retention
5) Ethnicity

3.4. Chapter Summary

The systematic and objective processes are able to be replicated with similar outcomes and results. The article written by Lu, Barriball, Zhang and While (2011) was used as a guideline in the structure of this research paper. The results or findings of this study should critique and analyse current policies and legislation of workplace bullying in the health sectors of New Zealand and Australia. The themes should also shed some light on the current gap in research and literature and legislation differences between Australia and New Zealand.

CHAPTER FOUR – RESULTS

Chapter three outlined the selection, review, inclusion and exclusion strategy used to obtain data for this study as shown in the flow diagram in Figure 1 and Table 2.

The objectives of this study are firstly to investigate and identify the antecedents (or causes) of workplace bullying in the health sector of Australia and New Zealand (Australasia) that lead to employee job-related and health-related outcomes. Secondly, the study seeks to determine the consequences of workplace bullying in the health sectors of Australia and New Zealand on job-related outcomes and/ or employee health and well-being.

This chapter presents and discusses the findings from the analysis conducted in this study. The complete data analysis and categorisation of thematic analysis can be found in Table 4 in Chapter 3 of this study. Fifty papers were obtained and included in this systematic review study and the results and analysis will be presented in this chapter.

4.1 Status of workplace bullying in the health sectors of Australia and New Zealand

4.1.1. Annual publications

As shown in Table 5, the total number of publications on the topic of workplace bullying in the health sectors of Australasia have almost doubled over the last 10 years, corresponding to the increasing concern over workplace bullying internationally (Blackwood & Bentley, 2013). Australasian publications on the subject of workplace bullying only began in 2002 – according to the specific inclusion criteria of this study, there was no record on any publications between 1985-2001. This fact may be a sign that the concern over workplace bullying, specifically in the Australasian health sector, has only recently emerged, perhaps relating to the possibility that early research participants were reserved and not as open and confident in dealing with this issue compared to participants of later years.

As shown in Table 5, Australia published 38 papers in the period 1985-2015 while New Zealand published 12 papers. However, there were also two publications that contain data from both the two countries during this time. The highest number of Australasian publications occurred in 2012 with 12 articles followed by nine articles in 2014 and six articles in 2013. To be more specific, in 2012, Australia published 10 articles and eight articles in 2014, whereas New Zealand's highest publication number was in 2013 when it published three research papers and two publications each year in 2011 and 2012. There is no record of any publication in 2005; however, publications started increasing from 2006 to 2015. Overall, the development of academic interest in publication in this field within Australia and New Zealand started developing in the early 2000's, specifically from 2002 onwards. Following Table 5 is Figure 3 that visualises the results in Table 5.

Table. 5: Total Annual Publications in Australia and NZ 1985 - 2015

Country	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Total
Australia																		1	1	2		3	2	1	2	3	1	10	3	8	1	**38**
New Zealand																			1					1	1	1	2	2	3	1		**12**
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**2**	**2**		**3**	**2**	**2**	**3**	**4**	**3**	**12**	**6**	**9**	**1**	**50**

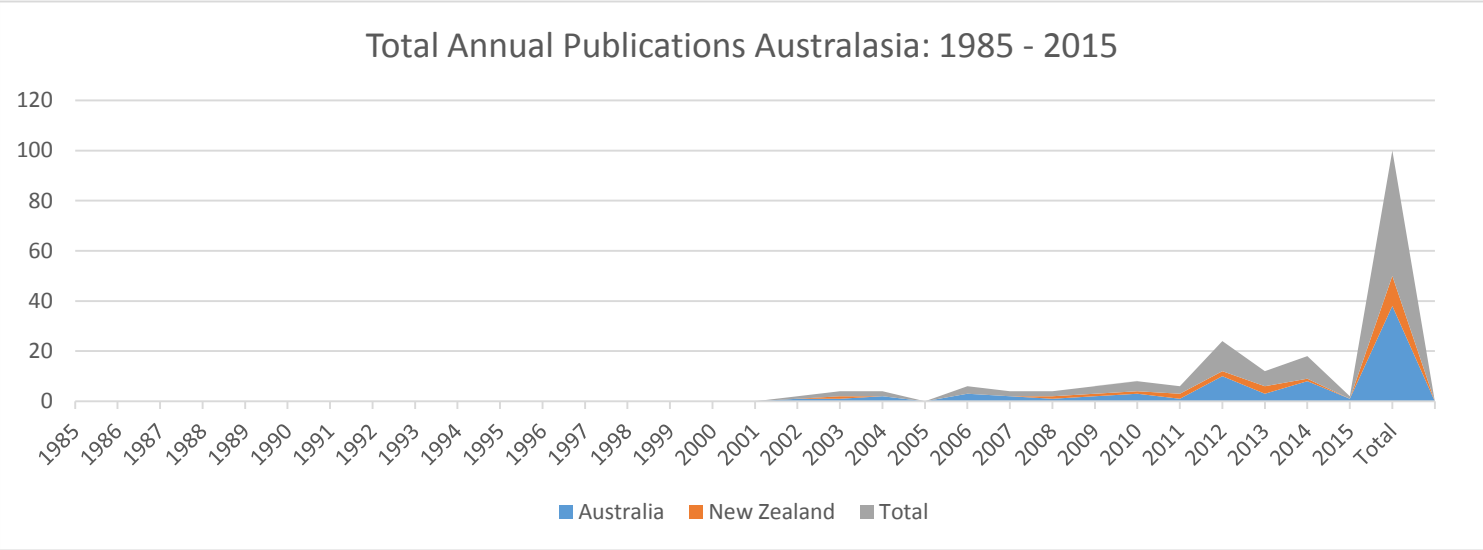

Fig.3: Publication trend in Australia and NZ 1985 - 2015. NZ = 12, Australia = 38 (Total = 50)

4.1.2. Authorships

To control the duplicates of the data an authorship over the 30-year of research period, most papers were published by two and three authors followed by co-authorship between four authors. Altogether, 13 papers were published in collaboration between three authors and 12 papers were published in collaboration between two authors in Australasia; however, single-authorship was unpopular with only three published papers. Collaboration between four authors resulted in 11 publications, five authors collaborated to publish five papers and six authors collaborated to publish six papers. However, papers published with the collaboration of five authors occurred only in Australia compared to no publications in New Zealand. The publication of academic papers within Australasia only started in 2002. Table 6 shows the overall analysis and numbers of publications within Australasia between 1985 and 2015. Following Table 6 is Fig.4 to visualise the results in Table 5.

Table. 6: Australasian Authorship Numbers 1985 - 2015

Authorship	**Frequency**
Single author	3
Two authors	12
Three authors	13
Four authors	11
Five authors	5
Six authors	6
Total	**50**

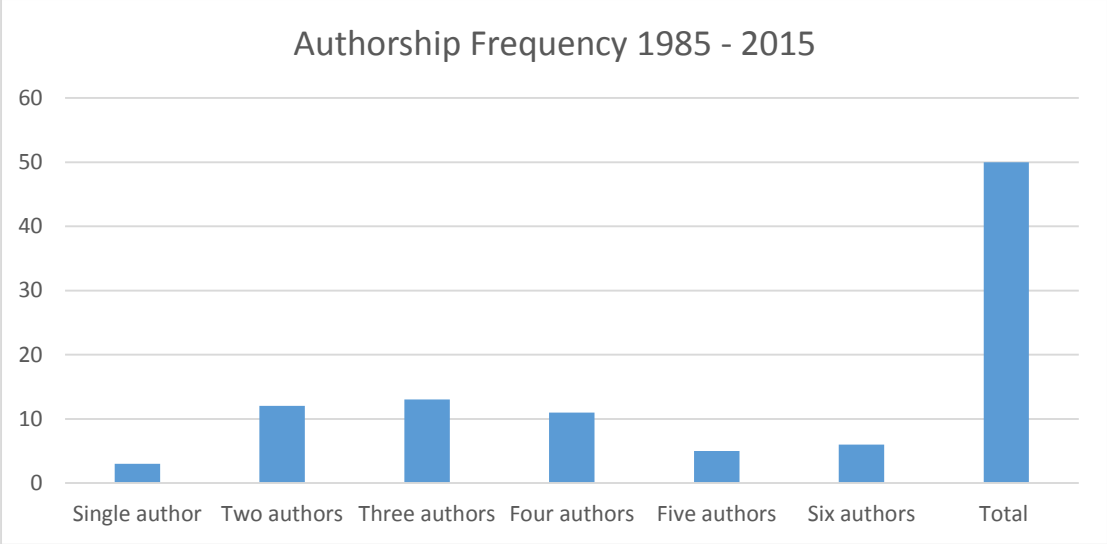

Fig. 4: Authorship graph 1985 - 2015

The number of papers published in Australia between 1985 and 2015 with two or three authors was the most significant at 13 whereas the number of papers published in New Zealand with six authors was most significant at four. Single authors published three papers in total, of which two were in New Zealand and one in Australia. The highest authorship frequency was thirteen publishing papers in collaboration between three authors in Australia compared to four publishing papers being the highest in New Zealand in between collaboration between six authors. Overall, Australian published papers involved a higher frequency of co-authorship than in the case of New Zealand. This can be seen in Table 7 below. According to Merlin and Persson (1996), co-authorship is an increasing trend in a number of fields of study. Involving more authors in a research paper not only provides a greater pool of knowledge and experience but also speeds up the writing process when there is urgency to produce findings on a specific research topic while the information and findings are still relevant and current (Merlin & Persson, 1996).

Table 7 below presents specific analysis of the trend in Australia and New Zealand authorship between 1985 and 2015. Following Table 7 is Figure 5 which visualises the results in Table 7.

Table. 7: Australia and NZ Authorship Numbers 1985 – 2015

Authorship	Frequency (Australia)	Frequency (NZ)	Total
Single author	1	2	**3**
Two authors	10	2	**12**
Three authors	11	2	**13**
Four authors	9	2	**11**
Five authors	5	0	**5**
Six authors	2	4	**6**
Total	**38**	**12**	**50**

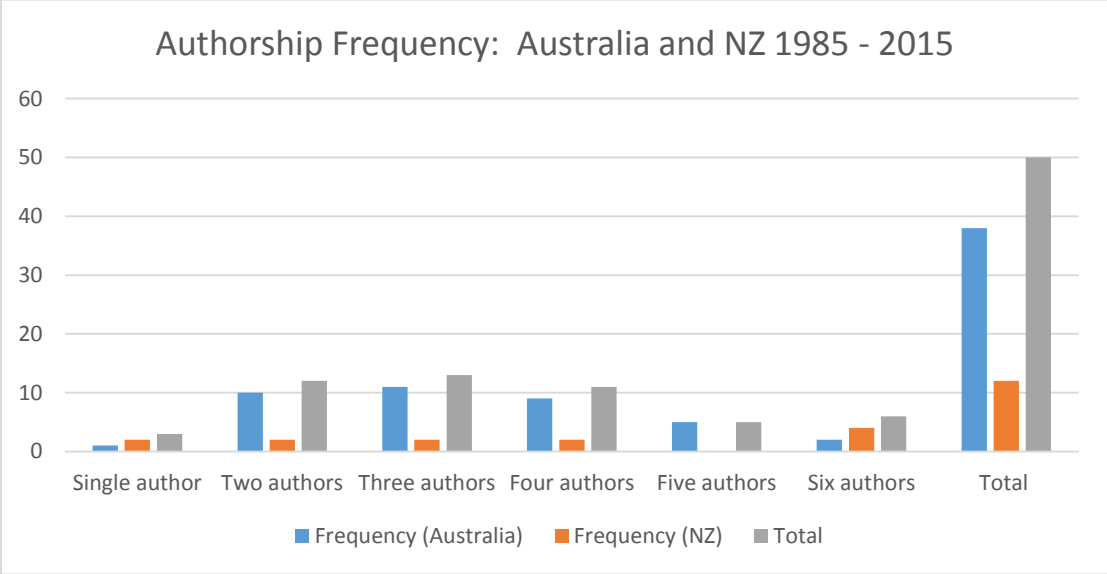

Fig. 5: Australia V NZ Authorship graph 1985 - 2015

4.2 Themes

The findings of this study were analysed, organised and categorised into five themes through content analysis (as shown in Table 8). In the following sections, a systematic review of knowledge on workplace bullying in the health sectors in Australia and New Zealand will be discussed under the five themes that were categorised in the data found. Table 8 shows the number of articles published in each theme within a five-year gap. Following Table 8 are the results of this study.

Table. 8: Data Categorised in Themes through Content Analysis

Themes	1985-1990	1991-1995	1996-2000	2001-2005	2006-2010	2011-2015	**Total**
Ethnicity						2	**2**
Retention				1	1	3	**5**
Intention to turnover					2	5	**7**
Horizontal bullying				1	8	4	**13**
Psychological stress				3	3	17	**23**
Total				**5**	**14**	**31**	**50**

4.2.1. Ethnicity

A total of two research papers were analysed and categorised in this category. Of these studies, one was a cross-sectional questionnaire survey (Bhandari et al., 2014) and the other one a self-report questionnaire survey (Gardner et al., 2013).

Bhandari et al., (2014) found that there are four factors that influence job satisfaction. These four factors are supportive work environments, communication in the English language, interpersonal relationships and salary. In their (Bhandari et al. (2014) study, a group of nurses showed a negative correlation between the duration of their time in Australia and satisfaction within their work environment. In many developing countries, including Australia and New Zealand, there is a labour dependence on international recruitment (Bhandari, Xiao & Belan, 2014). Participants in this study included 151 overseas-qualified nurses (60% response rate) that migrated from 24 countries, of which India, China, the Philippines and the UK being the top four. It has been found that there are more challenges in terms of communication, discrimination and racism that are faced by nurses from a non-English speaking background (Bhandari et al., 2014). Participants in this particular study revealed that there were issues relating to discrimination, racism and isolation. For example, most managers still preferred a local nurse instead of an overseas-qualified nurse even though they were qualified. This showed a level of racism with no equal opportunity for career development. In addition to this, the absence of family support contributed to the result. It was also reported that there were no education programs available in the workforce that advocated cultural diversity and promoted equal rights between local and overseas-qualified nurses, Discrimination based on skin colour was also reported.

In Gardner et al.'s (2012) study on bullying in the New Zealand health sector, participants in included 727 employees with a response rate of 42%. Pacific Islanders, Asians and Indian respondents reported higher rates of negative acts/bullying than European and Maori respondents. However, the results also showed a lower significance of psychological strain in Pacific Islanders, Asians and Indians than in the case of New Zealand Europeans. Despite the higher level of negative acts reported by Pacific islands, Asians and Indians, this lower

level of psychological strain may have been a result of supervisors' willingness to report incidents of workplace bullying. The authors also suggested that gender differences may have been reflected in the choice to report incidents of bullying. Women were reported to have had lower form of support compared to men.

It can be concluded that ethnicity in Australia and New Zealand is an important issue when it comes to job satisfaction and productivity within the health sectors. Ethnicity has a strong influence on community status relationships in both Australia and New Zealand and the work-force has broad ethnic affiliations resulting from racial or cultural ties. Therefore, it is crucial that steps are taken within the health sector and any other sector to support education and to advocate for diversity and equal opportunity. Both of the studies discussed above referred to leadership and the important need for supervisors and others in authority to recognise the issue of workplace bullying, especially in handling reported incidents of bullying. Although the study by Gardner et al., (2012) reported a higher level of negative acts, a lower level of psychological strain was also reported – possibly due to supervisor support. It is important that supervisors and managers or leaders are not biased in handling reports of workplace bullying. Discrimination and racism in this sector needs to be further addressed and advocated (Table 9).

Table 9: Summary of Studies Relating to the Ethnicity Theme Category

Author, year of publication and origin of study	Study participants, sample size & response rate	Methods	Data Analysis	IV	DV	Key findings
Bhandari, K.K., Xiao, D.L. & Belan, I. (2014), Australia	151 overseas-qualified nurses, 60%	Cross-sectional survey questionnaire	Job satisfaction of overseas-qualified nurses Questionnaire	Discrimination Racism Language barrier Communication breakdown Overseas-qualified nurses	Ethnicity	1) There were no education programs on cultural diversity available in the nursing workforce in the hospitals included in the study 2) Language was a problem in which communicating in English was a barrier to expression (respondents) 3) Participants reported that there was a feeling of racism, discrimination and isolation 4) Most managers still preferred local nurses though the overseas nurses were qualified too 5) The awareness of equality and peer support needs ongoing advocacy
Gardner, D., Bentley, T., Catley, B., Cooper-Thomas, H., O'Driscoll, M. & Trenberth, L. (2013), New Zealand	727 health sector employees, 42%	Self-report questionnaire survey	ANOVA Chi-square test Moderated regression	Psychological strain Absenteeism Stress Anxiety Discrimination Bullying	Ethnicity	1) Pacific Islanders and Asian/Indian respondents reported higher rates of negative acts/bullying 2) Pacific Islanders and Asian/Indians reported lower significance in psychological strain than New Zealand European respondents. A higher level was expected 3) Negative acts were related to psychological strain and direct effects of ethnicity on strain 4) Negative acts were small but statistically significant in the interactions between supervisor support and colleague support 5) Gender differences may have been reflected in the willingness to report being bullied 6) Negative acts were related to psychological strain

4.2.2. Retention

A total of five research papers were analysed and categorised in this category. Within these five studies, there was a retrospective cohort analysis (North et al., 2013), a mixed cross-sectional online survey (Parker et al., 2014), a case study (Stevens, 2002), a secondary analysis (two qualitative data sets and electronic survey) (Phillips et al., 2014) and lastly a qualitative analysis action research project over a 12-month period (Johnstone et al., 2007). (Table 10).

North et al., (2013) included 1236 newly graduated nurses in New Zealand in their retrospective cohort study on retention. These nurses were tracked for five years. The authors found that within five years of graduation, 26% of the cohort had left the NZ nursing workforce with 18% leaving in the first year – 42% of the cohort (under 25s) had the highest loss which was 32% in five years. Within these five years, community hospitals were the most frequent employment setting. The five-year retention rates within the four largest areas of practice were surgical 26%, medical 16%, mental health 60% and 10% in continuing care. The five-year separation rates between three main ethnic groups (75% Europeans, 11 % Asian and 7% Maori) were not significant (P = 0.235). The lowest separation rate was Maori at 21%, European at 20% and Asians at 30%. It was also found that at the start of the cohort, 94% were female and 6% were male (94 males in total). The five-year separation rates for male were higher at 30% and females at 25%. Overall, after the five years of this cohort study only 24% of those still practising had worked in different health boards.

In their study on new graduates and nursing retention in Australia, Parker et al. (2014) found that 55% of the participants had no intention of staying in their current role, 32% were unsure of how long they would be willing to stay and 3% were willing to stay for less than two years. This study included 282 newly graduated nurses with a response rate of 24% of which 35% reported English as their second language, with Chinese language being the most common first language. In total 26% of the participants in this study did not have enough information on how to carry out their job, resulting in 45% of the respondents reporting a high level of stress associated with the expectations in their current role. In terms of workplace perceptions

and impact, 94% reported their workload as heavy, 93% as physically demanding and 77% reported that their work stress was high. In addition to this, only 30% of participants reported their work morale was good, an issue that was affecting their transition into the workforce. In this study, most new graduates described their transition into the workforce as draining, demanding, stressful, and personally, emotionally and physically challenging.

Philips et al., (2014) also examined new graduate nurses' transition into their new role within Australia. The study included 392 new graduate nurses in the health care sector. The respondents reported that their work experiences were challenging and stressful. The study found that the new graduates were often allocated the intensive care unit (ICU) and other specialised areas on their first rotation – for example, scrubbing up to assist cardiologists on their first day of work. Assumptions made by senior nurses was that these new graduate nurses have had experience in the specialised areas. As new graduates this shows that they were presented with a high level of responsibility and challenged beyond their beginning skill set. Participants indicated that they had experienced insufficient staffing. This had resulted in inappropriate rostering where new graduate nurses were rostered on night-shifts after a whole day of orientation and were also placed in charge of weekend shifts. The lack of respect from the older nurses and the lack of communication was also reported to be an issue where there was no support for new nurses.

Johnstone et al., (2006) also examined graduate nurses in health care sector in Australia which focused in designing and providing clinical risk management (CRM) education. This study included 45 participants of which 11 were newly graduates nurses. It was found that safe handover, medication incidents and needle injuries were ranked highest risk (3.9 - 4.2) compared to workplace bullying (3.1 - 3.3). The data of this study suggests the need for a specific inductional discipline based on the CRM program for new graduate nurses to help with their transition into the workforce.

In her study of nursing retention in an Australian teaching hospital, Stevens (2002) found that the focus of the hospital was more on recruitment than on retention. The study found that a culture of workplace bullying amongst nurses was the reason why many nurses planned to leave their jobs. In response to these findings, the hospital developed numerous strategies to reduce the turnover rate. Three years before these strategies were developed, the nursing turnover rate was 28.4%. A year later, the turnover rate dropped to 22% and further dropped to 21.9% in the three subsequent years.

In summary, retaining employees in the health sector is a problem and it is as important as recruitment. In order to retain new employees in the health sector, there must be clear roles and processes in place that facilitate an easy transition and also retention strategies that address the turnover rate. The research has found that most newly graduate nurses intend to leave the workforce because of their unclear roles, the lack of processes in place to help them transition into the workforce, lack of respect from older staff, being rostered into areas that do not match their skill sets and being bullied by other older nurses and management. To address these issues, retention strategies and strategies to decrease the possibility of a continuous bullying culture must be put in place.

Table 10: Summary of Studies Relating to the Retention Theme Category

Author, year of publication and origin of study	**Study participants, sample size & response rate**	**Methods**	**Data Analysis**	**IV**	**DV**	**Key findings**
North, N., Leung, W. & Lee, R. (2013), New Zealand	1, 236 nurses	Retrospective cohort analysis	Chi-square test Regression modelling Paired t-test Shapiro-Wilk test Statistical analysis	Stress Work load Nurse shortages Workplace violence Bullying Shifts Burnout	Retention	1) Within five years of graduation, 26% of the cohort had separated from the NZ nursing workforce - 18% in the first year 2) Five-year retention rates in the four largest practice areas were: surgical 26%, medical 16%, mental health 60% and community care 10% 3) After 5 years, 24% of those practicing (n = 920) worked in different health board regions 4) The under 25's (n=517), 42% of the cohort, had the highest loss - 32% in five years.
Parker, V., Giles, M., Lantry, G. & McMillan, M. (2014), Australia	282 nurses, 24% response rate	Mixed cross-sectional method Online survey and focus groups	SPSS Cronbach alpha scores (values of 0.7) Chi-square test Themed analysis (Qualitative coding)	Work pressure Stress Workplace environment Communication Language barrier	Retention	1) In this study, most new graduates described their transition into the workforce as draining, demanding, stressful, emotionally and physically and personally challenging 2) Pressure on new graduates are high along with the high expectation from their workplace to perform and be work ready 3) New graduates are less likely to be bullied when they have the support from older staff 4) 35% reported English as their second language - Chinese language was the most common 5) 32% were unsure how long they would like to stay with 3% intending to stay less than two years

						6) 55% indicated their indication to stay for five years or longer
Stevens, S., (2002), Australia	A large Australian teaching hospital (Confidential)	Case study	N/A	Recruitment Nursing shortages Bullying Work environment Work conflict Management culture Intimidating behaviour	Retention	1) Nursing shortages focused on recruitment but retention was also a problem 2) This study found that in this hospital, the bullying culture amongst the nurses was the main reason why many nurses did not intend to stay 3) The hospital developed numerous strategies to address this issue and reduce the nursing turnover rate 4) Three years before the strategies were implemented, the turnover rate was 28-4% A year later the rate dropped to 22%
Phillips, C., Kenny, A., Esterman, A. & Smith, C. (2014), Australia	392 electronic survey of nurses 67 focus groups of nurses Interviews	Secondary analysis (Two qualitative data sets and electronic survey)	Thematic analysis Interpretive description NVivo 8 software	Underpaid Bullying Insufficient staffing Work environment Work pressure	Retention	1) Participants indicated that assumptions were made by senior nurses that these new graduates had had previous experience in high responsibility and specialised areas and did not need support. For example, participants were allocated straight into an ICU (intensive care unit) or straight into scrubbing and assisting the cardiologist on their first day at work. 2) Inappropriate staff allocation as some new graduates were on orientation during the day and rostered for night shift (tiredness) 3) Most new graduates are challenged beyond their beginning skill set 4) Participants indicated that there is no respect of the new graduates 5) Communication and tone is a big issue - where there is no support

Johnstone, M., Kanitsaki, O., Currie, T., Smith, E. & McGennisken, C. (2007), Australia	11 newly graduated nurses	Qualitative analysis	SPSS	Bullying	Retention	1) The data suggested that there is a need for an inductional discipline-specific, loyally-based clinical risk management (CRM) program for new graduates to help with their transition
	34 key stakeholders (KSH) - nurse unit managers, clinical teachers, senior nurse administrator	Action research project (12 month period)	Thematic analysis Analysis triangulation (Patton, 2002)	Staffing Pressure Cultural safety Incident reporting Clinical risk		2) In this study, safe handover, medication incidents and needle injuries were ranked highest risk (3.9-4.2) compared to workplace bullying (3.1-3.3)

4.2.3. Intention to turnover

A total of seven research papers were analysed in this category. Of these, one was an online questionnaire study, two were qualitative studies of which one was a collective auto-ethnography and the other was a national survey, a quantitative study survey, a cross-sectional survey and two e-Cohort studies of which one was web-based study with a qualitative content study and the other was an electronic cross-sectional survey (Table 11).

Askew et al., (2012) revealed that 25% of the participants in this study admitted to being bullied in the previous 12 months. This study included 747 doctors, in the Australian medical workforce. 25% of these doctors also admitted to experiencing persistent behaviours from the organisation, which have undermined their decisions and affected their confidence and self-esteem. The victims of such negative behaviour reported having poorer mental health ($P<0.001$) and taking a lot of time off work sick ($P<0.001$). In fact, most doctors in this study have admitted to decreasing their number of working hours and taking more time off on sick leave. Similarly, Morrison (2008) investigated negative work relationships and organisational outcomes in the New Zealand and Australian health sector. The study included 277 New Zealand health care employees with a response rate of 68% and 20 Australian healthcare employees with a 4.9% response rate. It was found that negative relationships at work led to a decrease in organisational commitment and a significant increase in the intention to leave. In total, 50% of the participants in this study reported having at least one negative relationship. It was found that high stress levels, work conflict and bullying were also outcomes of negative workplace relationships and was significantly linked to the high rate of intention to leave. Adding to Morrison's study on a negative work environment is the study by Dawson et al. (2014). This study found that limited career options or growth, colleague-to-colleague attitudes, a negative working environment and lack of recognition were key factors that affected nursing turnover in Australia. In this study the negative work environment was described by the participants as reflecting a poor skill-mix, a low patient-staff-ratio, a lack of decision-making involvement, and feelings of being undervalued and disempowered. These factors were obstacles for nurses to enjoy their work role.

Bogossian et al., (2014) found that work environment conditions, hygiene factors, poor pay and horizontal and lateral bullying were reasons why nurses left the profession in Australia, New Zealand and the UK. These factors related to workload, shift work, violence and financial remuneration. The high demand for clinical time contributed to chronic shortages and stress which affected work-life balance. This study included 66 nurses of which 71% were Australian registered nurses, 12% were New Zealand registered nurses and a further 12% were registered nurses in the UK. It was also found that younger nurses were being given "bad shifts'" and that shift-work came with high occupational risk. Participants reported that nurses bully each other internally and are also victims of physical and verbal bullying from the public.

Berlin et al.'s (2012) study of nurses in the Australian health sector found that a higher retention rate was significantly correlated with a lower turnover rate. Results indicated that the turnover intention was significantly correlated with retention factors. The findings suggested that retention strategies, personal perspective and fairness and equity were significantly correlated with a lower turnover rate. In other words, increased attention and support of retention factors resulted in a decrease in the turnover rate. This study included 379 nurses with a response rate of 12.6%. Salary packaging, professional development leave and allowances were effective workplace retention incentives. The study found that more than half of the participants planned to remain in the profession within Queensland Health and the remaining had intentions to quit in the next 12 months.

Rodwell et al.'s (2014) study of nurses in Australia included 250 participants with a response rate of 33%. The study found that 40% of the participants intended to quit, 33% experienced strain and only 30% felt job satisfaction. Results of this study indicated that direct and indirect personal attacks, isolation and abusive supervisors were positively linked to lower job satisfaction and an increase in the intention to quit the profession.

Kidd et al., (2010) study of nurses in the New Zealand health sector included 19 participants. The study found that vulnerability was a problem in the nursing workforce. In total, 10 of the participants described their history of being an abused child and joining the nursing workforce with the hope of helping others in a similar vulnerable position and to receive care from their colleagues and vice versa. One participant suffered from a mental disorder which led to frequent absence from work. This was treated as a disciplinary matter with recognition that the behaviour was a result of being abused. Most of the participants reported being exhausted and burned-out and having a high intention to quit.

In conclusion, the health sectors in Australia and New Zealand are associated with a negative workplace environment largely because of the kind of work that is involved, for example in health sectors and public sectors. Negative work environment refers to work systems, colleagues, management, and supervisors. Workplace violence, aggression and bullying is widely experienced. According to the studies discussed above, nurses intend to quit the profession because there is not enough emphasis on creating strategies to deal with the turnover rates. It has been proven that high retention rates are significantly correlated with low turnover rates. In order to have a low turnover rate and retain employees in the health sectors of Australasia, it is necessary to have a solid baseline of retention strategies such as salary packaging, professional development and allowances.

Table 11: Summary of Studies Relating to the Intention to Leave Theme Category

Author, year of publication and origin of study	Study participants, sample size & response rate	Methods	Data Analysis	IV	DV	Key findings
Morrison, R.L. (2008), New Zealand & Australia	NZ health care (including psychology, psychiatry and physiotherapy), 68% response rate 20 Australia health care workers, 4.9% response rate	Online questionnaires (Internet-based)	Chi-square test Comparative Fit Index (CFI) Parsimonious Comparative Fit Index (PCFI) Root Mean Square Error of Approximation (RMSEA)	Negative work environment Bullying Turnover Work conflict Negative relationships	Intention to turnover	1) Negative relationships in the workplace. Less organisational commitment relates significantly to the intention to leave and job satisfaction. 2) Stress is another outcome of negative workplace relationships 3) 50% of respondents reported having at least one negative relationship
Bogossian, F., Winters-Chang, P. & Tuckett, A. (2014), Australia, New Zealand, the UK	66 nurses and midwives Response rates: 71% Australia 12% New Zealand 12% United Kingdom	e-Cohort longitudinal Web-based study (NMeS) (Qualitative content analysis)	Content analysis (CA) Thematic analysis	Burnout Workload Shift work Violence Financial remuneration Work culture Work life balance Work environment	Intention to turnover	1) Work demand exceeds clinical time that is available 2) Work load and work demands contributed to chronic shortage 3) Shift work carries high occupational health risks 4) Junior nurses are given bad shifts 5) Nurses engage in bullying each other and also experience bully from others and are also victims of physical and verbal abuse 5) Lateral and horizontal bullying are reasons why nurses leave the profession 6) Poorly paid profession which is also a reason why nurses recognize that there are better opportunities elsewhere

Belbin, C., Erwee, R. & Wiesner, R. (2012), Australia	379 nurses, response rate	12.6%	Quantitative study survey (positivist approach)	SPSS Version 11 Descriptive analysis Multiple regression analysis Data reduction using factor analysis (22 retention factors)	Stress Turnover Retention strategies Performance appraisal and development Salary packaging Lack of leadership	Intention to turnover	1) Salary packaging, profession development leave and allowance are effective workforce retention strategies 2) Higher retention scores were positively correlated with lover turnover intention 3) The findings suggested that the intention to turnover was significantly correlated with opportunity retention factors, followed by strategies, personal perspective and fairness and equity. 4) Increased support in retention factors resulted in a decreased intention to turnover. 5) More than half of the participants were motivated by the economic downturn to stay with Queensland Health and slightly more than half had intentions to quit within the next 12 months.
Dawson, A.J., Stasa, H., Roche, A.M., Homer, C.S. & Duffield, C. (2014), Australia	362 nurses		Qualitative design national survey	NVivo Themed analysis	Work environment Leadership Turnover Personal management Workload Over-worked Workplace culture Stress Burnout	Intention to turnover	1) Poor work environment was an obstacle for nurses to enjoy their role Example - poor skills-mix, low patient-staff ratio, reduced physical resources, lack of involvement in decision making, constant change, low morale, undervalued, disempowerment, dissatisfaction, burnout, stress and issues with shifts, leave and pay. 2) Factors affecting turnover - limited career option, poor staff support, lack of recognition and poor staff attitudes 3) Low patient-to-nurse ratio 4) Poor management and staff relationships

Askew, D.A., Schluter, P.J., Dick, M., Rego, P.M., Turner, C. & Wilkinson, D. (2012), Australia	747 doctors	Electronic cross-sectional survey (e-Cohort study)	SAS software, Version 9.2) (SAS Institute., Cary, NC, USA) Student t-test Fisher's exact test SPSS 19 (IBM Corp, 2010)	Stress Bullying Harassment	Intention to turnover	1) 25% of respondent admitted to being bullied in the last 12 months 2) Bullied doctors were not satisfied with their role and planned to decrease the number of hours worked in medicine in the next 12 months Had also taken more sick leave in the last 12 months 3) 25% of doctors responded that persistent behaviours in the last 12 month had undermined their professional confidence and self-esteem
Rodwell, J., Brunetto, Y., Demir, D., Shacklock, K., & Farr-Wharton, R. (2014), Australia	250 nurses, 33% response rate	Cross-sectional survey (paper-based survey)	Chi-square statistic ratio SEM CFI TLI Standardized root square residual (SRMR) Single indicator latent variable (SILV)	Quit Abusive supervisor Strain Burnout Stress	Intention to turnover	1) 40% of respondents intend to quit 2) Only 30% had job satisfaction 3) 33% under strain 4) Attacks were directly and indirectly related to job satisfaction and intention to quit 5) Isolation was positively related to job satisfaction 6) Results indicated that the outcome of any form of abusive supervision and direct personal attacks linked with an increase in the intention to quit via increased psychological strain.
Kidd, J.Q, & Finlayson, M.P. (2010) New Zealand	19 nurses	Qualitative study Collective auto-ethnography	Interpretive technique Narrative style Thick description	Mental illness Distress Reduced nurses' progression from stress Stress	Intention to turnover	1) In this study, vulnerability was an issue in the nursing workforce. 2) 10 of the participants joined the nursing workforce because of their history as an abused child and in the hope of helping others who might have similar vulnerabilities 3) A few of the participants explained their hope that joining the nursing workforce would also include being cared

	for by their colleagues and vice versa.
Bullying	
Vulnerability	4) A participant in this study suffered a co-existing mental disorder of which the respondent's absence and illness was treated as a disciplinary matter with recognition of the abuse.
Workload No colleague support	5) Nurses who suffered from mental disorders and remained in the profession had negotiated with their governing body to remain in the profession while receiving care. However, it appeared that many nurses in this dilemma did not see any success in moving forward other than silence and expulsion.
	6) Participants in this study, especially newly qualified nurses, expressed that there were intolerable tensions that were impossible to deal with or negotiate over and they became mentally unwell.

4.2.4. Horizontal bullying

It is evident in the literature that horizontal bullying is an issue that is witnessed and experienced in any organisation or sector. A total of 13 studies were analysed and categorised into this theme. Of the 13 research papers collected, three were semi-structured in-depth interview studies of which one research paper was based on a narrative study (Gabrielle et al, 2008; Hutchinson et al., 2010; Bentley et al., 2009), two research papers used the mixed method approach (Hutchinson et al., 2009, 2010), two used qualitative methods (Evans et al., 2008; Eagar et al., 2010), and six individual research papers used a national survey (McKenna et al., 2002), an online survey (Cooper-Thomas et al., 2013), a systematic quantitative survey (O'Driscoll et al., 2011), an explorative descriptive survey (Clendon et al., 2012), a cross-sectional survey (Hutchinson et al., 2015) and an explanatory multiple case study survey (Duddle et al., 2007). (Table 12).

McKenna et al., (2002) found that horizontal violence is experienced by most new graduates in all clinical settings, resulting in a high rate of absenteeism from work and also the intention to leave the profession. Interpersonal conflict was a common type of threat and assault. This study included 551 nurses in New Zealand with a response rate of 47%. Findings showed that nearly half of the bullying cases were not reported. In total, 12% of the respondents expressed feeling distressed from the experience and were given a formal debriefing, 31% felt undervalued, 17% felt they had been blocked from learning and development opportunities, 16% felt distressed by other people's conflicts, 23% expressed being overloaded with work responsibilities without any appropriate guidance and supervision and 34% of the participants reported having experienced negative acts (bullying behaviours) such as rude, abusive and humiliating comments. In terms of interpersonal conflicts, the following were experienced at least twice a week: 5% reported that they had experienced verbal sexual harassments, 4% experienced inappropriate racial comments, 3% experienced harassment after following the complaints processes and 3% experienced verbal threats. This study noted that is it important that employees must feel confident and safe when and if they want to report any case of horizontal bullying and/ or horizontal violence. In a similar study that also focused on new graduate nurses, Evans et al. (2008) interviewed 13 new graduate nurses in

Australia. They found that these new graduate nurses were not supported or acknowledged as team members by unit managers in the clinical environment in New South Wales (NSW), Australia. Participants expressed that unit managers had powerful characters in the ward environment and/ or hospitals. On the same topic, Duddle., et al., (2007) found that new graduate nurses were challenged and found it hard to communicate with the older nurses which affected their transition into the profession. It was also found that the respondents did not voice their opinions and views to management to avoid conflict. The work environment had also become a stressful place where there was continuous yelling and out-bursts, although employees were constantly reminded not to take things personally.

In a New Zealand study, Clendon et al., (2012) focused on the experience of younger nurses under the age of 30. This study included 306 nurses under 30 years old with a response rate of 59%. It was found that younger nurses (similar to new graduate nurses) received little support and respect within the profession. As was found in the studies above, systems were controlled by policies and people in management that did not give the opportunity for younger nurses or new graduate nurses to grow and develop or make decisions within the sector. For example, respondents in this study reported that there had been suggestions to improve internal work processes but to no avail. Senior nurses and management took the better shifts which led to younger nurses struggling with work-life balance due to being allocated bad shifts based on the fact that most of them were not married. Bad shifts include working on weekends and at night. Although respondents knew their employment contracts allowed them to do a 24-hour roster and change shifts, they were nevertheless allocated these bad shifts continuously. Respondents reported that the work environment, shift work, bullying, having no voice or opportunity to grow and having no support from management was causing higher stress levels and increased their intention to leave the profession.

Bentley et al., (2009) also focused their study on nurses in the New Zealand health sector. The study found that bullying occurs in all levels of the health sector hierarchy – from senior managers to lower level staff members. The majority of the respondents in this study perceived leadership and management as a risk factor. The other bullying risk factors

included work pressure, lack of resources, inadequate reporting systems, communication breakdown at all levels, attitude towards the "weaker" individual (overseas nurses) and lack of support from management and colleagues. Nurses from overseas were more likely to be bullied because of their lower status. Respondents reported the lower level staff experience of being bullied from higher level staff such as supervisors, senior nurses and doctors. The study noted that the nature of the health sector hierarchy was a key factor in creating ideal conditions for bullying to occur. Similarly, Cooper-Thomas et al. (2013) also conducted their study on the New Zealand health sector. This study included 727 healthcare employees. The study found that 133 health sector employees were classified as being bullied (experiencing at least two negative acts weekly over the past six months). The study focused on the organisational strategies against bullying as perceived by targets and non-targets. The results showed negative correlations between the three contextual work factors: constructive leadership, perceived organisational support and organisational anti-bullying initiatives and workplace bullying. O'Driscoll et al. (2011) also conducted a study on the New Zealand health sector with a 68% response rate. The study found that 12.4% of respondents reported being bullied occasionally, "every now and then". 17.8% experienced being bullied based on the inclusion criteria of experiencing two negative acts weekly. The majority of the respondents reported that the most common and frequent negative acts they experienced were threats of violence, physical abuse, excessive teasing, sarcasm and being the centre of a practical joke. The sources of bullying were reported to be employers at 31.6%, senior managers at 36.9%, middle managers at 32.8%, supervisors at 36.4%, and colleagues at 56.1%, subordinates at 19.5% and clients and customers at 26.9%. The results also indicated that 40% of the respondents had experienced psychological strain.

Eagar et al. (2010) used focus groups in their study that which consisted of 30 registered (RN) and enrolled nurses (EN) in Australia. In Australia an RN has completed a 3-year undergraduate degree and an EN has normally attended a 12-18-month course, receiving a certificate or diploma qualification from a training college or institute. The study found that most ENs felt belittled, bullied, disposable and not included in any handover by the RNs in the nursing team. The ENs reported that their practice was not supported by RNs who refused to

supervise them. There was continuous conflict between the RNs and ENs in terms of responsibilities and hierarchy. Eager et al. concluded that it is vital that there are set of guidelines and processes that align an RN and EN in terms of responsibilities to avoid any conflict.

Hutchinson et al. (2009) found that power relations within the health sector are being used to construct and corrupt legitimate processes for authoritative personal gains. This study included 26 nurses in Australia who had experienced bullying. Of these nurses, 14 held senior clinical positions that were involved in providing clinical leadership in their specialist field. Results showed that powerful people in the sector who were involved in corruption also had the power to reward employees and this often led to nepotism occurring in the process. Similarly, an Australian study by Hutchinson et al., (2015) revealed that within the health sector there was leadership and management cover up and bullying that left victims feeling like they were perpetrators. For example, policies were not followed and reports were amended to reflect what the management wanted. This study included 234 healthcare employees in Australia with a response rate of 7%. This study revealed that managerial bullying was embedded in the system from the top level down. Results of the study also revealed management chose not to be made aware of bullying incidents. Bullies were protected by management and were promoted to better paying positions because of their bullying behaviour. Results showed that not none of the participants in this study could identify any internal anti-bullying policies or an external intervention agency. Hutchinson et al. concluded that in the public health sector, victims of bullying are not supported and that the problem lies with management and leadership rather than the bullying itself.

A study by Hutchinson et al. (2010) confirmed that organisational characteristics are antecedents of workplace bullying. They found that management plays a vital role in workplace bullying in terms of strategies being effective or not and when addressing the issue of workplace bullying there needs to be an organisational focus and work groups. This study included 370 nurses in the Australian health sector with a response rate of 7.4%. The study found that the health effects caused by workplace bullying led to the interruption of work and career paths. Respondents expressed that due to being bullied in the workplace, they had stopped participating in staff activities. Overall, the study found that the three platforms that encourage workplace bullying are the formation of informal alliances, the misuse of legitimate authority, processes and procedures and thirdly, organisational tolerance and rewards.

Gabrielle et al., (2008) focused their study on 12 older nurses in Australia between the ages of 40 and 60. Respondents reported that it was difficult to adapt to ageing in this profession. Frequent experiences of bullying instances and lack of support had contributed to their sense of burnout. Respondents suggested that older nurses need to have retraining programs and to be empowered. Results showed that older nurses had a lower sense of personal achievement and a higher sense of vulnerability compared to younger nurses. The study noted that despite the past experience of the older nurses in the health sector, most of the respondents found it hard to adjust, especially with the mental and physical changes associated with ageing.

Hutchinson et al. (2010) found that there are a number of standard bullying behaviours – identification of which provides insight into to the bullying experienced by nurses. This study included 26 nurses in the Australian health sector. Standard bullying behaviours are personal attacks, erosion of professional competence and reputation, and attacks through work roles and tasks. Respondents expressed that personal attacks were being used to make victims feel isolated, intimidated and degraded. Respondents described erosion of professional competence and reputation as being reflected in the lack of career growth and development opportunities. Being attacked through work roles and tasks was expressed as intentional obstruction that made it hard for victims to perform their roles.

In conclusion, as in any other organisation, management and/ or leadership in the health sector plays a vital role in creating a positive work environment or better place to work in. Management has the power to create policies and strategies that encourage such an environment and to also follow processes and procedures when dealing with cases of workplace bullying. Horizontal bullying in the health sectors of Australasia is a problem and is a topic that is increasingly being researched in the literature. However, three issues have been observed in this theme. Firstly, there is a lack of sufficient policies and strategies that deal with workplace bullying in the health sectors of Australasia. Secondly, managers and leaders fail to follow existing processes and procedures when dealing with workplace bullying cases. Lastly, management often fails to support employees at any level with respect and fails to provide career opportunities. The reality of the situation is that employees in any organisation or sector are human and are significantly impacted by workplace bullying which negatively affects their job satisfaction.

Table 12: Summary of Studies Relating to the Horizontal Bullying Theme Category

Author, year of publication and origin of study	Study participants, sample size & response rate	Methods	Data Analysis	IV	DV	Key findings
McKenna, B.G., Smith, N.A., Poole, S.J & Coverdale, J.H. (2002), New Zealand	551 nurses, 47% response rate	National survey	SPSS (SPSS Inc., Chicago 2002) Chi-square analysis Impact of Event Scale	Emotional abuse Horizontal violence Bullying Inter-personal conflict Distress Sexual harassment	Horizontal bullying	1) Horizontal violence was witnessed by most new graduates across all clinical setting 2) High numbers of absenteeism from work 3) A significant number of participants were considering leaving work 4) Half of the bullying incidents were not reported of which 12% of those who reported a distressing incident received a formal briefing The majority of participants reported not being trained in managing behaviour 5) 31% felt undervalued 6) 17% felt they were being blocked from learning development and opportunities 7) 16% felt distressed by other people's conflicts 8) 23% expressed being overloaded with responsibilities without appropriate guidance and support 9) 34% had experience bullying behaviours such as rude, abusive humiliating comments 10) The following percentages were found relating to interpersonal direct verbal direct and indirect conflicts: 5% experienced verbal sexual harassment, 4% inappropriate comments and gestures in regards to race, and 3% verbal threats 3% of harassments were followed by a formal complaints processes

Gabrielle, S., Jackson, D. & Mannix, J. (2008), Australia	12 nurses aged 40-60 years old	Semi-structured in-depth interviews (Narrative-based study)	Thematic analysis Feminist approach	Stress Burnout Bullying Ageing Nursing shortage	Horizontal bullying	1) Theme 1: Feeling uncared for (unsupportive work relationships, workplace bullying) 2) Theme 2: Adapting to ageing in their nursing career
Evans, J., Boxer, E., & Sanber. S., (2008), Australia	13 nurses	Qualitative descriptive design (face-to-face interviews)	Thematic analysis Transcribed verbatim Contextual data	De-valued Bullying Shift work Unsupportive behaviour	Horizontal bullying	1) New graduate nurses were not supported in a clinical environment in New South Wales 2) Respondents felt that nurse unit managers had a powerful character in the ward setting environment 3) New graduates were not acknowledged by the unit managers 4) Both new graduates and experienced nurses expressed their dissatisfaction on not being prepared with the appropriate skills and the reality of the work environment back in universities
Hutchinson, M. & Jackson, D. (2015), Australia	234 healthcare employees, 7% response rate	Cross-sectional survey	Qualtrics ™ software Thematic analysis NVivo 9 ™ qualitative analysis software	Power Leadership Emotional distress Managerial bullying	Horizontal bullying	1) Discursive legitimation of managerial bullying. Leadership and management covered up bullying in a way that the victims felt like they were perpetrators 2) In the health sector, bullying was described as chronic from top to bottom (entrenched in the system). 3) The problem lies in management and leadership not the bullying 4) Bullies are protected by management and often promoted to better paying positions in response to their bullying behaviour

Hutchinson, M., Vickers, M.H., Wilkes, L. & Jackson, D. (2010), Australia	26 nurses	Semi-structured in-depth interviews	NVivo software program Transcribed verbatim	Verbal abuse Horizontal violence Organisational behaviour Bullying Workplace violence	Horizontal bullying	1) This study provides an insight into the complexity and tactics involved in bullying 2) Personal attacks had been widely used where respondents felt isolated, intimidated and degraded 3) Erosion of professional competence and reputation through which respondents felt their career had been damaged and limited in growth 4) Respondents felt they been attacked and obstructed in their roles, making it difficult to perform their jobs
Clendon, J. & Walker, L. (2012), New Zealand	306 nurses, 59% response rate	Explorative descriptive design	Thematic analysis Descriptive analysis	Emotional distress Verbal abuse Bullying Younger new graduate nurses Burnout Generational differences	Horizontal bullying	1) There was not much support and focus for younger nurses 2) The work environment was controlled by systems and policies that did not give the younger nurses the opportunity to make decisions or grow within the sector Nurses were not challenged enough 3) Struggle to maintain shift work and work/life balance 4) There was little respect given to the younger nurses 5) Intention to leave for a new start
Duddle, M. & Boughton, M. (2007), Australia	15 nurses	Explanatory multiple case study design	Interpretive interactionism Thematic analysis	Negative work environment Work conflict Bullying Horizontal violence	Horizontal bullying	1) New graduates found it difficult to interact with other nurses which affected their transition into the new job 2) Negotiating territory where the respondents did not voice their opinions to managers/leadership to avoid conflict 3) Work environment was stressful - there was a lot of yelling and emotional outbursts, despite being reminded not to take things personally

Hutchinson, M., Wilkes, L., Jackson, D. & Vickers, M. (2010), Australia	370 nurses, 7.4% response rate	Mixed method (in-depth qualitative interviews and randomized mail survey)	AMOS Version 7 (SPSS Inc., Chicago, IL, USA) Chi-square statistic Comparative Fit Index (CFI) Tucker-Lewis Index (TLI) Normed Fit Index (NFI) RMSEA SEM	Distress Work environment Negative work environment Work interruption Negative health effects	Horizontal bullying	1) The health effects caused by bullying were identified as leading to work and career interruption 2) Due to workplace bullying, nurses tended to withdraw and avoid participation or involvement in activities 3) The three platforms that encourages workplace bullying are (i) informal organisational alliances, (ii) organisational tolerance and reward of bullying and (iii) misuse of legitimate organisational processes and procedures 4) Organisational characteristics are confirmed as antecedents of workplace bullying.
Hutchinson, M., Vickers, M.H., Wilkes, L. & Jackson, D. (2009), Australia	26 nurses	Paper report mixed-methods (Qualitative in-depth, semi-structured interview, narrative data)	NVivo software Thematic analysis Transcribed verbatim Constant Comparative Method (Lincoln & Guba, 1985)	Interpersonal conflict Organisational pressure Workplace violence Corruption Mobbing Bullying	Horizontal bullying	1) Power relations were used to corrupt legitimate processes for legitimate authority personal gain 2) Those involved in corruption and being abusive were rewarded with promotion - nepotism occurred during the process 3) Organisational environments where the alliance of bullies controlled promotions, appointments and the reporting processes
Cooper-Thomas, H., Gardner, D., O'Driscoll, M., Catley, B.,	727 health care	Online survey	Anti-bullying initiatives	Work environment	Horizontal bullying	1) 133 employees were classified as being bullied (experienced two negative acts

Bentley. T. & Trenberth, L. (2013), New Zealand		(Computer-based survey)	Principal axis single factor accounting for 70.39 variance	Leadership		per week over the past six months)
			Hierarchical linear regressions analysis	Bullying		2) Correlations revealed negative relationships between bullying and the three workplace contextual factors which are constructive leadership, perceived organizational support and organizational anti-bullying initiatives
			Two negative acts per week for over the past six months	Strain		
				Performance		
Eagar, S.C., Cowin, L.S., Gregory, L. & Firtko, A. (2010), Australia	30 registered nurses and enrolled nurses	Qualitative method of six focus groups	Constant comparison method Grounded research (Glasser & Strauss, 1967; Polit & Beck, 2006)	Work load Bullying Harassment Intra-professional workplace conflict	Horizontal bullying	1) Scope of practice and communication amongst nurses: continuous conflict between registered nurses (RN) and enrolled nurses (EN) in terms of responsibilities 2) Most EN's reported to feeling belittled and disposable and complained of being denied access to handover by RNs in the nursing team 3) EN participants reported that numerous times their practice was not supported by the RNs who refused to supervise them
O'Driscoll, M.P., Cooper-Thomas, H.D., Bentley, T., Catley, B.E., Gardner, D.H. & Trenberth, L. (2011),	1,700 employees in 36 organizations in NZ 68% were from the health and education sectors	Systematic quantitative survey	Negative Acts Questionnaire (NAQ-R) General Health Questionnaire (GHQ-12;	Work load Bullying	Horizontal bullying	1) 12.4% reported to have been bullied "every now and then" 2) 17.8% were scored on being bullied based on the criterion of experiencing two negative acts at least weekly

New Zealand	(Health sector % is not clearly separated in the article)		Goldberg, 1972) Mean bullying score (Cronbach alpha)	Strain Well-being Copenhagen Psycho-Social Questionnaire (COPSPG; Kristensen et al. 2005)		3) Least frequently reported experiences: threats of violence/physical abuse, excessive teasing/sarcasm and being the centre of practical jokes 4) It was reported that sources of bullying were employers (31.6%), senior managers (36.9%), middle managers (32.8%), supervisors (36.4%), colleagues (56.1%), subordinates (19.5%) and clients/customers (26.9%) 5) Findings indicated that assessed behaviours explained 40% of respondents having experienced psychological strain which impacted them as individuals
Bentley, T., Catley, B., Gardner, D., O'Driscoll, M., Trenberth, L. & Cooper-Thomas, H. (2009), New Zealand	NZ health sector (participants number not specified)	Semi-structured (Qualitative group interview and individual face-to-face interview)	Thematic content analysis	Horizontal bullying Harassment Work pressure Aggression Emotional abuse Leadership	Horizontal bullying	1) Health sector - bullying occurred at all levels of the organisation - from senior managers to lower level staff, and between clinicians at different levels of the hierarchy 2) Hierarchical nature of the health sector was a key factor in creating the ideal conditions for bullying to occur 3) Other risk factors for bullying: work pressure and lack of resources, attitudes towards the "weaker" individuals, inadequate reporting systems, communicating failures and lack of support from management and staff 4) Most of the respondents perceived leadership quality as a risk factor. 5) Nurses from overseas were more likely to be bullied due to their lower status 6) Lower-level staff/nurses tended to experience bullying from higher level staff such as their supervisors, doctors, senior nurses and employees in the residential care sector

4.2.5. Psychological stress

It is evident in the literature that psychological stress is one of several health issues caused by workplace bullying. A total of 23 research papers were analysed and categorised into this theme. Of the 23 research papers collected, seven were questionnaire surveys of which one was a descriptive study and a cross-sectional study, seven were cross-sectional studies, and the remaining were a qualitative mixed method study, an online survey, a qualitative semi-structured research project, a self-administered survey, a discreet choice experiment (DCE), a case study of a hospital, an explanatory cross-sectional self-report survey (longitudinal study) and two qualitative analyses. (Table 13)

The theme of psychological stress was further analysed and categorised into minor themes. Of the 23 research papers that were collected, 10 articles were analysed and themed under emotional abuse, nine articles were themed under aggression which included violence cases, abusive behaviour and harassment and four articles were themed under health distress which included any form of negative health impact such as depression and being sick. The three minor themes all contributed to psychological stress. In analysing and categorising these themes, it became clear that they are all inter-related in that they cause negative health issues to the victims through workplace bullying. Workplace bullying has been identified as a health and safety issue in health care (Rutherford & Rissel, 2004).

Emotional abuse

Of the 23 research papers that were collected under psychological stress, 10 articles were further analysed and themed under emotional abuse. Emotional abuse is a consequence of bullying in the workplace.

Rodwell et al. (2013) found in their of the Australian health sector study that there was a high number of reported incidents of workplace bullying. The study included 267 hospital nurses and midwives with a 23.1% response rate and 68 aged-care nurses with a 29.8% response rate. Nurses and midwives reported a higher rate of psychological stress compared to the aged-care nurses. Results showed a significant level of workplace bullying associated with

higher psychological distress ($F(1, 252) = 5.75$, $P < 0.05$), lower work commitment rate ($F(1, 253) = 18.18$, $P < 0.001$), and job satisfaction level ($F(1, 254) = 6.79$, $P < 0.01$). The authors concluded that the workplace bullying of employees affects organisational outcomes.

Demir and Rodwell (2012) included 207 nurses in their Australian health sector study with a response rate of 26.9%. The study found that 62.3% of the respondents reported “no” to workplace bullying while 18.6% reported “yes”, 13.2% reported to “very rarely” experiencing workplace bullying and 1.5% reported they had experienced workplace bullying “every now and then”. There was a high frequency of reported internal and external emotional abuse although there was no exposure to workplace aggression. Results showed that workplace bullying and verbal sexual harassments were related to an increase in psychological stress, bullying and internal emotional abuse were related to a lower rate of work commitment, and external threats were related to high work demands. In regards to antecedents, workplace bullying had a significant negative affectivity (NA) as well as less support from colleagues and supervisors. Similarly, Rodwell et al. (2013) found that workplace bullying, external emotional abuse and less support from colleagues and supervisors was related to high NA. Rodwell et al.’s (2013) Australian study included 547 nurses with a 34% response rate and 223 healthcare administration staff with an 85% response rate. It is important to note the huge difference in response rate between the nurses and the healthcare administration staff. This is possibly due to the nature of their work as most healthcare administration staff sit in front of computers and potential respondents had more time to fill in the survey compared to nurses. Results showed that 26% of nurses and 27% of the administration staff had experienced a form of bullying. The most frequent form of bullying reported by 29% of nurses was external abuse while 20% of administration staff reported internal abuse. Emotional abuse was highly linked to job demands and supervisor support was insignificantly linked with internal abuse.

In the study by Rutherford and Rissel (2004) 50% of the participants reported that they had experienced a form off bullying in the past 12 months. This study included 311 healthcare employees in Australia with a 79% response rate. Of the 311 participants, 60% were employed in clinical settings, 23% in management and 16% in public health promotions.

Results showed that 49% were bullied by peers and colleagues, 42% by clients and 38% by managers and supervisors. Out of all these cases of bullying, only 36% were reported. The level of bullying was significantly high and the authors concluded that more attention to the development of strategies to address the problem was required. Results showed that the types of bullying reported were intimidating behaviour, shouting or ordering, use of abusive tones or language, physically threatening behaviour, comments towards race, age or gender and unwanted sexual comments. These behaviours constitute emotional abuse and led to respondents feeling isolated from the group.

Huntington et al. (2011) included 162 Australian nurses in their study. They found that physical and emotional abuse in the Australian health sector exists for four reasons: increasing work pressure and work load; work systems and management are power driven therefore staff are left feeling devalued and not supported in further career development; the work culture is organised in a way where there is unequal power amongst colleagues; and physical and mental sacrifice due to the type of work involved such as lifting patients and. Similarly, Rodwell and Demir (2014) found that emotional abuse results from increasing work pressure. This study included 269 Australian nurses that worked in the elderly care setting. High job demands were found to be related to external verbal sexual harassment. This was in turn was related to the type of work that was required of participants within their profession. Negative affectivity (NA) is related to internal and external emotional abuse and threat of assault. In total, 36.4% of participants reported physical external assault, 35.7% reported external threats of assault and 28.6% reported external emotional abuse. The majority of bullying experiences had not been reported. In their study of healthcare professionals in Australia Cashmore et al. (2012) also found that the majority of the perpetrators of bullying were external sources (patients, visitors and family members) followed by internal sources (colleagues/staff). The study included 299 healthcare professionals with a 42% response rate. In total, 76% of the participants had experience negative acts of which majority were verbal abuse, 16% had experienced physical abuse and 48% had experienced bullying from colleagues. The high rate of bullying resulted in a high rate of emotional distress leading to reduced productivity and job satisfaction while at work.

The study by Allen et al. (2014) of the Australian health sector included 762 nurses. The study found that bullying was significantly linked to burnout which presented a strong negative toll on the participants. In total, 38% of the participants experienced high to very-high levels of burnout. Results of this study also found that psychological detachment did not significantly moderate the relationship between bullying and burnout; however, psychologically detaching from work may limit the risk of burnout. It was noted that the development of policies and strategies in healthcare organisations to address this issue is crucial. The study by Hayes and Bonner (2014) included 417 Australian nurses similarly found that a negative work environment led to stress, burnout and emotional exhaustion which then contributed to a low rate of job satisfaction. Nurse's job satisfaction predicted their level of burnout, emotional exhaustion and job stress. The study found that there was a positive and strong correlation between the work environments and feeling valued and supported by management.

Roche et al.'s (2010) study of the Australian health sector included 2,487 nurses. The study found that 65% of the participants experienced emotional abuse, 66% experienced threats of violence and 50% experienced perceived violence. One third of the respondents had experienced emotional abuse in their last shift, 14% had experienced a threat of violence and 20% had experienced actual violence. Those of higher skill mix in this study reported fewer incidents of violence at the ward level. Violence was reported as being a natural occurrence for nurses in wards which affected their job satisfaction. The study concluded that it is vital to understand the work environment in relation to violent outcomes.

Aggression

Of the 23 research papers that were collected under psychological stress, nine articles were further analysed and themed under *aggression.* This minor theme included violence cases, abusive behaviour and harassment.

Rodwell and Demir's (2012) study included 273 nurses and midwives in Australia with a response rate of 37.1%. The authors found that there was a high level of workplace bullying reported. In total, 18% of participants reported being bullied occasionally or frequently and 10% reported emotional abuse internally and externally. The types of violence reported were predominantly internal assaults. Internal physical assault was more significant amongst nurses and midwives who had been employed for nine years or less or between 10-14 years. External threats of assault were significant amongst nurses and midwives employed nine years or less or between 10-14 years. It was also found that employees who were rostered for morning shifts experience more workplace bullying compared to the remaining work shifts. The authors concluded that it is important for management or supervisors to spread the shifts fairly between the newer and older nurses to avoid having the same staff who are rostered on morning shift continuously experiencing bullying. The study revealed two antecedents of bullying: a positive relation between NA and bullying ($B = 0.08$, $p < 0.001$) where high levels of NA were linked to bullying acts; and a positive relationship between those rostered for morning shifts and bullying ($B = 0.66$, $p < 0.05$), meaning morning shift workers experiencing more bullying acts than those on other shifts. The study of Demir and Rodwell (2012) included 207 nurses and midwives with a response rate of 26.9%. The authors found that the consequences of violence and workplace aggression resulted in an increase in emotional trauma and psychological distress which lead to lower organisational commitment. The authors found that the antecedents of aggression included four aggression types: bullying, internal emotional abuse, external emotional abuse and external threats of assault. The consequences of these aggression types were that bullying [F (1,199) = 5.76, $p < .05$] and internal abuse [F (1,201) = 9.28, $p < .05$] were found to be highly associated with lower commitment levels. NA was significant for commitment in external emotional abuse and external threats of assault. Bullying was also linked to high NA, low supervisor support and

low job control. Farrell and Shafiei (2012) also focused on aggression and bullying in the Australian healthcare sector. This study included 2,407 nurses and midwives with a 30% response rate. The study found that 52% of participants experienced some form of workplace aggression – 32% were reported to be bullying acts from colleagues, managers or supervisors and 36% were reported as aggression and violence from patients or their relatives and/ or visitors. Respondents revealed that they were more worried about being bullied by their colleagues than aggression from patients. It was concluded that there is a need to create realistic training programs and to develop policies and strategies that address the issue of workplace aggression and bullying and how it should be handled when incidents arise.

Scott et al.'s (2015) Australian study on workplace violence and bullying included 441 aged-care nurses with a 50% response rate, 497 public nurses with a 47% response rate and 498 private nurses with a response rate of 29%. In the study there was a 29% report of abuse from nurses who had been employed less than five years compared to 4% of nurses who had been employed 35 years or more. In total, 40% of nurses who had been employed for less than five years experiencing bullied acts from medical practitioners compared to 13% of those who had been employed five or more years. Male nurses employed in the public sector were found to have experienced more workplace violence compared to female nurses; that is, (P=0.003) with 72% of male nurses and 45% of female nurses reporting abuse. In this study, horizontal bullying was not evident and instead related to employees' years of experience. In terms of effective strategies being in place to address aggressive behaviour from staff and non-staff, 70% reported strategies were effective in the public sector and 65% reported they were effective in the private sector. In total, 71% of participants employed in the aged-care setting and 55% of participants employed in the private sector were aware of existing policies that addressed workplace violence. Meloni et al. (2011) conducted their case study in an Australian hospital and also tested the effectiveness of policies and strategies. Their aim was to identify the different outcomes before and after the implementation of a Zero Tolerance of Bullying and Harassment program (ZTBH). This case study took place over three years at Calvary Health Care ACT (CHCA) and included approximately 1200 employees with a

response rate of 55%. Before the implementation of the program, there was a significantly high rate of perceived workplace bullying and harassment and a low level of trust in managers when reporting bullying cases. This program was established to create awareness and encourage employees experiencing bullying to seek help from within the organisation. Nearly three years after the implementation of the program, results of the latest employee satisfaction survey showed that the program had had a positive impact with an increase in staff job satisfaction and improvement in the harassment and bullying section. Employees also knew where and how to report bullying or harassment at work.

Mayhew et al. (2004) found that violence in the health sector and/ or industries were different at all levels. This study included 400 employees from within the public health system in Australia. Respondents were from 45 different hospitals, 14 ambulance stations and a number of community health centres. Results showed that experiences of violence varied within the occupational groups. For example, nurses in the emergency wards witnessed more violent cases compared to nurses employed in the community health centres. Amongst the 400 employees that were interviewed, 585 separate cases of negative acts or bullying were reported of which 447 were cases of verbal abuse, 131 were cases of being threatened, 80 were cases of assault and 42 were cases of bullying. According to the responses, there were no cases of injury from cases of verbal abuse, threats, assaults or bullying. However, the GHG-12 score (12-item General Health Questionnaire) was closely correlated with the number of violence and bullying incidents. Farrell et al.'s (2006) study included 2,407 nurses in the Australia health sector with a response rate of 38%. The study found that a significantly higher number of bullying cases (verbal and physical) were reported in public hospitals compared to private hospitals. Findings showed that 63.5% of the participants had experienced a form of aggression – either verbal or physical abuse. Similar to the findings of Scott et al. (2015), a significant number of victims of verbal and physical abuse were male compared to female. Due to the high rate of aggression, 11% of the respondents indicated that they wanted to leave the profession at some stage in their career. Hills et al.'s (2013) study included 9,949 health sector employees in Australia with a 57.9% response rate. The authors also found that there was a higher risk of aggression in a public hospital-based medical setting compared to a community based hospital setting. That is, a lower rate of

aggression was reported amongst general practitioners and specialists in the community compared to those employed in public hospitals. The findings suggested four intervention strategies with a prevalence rate greater than 60% –that is, policies, protocols and/or procedures for aggression prevention and minimisation which together can set a strategic direction for any organisation.

Scott et al., (2015) found that autonomy in the health sector is the highest value for money. Participants reported that they were more willing to sacrifice up to 19% of their salary for adequate autonomy than to deal with violence and workplace bullying and the poor processes in place to deal with it. The study also revealed that high rates of violence and workplace bullying is significantly associated with psychological stress. Nurses reported that they had no intention of changing to increase their working hours but instead wanted a 10% decrease in hours. It was noted in this study, to improve retention and job satisfaction in the health sector, focusing on autonomy, addressing violence and bullying processes and reasonable working hours is vital.

Psychological distress

Of the 23 research papers that were collected, four articles were analysed and themed under *psychological distress*. This minor theme included any form of negative health impact such as depression and being sick.

Rodwell & Demir's (2012) study included 233 hospital nurses in Australia with a response rate of 29.1% and 208 aged care nurses in Australia with a response rate of 43.8%. The authors found that hospital nurses regarded psychological distress to be the result of bullying whereas aged care nurses regarded depression to be the result of bullying. Results of this study indicated that workplace bullying had detrimental impact on both hospital nurses and aged care nurses. In total, 37.3% of hospital nurses reported that they had experienced some form of bullying and 35.6% of aged care nurses reported they had been bullied at work. Similarly,

in their study of health care administration staff in Australia, Rodwell et al. (2014) found that psychological distress was the most significant type of bullying and that bullying was linked to a lower level of commitment. This study included 150 health care administration staff with a 76% response rate. Results showed that 77% of participants reported not being bullied in the past 6 months, 12%, 7%, 3% 0% and 1% indicated they had rarely being bullied and 23% indicated they had been bullied in the last six months and that the bullying had not been a one-off incident. The significant effect found in this study was lower organizational commitment and well-being with the effect on commitment remaining over and above NA. It was also reported that a more significant level of distress was found amongst the full-time employees compared to part-time employees. Health care staff 34 years old and younger indicated they had significantly lower job satisfaction levels compared to other age groups.

Heugten's (2012) New Zealand study included 17 social care workers. Participants reported that they had suffered from health-related issues caused by workplace bullying. The heath related issues reported were headaches, skin problems, poor concentration, digestive problems, anxiety, memory problems and depression. Nine of the respondents reported that they had consulted their general practitioners about these health issues of which five were diagnosed with clinical depression, although only two were give medication for depression. The study revealed that bullying in the health sector is a common problem with psychological and health consequences for the employees. Respondents in the study reported that they felt a work/ life balance was impossible and that they had isolated themselves professionally and socially as bullying continued to take its toll.

Hutchinson et al. (2006) focused their study on alliances that control bullying and the reporting processes in the Australian health sector. This study included 26 nurses with 75% of participants having been employed for over four years with their current employer. Amongst these, 14 held senior positions in their specialised field. The study found that bullies were embedded in the system, meaning that the allies of bullies were in leadership roles and were able to control appointments, promotions and reporting systems. For example, a senior member who was a member of the "alliance" could control, trivialise or minimise reports of

bullying. The reporting system was meant to provide safety and protection for employees who were victims of bullying in the workplace. Unfortunately, having allies meant that bullies were protected. The authors noted that identification and development of informal networks was needed to respond to these bullying episodes.

In summary, bullying in the health sectors in Australia and New Zealand has significantly negative health and psychological consequences. This in turn affects work commitment and job satisfaction. It is important to recognise and address bullying and its psychological consequences in order to inform supervisors, managers, leaders, human resources and policy makers. Developing strategies to address workplace bullying will also help with recruitment and retention, especially important considering the current shortage in health sector employees and nurses.

Table 13: Summary of Studies Relating to the Psychological Stress Theme Category

Author, year of publication and origin of study	Study participants, sample size & response rate	Methods	Data Analysis	IV	DV	Key findings
Rodwell, J., Demir, D. & Steane, P. (2013), Australia	267 hospital nurses/midwives, 23.1% response rate 168 aged care nurses, 29.8% response rate	Questionnaire survey	Predictive analysis software 18.0 Chi-square test ANOVAS	Emotional abuse Bullying Distress	Psychological stress	1) High percentage of bullying exposure was reported - nurses/midwives 34.8% and aged care nurses 35.5% 2) Nurses/midwives experienced a higher level of psychological stress 3) Lower work commitment 4) Lower job satisfaction level 5) Nurses were affected by bullying in relation to psychological and organizational-oriented outcomes 6) Significant level of workplace bullying which is associated with higher psychological distress ($F(1, 252) = 5.75$, $P < 0.05$), lower work commitment rate ($F(1, 253) = 18.18$, $P < 0.001$), and job satisfaction level ($F(1, 254) = 6.79$, $P < 0.01$
Hegney, D., Plank, A & Parker, V., (2003), Australia	441 aged care nurses 50% response rate 497 public nurses, 47% response rate 498 private, 29% response rate	Questionnaire survey	SPSS for Windows (Release 10.0.5, SPSS, Chicago, USA)	Workplace violence Aggressive behaviour Emotional abuse Bullying	Psychological stress	1) 29% of nurses that were employed less than 5 years reported abuse compared to 4% to nurses who had been employed for 35 years or more 2) 40% of abuse reports were from nurses who had been working less than 5 years Workplace violence (WV) from medical practitioners compared to 13% with five or more years' experience 3) Horizontal bullying was not significant. It was evident in the aged care i.e. nurses Level 1 experience WV more from visitors and relatives than than other nursing designations 4) Effective strategies being emplaced to address aggressive behaviour from staff and non-staff: 70% reported effective in the public sector and

						65% in the private sector 5) Only 71% in the aged sector and 55% in the acute private sector were aware of such policies dealing with non-staff 6) Male nurses employed in the public sector reported to experience more workplace violence compared to female nurses For example, (P=0.003) with 72% of male nurses and 45% of female nurses reporting abuse.
Demir, D. & Rodwell, J. (2012), Australia	207 nurses and midwives, 26.9% response rate	Cross-sectional survey	Predictive analysis software (PASW) 18.0 (SPSS Inc., 2009) Job Demand-Resource model (JD-R) and NA variables ANCOVAs	Emotional abuse Workplace aggression Bullying Distress Stress	Psychological stress	1) 62.3% reported "no" to workplace bullying, 18.6% indicated "yes", 13.2 very rarely, 1.5% indicted "yes, now and then" 2) High frequency of reported internal and external emotional abuse whilst not exposed to workplace aggression 3) Bullying and verbal sexual harassment were related to a high rate of psychological distress 4) Bullying and internal emotional abuse were related to a lower rate of work commitment 5) External threats were related to high work demands 6) In regards to antecedents, bullying was related to high negative affectivity (NA) as well as low support from supervisors and colleagues.
Mayhew, C., McCarthy, P., Chappell, D., Quinlan, M., Barker, M. & Sheehan, M. (2004), Australia	400 in the public health system (45 different hospitals and 14 ambulance stations and a number of community health centres in the state of New South Wales (NSW)	Qualitative analysis (Face-to-face interview)	General Health Questionnaire (GHQ) General Anxiety Disorder (GAD) diagnostic tool Post-Traumatic Stress Disorder	Emotional trauma Bullying Emotional stress	Psychological stress	1) Violence in the health industry was not homogeneously distributed across the health workforce. 2) Experiences of violence varied significantly within occupational groups - nurses in the emergency wards witnessed more violent cases compared to nurses employed in community health centres

			(PTSD) tool			3) 400 health workers interviewed had experienced 585 separate incidents that involved 447 cases of verbal abuse, 131 cases of threats, 80 cases of assaults and 42 cases of bullying. From reports submitted, there were no cases of injury from the cases of verbal abuse, threats, assaults and bullying.
			Prolonged Duress Stress Disorder (PDSD)	Workplace injuries		
				Shift work		4) However, the GHQ-12 scores were closely correlated with the number of violence/bullying incidents
				Violence		
				Aggression		
Huntington, A., Gilmour, J., Tuckett, A., Neville, S.,	162 in nursing practice	Qualitative analysis	Code process described by Braun and Clarke (2006)	Physical abuse	Psychological stress	1) Physical and mental health was sacrificed (i.e. moving, lifting patients, fatigued, drained, exhausted, tired, emotional burden etc.)
Wilson, D. & Turner, C. (2011),			Thematic analysis	Emotional abuse		2) Increased work hours and pressures and ridiculous work load = 'unpleasant', 'turmoil' 'work situation)
Australia			Flexible style of data analysis	Bullying		3) Work system and management were power driven therefore staff were left feeling devalued and not supported
				Stress		4) Work culture was organised in a way where there was unequal power amongst colleagues
				Workplace injuries		
				Shift work		
Hills, D.J., Joyce, C.M. & Humphreys, J.S. (2013),	9949 doctors in clinical practice, 57.9 % response rate	Exploratory cross-sectional,	Pearson's Chi-square test	Workplace aggression	Psychological stress	1) Public hospital-based medical setting experienced a higher risk of aggression compared to community-based hospital setting
Australia		self-report survey		Bullying		2) A low prevalence rate of aggression prevention actions were found for general practitioners and specialists - largely doctors compared with public hospitals
		(Longitudinal study)		Harassment		3) Four intervention strategies that had a

						prevalence rate greater than 60% were policies, protocols and/or procedures for aggression prevention and minimisation (65.6%). Can set a strategic direction for any organization
Allen, B.C., Holland, P. & Reynolds, R. (2014), Australia	762 nurses	Cross section quantitate study	Statistical Package for the Social Sciences (SPSS, Chicago, IL, USA) Version 20.0 software program Cronbach's alpha of 0.70	Burnout Bullying Psychological detachment	Psychological stress	1) Bullying was significantly associated with burnout 2) Psychological detachment did not moderate the relationship between bullying and burnout 3) Bullying presented a strong negative toll on nurses 4) 38% of the participants experienced a high to very high level of burnout (54 out of 100 in this study)
Meloni, M. & Autin, M, (2011), Australia	Calvary Health Care ACT (CHCC) 1,200 employee, 55% response rate	Case study of ACT hospital Employee satisfaction survey	Bullying and harassment program experiment for 3years (Zero-tolerance approach)	Harassment Bullying Stress Less employee engagement Turnover	Psychological stress	1) High rate of perceived bullying and harassment in the workplace and a low level of trust in the management over bullying and harassment issues 2) CHCA Zero Tolerance of Bullying and Harassment program established to raise awareness and encourage bullied employees to seek help from within the organisation 3) After nearly three years of the zero-tolerance program, there had been a positive impact including the contribution to an overall increase in staff satisfaction and improvement in the harassment and bullying as revealed in the latest employee satisfaction survey 4) Employees now knew where and how to report bullying or harassment at work
Rodwell, J. & Demir, D. (2012), Australia	273 nurses and midwives, 37.1% response rate	Cross-sectional design	Predictive analysis software (PASW) 17.0 (SPSS Inc. 2010) NA and demographic	Workplace aggression Occupational health	Psychological stress	1) There was a relationship of shift times/work schedule and bullying with morning shift more likely to experience bullying compared to other shifts 2) The study found that there was a high level of bullying: 18% reported occasional or frequent bullying

			variables DCS variables (job demands, job control, supervisor support, co-worker support and outside work support)	Bullying Internal physical assault		and 10% reported emotional abuse internally and externally as well as external threats of assault 3) Violence types revealed that internal physical assault was more significant amongst nurses and midwives 4) External threats of assault were significant amongst nurses and midwives employed nine years or less or between 10-14 years 5) Antecedent 1: NA and bullying (B = 0.08, p < 0.001) where high levels of NA were linked to bullying acts 6) Antecedent 2: relationship between those rostered for morning shifts and bullying (B = 0.66, p < 0.05), meaning morning shift workers experienced more bullying acts than those on other shifts
Demir, D. & Rodwell, J. (2012), Australia	207 nurses and midwives. 26.9% response rate	Cross-sectional survey	Predictive analysis software (PASW) 18.0 (SPSS Inc. 2009) ANCOVAs JD-R and NZ variables	Emotional abuse Distress Workplace aggression Stress Workplace bullying	Psychological stress	1) High rate of nurses reported exposure to workplace bullying and internal and external emotional abuse violence types 2) External threat/assault was associated with high job demands and high negative affectivity (NA) 3) Internal emotional abuse was associated with a low level of support 4) Bullying was linked to high NA, low supervisor support and low job control 5) In regard to antecedents, 4 types of aggression were discovered: bullying, internal emotional abuse, external emotional abuse and external threat of assault 6) Consequences of the above were: bullying [F (1,199) = 5.76, p < .05] and internal abuse were highly associated with lower

						commitment levels. NA was significant for commitment in external emotional abuse and external threats of assault
Rodwell, J. & Demir, D. (2012), Australia	233 hospital nurses, 29.1% response rate 208 aged care nurses, 43.8% response rate	Cross-sectional survey	Predictive analysis software (PASW) 17.0 (SPSS Inc. 2010) ANCOVAs, Negative affectivity	Mental health Distress Workplace bullying Psychological well-being Depression	Psychological stress	1) Psychological distress was reported as an impact of bullying by hospital nurses 2) Depression was reported as an impact of bullying for by aged care nurses 3) 37.3% of the hospital nurses reported that they had experienced some degree of bullying 4) 35.6% of the aged care nurses reported that they had experienced being bullied at work
Rodwell, J., Demir, D. & Flower, R.L. (2013), Australia	547 nurses, 34% response rate 223 healthcare administration staff, 85% response rate	Questionnaire survey	SPSS 19.0 (IBM Corp 2010) JD-R and NA variables	Workplace aggression Negative work environment Workplace violence Internal/external emotional abuse Internal/external threat Internal/external physical abuse	Psychological stress	Note - The huge gap in the response rate may have been a result of the nature of work (administration staff sit in the office and had a greater opportunity to complete the survey compared to the nurses) 1) 26% of nurses and 27% of the administration staff reported having experienced some form of bullying 2) The most frequent type of violence against nurses was external abuse (29%) and internal abuse (20%) was reported by the admiration staff 3) There were not enough incidents of violence reported for analysis to be conducted. The sample from the nurses was only conducted for bullying, threats of assaults, internal and external emotional abuse and external physical assault. The healthcare administration staff sample was only conducted for bullying, external and internal abuse

						4) Emotional abuse was highly linked to job demands 5) Supervisors support was insignificantly linked with internal abuse
Scott, A., Witt, J., Duffield, C. & Kalb, G. (2015), Australia	990 nurses and midwives, 49% response rate	Discreet choice experiment (DCE)	Generalized multinomial logit model (GMNL) Willingness-to-pay (WPL) calculation SAS software	Work environment Work safety Long hours and shift types Pay and leadership	Psychological stress	1) Autonomy had the highest monetary value where nurses and midwives were willing to sacrifice 19% and 16% of their salary for adequate autonomy rather than dealing with violence and bullying. 2) To increase working hours by 10%, nurses would have to be paid an additional 24% of their annual salary 3) Nurses preferred no change in hours to a 10% decrease in hours 4) For future retention and job satisfaction policies, focusing on autonomy, addressing violence and bullying and reasonable working hours would improve this problem.
Rodwell, J. & Demir, D. (2014), Australia	269 aged care nurses	Cross-sectional survey	Job demands-resource model (JD-R) NA variables	Workplace violence Emotional abuse Threat of assault	Psychological stress	1) Majority of the bullying experiences were not reported 2) 36.4% reported external physical assault, 35.7% reported external threats of assault and 28.6% reported external emotional abuse 3) Internal threat of assault reported a low rate of 2.6%, 3.3% reported internal physical assault and internal verbal sexual harassment reported 0.8% 4) High job demands were linked with external verbal sexual harassment
Farrell, G.A. & Shafiei, T. (2012), Australia	1495 nurses and midwives, 30% response rate	Questionnaire survey (Descriptive study)	Chi square test and P value Descriptive statistics	Harassment Stress	Psychological stress	1) 52% experienced some form of workplace aggression (WA) 2) 36% experienced violence from patients or their relatives/visitors

			including frequencies			3) 32% experienced bullying from their colleagues, managers or supervisors
			and percentages	Bullying		4) This study suggests that employees were less worried about patient initiated aggression than bullying from colleagues
				Workplace aggression		5) Respondents clearly stated that they wanted better and more realistic training as well as the enforcement of policies and support when incidents are reported
				Work safety		
				Violence		
				Distress		
Heugten, K. (2012), New Zealand	17 social workers health	Qualitative semi-structured research project	Grounded theory approach to code data Version 7 (2006) and Version 8 (2008) of QSR International's NVivo qualitative data analysis software	Stress	Psychological stress	1) Participants in this study had suffered health-related consequences - for example, headaches, skin problem, poor concentration, digestive problems, memory problems, anxiety and depression.
				Negative work environment		2) Nine of the participants consulted their general practitioners about these health issues and five were diagnosed with clinical depression although only two had taken medication for depression
				Negative health impact		
				Bullying		3) No work-life balance
				Distress		4) Respondents reported that they had become increasingly isolated professionally and socially as workplace bullying continued to take its toll.
Rutherford, A. & Rissel C. (2004), Australia	311 health sector organization employees, 79% response rate (60% clinical work, 23% management and	Questionnaire survey	Epi Info™ Version 6 Microsoft excel	Emotional abuse	Psychological stress	1) 50% of the participants reported having experienced one or more forms of bullying in the past 12 months
				Leadership		2) In this study the largest source of workplace bullying was peers or colleagues (49%), followed by clients (42%)

	16%public health promotions)			Organizational environment		and managers or supervisors at 38% 3) Only 36% of the participants reported the incidents 4) The types of bullying reported were intimidating behaviour, shouting or ordering, use of abusive tones or language, physically threatening behaviour, comments about race, age or gender and unwanted sexual comments 5) Feeling of isolation from the group was related to a significant rate of emotional abuse
Farrell, G., Bobrowski, C. & Bobrowski, P. (2006), Australia	2,407 nurses, 38% response rate	Questionnaire survey	SPSS™ version (SPSS Inc., Chicago, IL, USA) Chi-squared test	Verbal abuse Physical abuse Distress Bullying Negative work environment Aggression Violence Work conflict	Psychological stress	1) 63.5% of the participants had experienced some form of aggression - either verbal or physical abuse. 2) A significant higher number of reported verbal and physical abuse incidents in public hospitals compared to private hospitals 3) Significant number of victims of verbal and physical abuse were males compared to females 4) 11% of the respondents wanted to leave the profession at some stage in their career
Hutchinson, M., Vickers, M.H., Jackson, D. & Wilkes, L. (2006), Australia	26 nurses	Qualitative Mixed method study (in-depth semi-structured interview)	Verbatim transcribed Constant comparative method (Lincoln & Guba (1985) NVivo software program (Richards 1999)	Abusive behaviour Emotional abuse Verbal abuse	Psychological stress	1) The alliance of bullies controlled appointments, promotions and the reporting processes. 2) A more senior member of the "alliance" was able to trivialise and minimise reports 3) Bullies were protected and promoted 4) Identification of informal networks requires new

						ways of thinking and responding to these bullying episodes.
Cashmore, A.W., Indig, D., Hampton, E.S., Hegney, D.G. & Jalaludin, B. (2012), Australia	299 health professionals, 42% response rate	Self-administered survey	Descriptive statistics Chi-Square	Physical abuse Emotional abuse Workplace abuse Bullying Harassment Verbal abuse Workplace environment	Psychological stress	1) 76% had experienced some form of negative act/abuse of which most were verbal abuse 2) 16% had experienced physical abuse. 3) Patients were identified as the main perpetrators followed by health staff/colleagues 4) 48% had experienced abuse at least once by their colleagues
Hayes, B., Douglas, C. & Bonner, A. (2014), Australia	417 nurses	Online Survey	SPSS (Chicago, IL, USA) Version 21 AMOS (Chicago, IL, USA) Version 22 software Little's MCAR test Normed Chi-square Comparative Fit Index (CFI) Goodness of Fit Index (GFI) Root Mean Square Error of Approximation (RMSEA)	Workplace environment Burnout Emotional exhaustion Job stress	Psychological stress	1) Nurse's work environment contributed to a positive outcome of job satisfaction. which also had a direct and indirect effect on emotional exhaustion by mitigating job stress 2) Job satisfaction had an indirect effect on emotional exhaustion by mitigating job stress 3) Job satisfaction did not have any direct effect on emotional exhaustion 4) A positive and strong correlation between work environment with feeling valued and manager support 5) Nurses job satisfaction predicted their level of burnout, emotional exhaustion and job stress
Rodwell, J., Demir, D., Parris, M.,	150 health care administration staff, 76% response rate	Questionnaire cross-sectional study	Descriptive analysis	Bullying		

Steanne, P. & Noblet, A. (2012), Australia		(Questionnaire data)	T-test ANCOVAs Harman's ex-post one factor test	Distress Job satisfaction Commitment Negative affectivity Psychological Emotional	Psychological stress	1) The significant effect found in this study was lower organizational commitment and well-being with the effect on commitment remaining over and above negative affectivity (NA) 2) 77% responded they had not being bullied in the past six months, 12%,7%, 3% 0% and 1% indicated they had rarely being bullied and 23% indicated they had been bullied in the last six months and not as a one-off incident. 3) Health care staff 34 years or younger indicated they had significantly lower job satisfaction levels compared to other age groups. 4) Results showed significant psychological distress as a type of bullying 5)Bullying was associated with lower levels of commitment 6) Full-time employees experienced a more significant level of distress compared to part-time employees
Roche, M., Diers, D., Duffied, C., & Catling-Paull, C. (2010) Australia	2, 487 nurses, 80.3% response rate	Cross-sectional method and primary data collection	SPSS version 16 (SPSS Inc., 2007) Nursing Work-Index Revised (NWI-R) Environmental complexity scale (ECS) PRN-80 (measure of patient acuity) Skill-mix	Workplace violence Emotional abuse Intention to leave Emotional violence Work environment	Psychological stress	1) One third of the participants experienced emotional abuse in the last five shifts worked. 2) 14% experienced some form of threat 3) 20% experienced actual violence. This was associated with increased ward instability which reflected the lack of leadership: difficult MD and RN relationship 4) Higher skill mix reported fewer reports of violence at the ward level 5) The intention to leave was associated with emotional violence and not threat or assault 6) 50% of respondents experienced perceived physical violence, 66% threats of violence and 65% emotional abuse

4.3. Conclusion

This chapter has systematically analysed the literature to determine the antecedents and consequences of workplace bullying that lead to employee job-related and health-related outcomes in the health sectors of Australia and New Zealand. There are many factors that can cause workplace bullying in the health sector setting. The literature identified the antecedents of workplace bullying that lead to job-related and health-related outcomes for employees are lack of communication on either horizontal or lateral levels, lack of support from colleagues, supervisors and/ or managers and no clear processes to remedy bullying. This leads to role conflicts and a negative work environment or unhealthy social environment. Secondly, the literature shows that the consequences of bullying on job-related outcomes and employee health and well-being are high turnover or the intention to turnover, decrease in job satisfaction, negative affectivity, low level of work commitment and negative relationships at work.

Developing and creating strategies to address the problem of workplace bullying in the health sector of Australasia is crucial. The literature makes evident that with the right policies and strategies to address this problem, the work environment can become a better and more positive place. The literature suggests that mediators need to stress the need to provide these prevention relationship policies and identify policies that focus on the antecedents of workplace bullying in order to prevent the causes of bullying.

CHAPTER FIVE: DISCUSSION AND CONCLUSION

The first objective of this study has been to investigate and systematically find answers as to what are the antecedents (or causes) of workplace bullying in the health sectors of Australia and New Zealand that lead to employee job-related and health related outcomes. The second objective has been to investigate and systematically find answers as to what are the consequences of workplace bullying in the health sectors of Australasia in terms of job-related outcomes and/ or employee health and well-being.

5.1. Introduction

This chapter begins by presenting the main conclusion of this research paper. The section briefly summarises the findings in relation to workplace bullying in general. The study found that the victims of bullying are negatively affected in terms of health and this affects the organisation as a whole in terms of commitment and productivity. Targets of bullying have low self-esteem, stress, burnout and psychological stress which affects their work commitment and in return affects organisation productivity which results in a significantly high turnover rate.

This second section also briefly summarises the findings of bullying in the health sector. This area has been extensively researched and it has generally been agreed that there is a high rate of workplace bullying at all the levels of the sector. This has led to negative work environments which affect the commitment of employees and also creates a base for further bullying to occur. Negative work environments refer to work systems, management and work load. It has also been found that horizontal bullying is widely practised in the health sector (Hutchinson & Jackson, 2014). For example, power relations within the sector are being used to construct and corrupt legitimate processes for authoritative personal gains (Hutchinson & Jackson, 2014). This has resulted in a high cases of workplace bullying, a phenomenon which leads to the need to explore bullying costs at the organisational level as an avenue for future research.

The third section of this chapter examines the literatures in Australia and New Zealand in relation to this study's findings regarding bullying in the health sectors of Australia and New Zealand. For example, the study found that bullying leads to a high turnover rate and that work environments are an antecedent of workplace bullying. It also found that there is a lack of information that links the different work environments and different healthcare establishments and that horizontal bullying and lack of career development and support is one of the common, major issues. The section will also highlight the lack of utilisation of the Negative Acts Questionnaire (NAQ) instrument within the health sectors of Australia and New Zealand and suggest the use of this instrument in future research in order to understand the link between individuals and organisational structure that results in workplace bullying.

The next section discusses the practical implications of this systematic research study. During the research process, it became apparent that there is insufficient current knowledge and/ or research on any updated legislations and policies at the government level. It was also recognised that negative work environments are an antecedent of bullying in regards to power relations which corrupt the work processes and system. This section also revisits the limitations that this systematic research study encountered in the process of gathering systematic reviews and the data of this study.

The chapter concludes with recommendations for future research in this area and a summary. These recommendations include exploring bullying in the Australian and New Zealand healthcare sectors as a whole as there is lack of knowledge and understanding of the antecedents and outcomes and/ or consequences of workplace bullying in this greater context. Further recommendations include researching bullying costs within the health sectors of Australia and New Zealand and providing knowledge on the current legislations in both countries that address bullying. It is also recommended that more longitudinal and process models be used to link horizontal bullying and power relations within organisational constructs as well as the use of the Negative Acts Questionnaire (NAQ) for further research or theoretical development on the link between organisational structure and individuals in positions of power that results in a bullying culture within an organisation.

5.1.1. Workplace bullying

On the individual level, victims of bullying in the workplace are affected negatively in regards to their health such as experiencing burnout, psychological distress and stress, which affects their work commitment resulting in high clinical errors, a high rate of absenteeism and an intention to turnover (Trepanier, Fernet, Austin & Boudrias, 2016). The findings of this study show that workplace bullying has significant consequences, not only on the individual level but also on the organisational level. In the nursing field, there is a high turnover rate and shortage of nurses (Farrell et al., 2006) due to nurses' exposure and vulnerability to bullying. The literature review in Chapter 2 identified that the high turnover rate in the health sector in general is an organisational consequence of bullying and that development strategies and policies are encouraged to address this issue. The results of this study show The results demonstrated that although a high intention to turnover as a result of bullying is still an issue, there have been a number of effective programs such as Zero Tolerance Bullying and Harassment and other policies that advocate the minimisation of this phenomenon that have been successful. Despite this, ongoing instances of bullying and the negative health effects and organisational consequences of bullying have led to an increase in literatures and researches that seek to identify the antecedents of workplace bullying (Demir & Rodwell, 2012; Samnani & Singh, 2012; Rodwell & Demir, 2012).

The findings of this study show that negative work environments are an antecedent of workplace bullying. Negative work environments are linked to work systems and the supervisors and managers within organisations. These are environmental settings that can set the basis for bullying to occur. Research has found that horizontal bullying is an antecedent of workplace bullying due to the systems, procedures and processes controlled by management (Hutchinson & Jackson, 2015; Demir & Rodwell, 2012; Hutchinson & Jackson, 2015; Hutchinson, Vickers, Wilkes & Jackson, 2009). Findings of this study show that horizontal bullying and/ or power relations within an organisation is used to construct and corrupt legitimate processes for authoritative personal gains. The findings of this research paper show that individual level antecedents have been examined but variables such as clear guidelines on work processes and professional training for supervisors and managers in

dealing with different personalities has not been thoroughly examined. The literature review in Chapter 2 identified this as a gap and this study recommends this as an area for future research.

Developing the right strategies and policies or processes and procedures within an organisation that address workplace bullying have been proven in the literature to have a positive effect on employees and/ or victims, improve job satisfaction and set a strategic direction for the organisation (Meloni & Autin, 2011; Hills, Joyce & Humphreys, 2013). The findings of this study show that effective programs such as Zero Tolerance and Harassment programs, along with targeted policies and strategies, minimise workplace bullying. In this way the focus is on the antecedents of workplace bullying and/ or any type of negative act linked to negative work environments, work systems and leadership.

It is clear that workplace bullying has negative consequences on employee health outcomes which in turn affect job-related outcomes, resulting in low organisational commitment and productivity from employees. This study confirms that negative work environments such as work systems, leadership, horizontal bullying, any form of negative act and less support in career development and growth are antecedents to workplace bullying. These negative work environments are one of the reasons for a high turnover rate in an organisation. This study could not find enough details regarding workplace bullying costs per employee in terms of lost work performance and/ or any legal costs at the organisational level. This is a vital area of research as it addresses the losses that companies and/ or sectors make or face in dealing with preventable costs. The results of such research could also encourage leaders to create the right programs, policies and strategies that can minimise this phenomenon.

5.1.2 Workplace bullying in the health sector

There has been extensive research on workplace bullying in the health sector (Rutherford & Rissel, 2004; Hutchinson & Jackson, 2015). Findings of this current study agree with the research findings that there is a high rate of workplace bullying at all the levels of the healthcare sectors in Australia and New Zealand. The consequences of this for nurses include a high nursing turnover rate and a shortage of nurses (Farrell et al., 2006) due to their exposure and vulnerability to bullying. The literature have has reported that the antecedents of bullying amongst the nurses are negative work environments that enable bullying to occur (Trepanier et al., 2016). These environments relate to work systems, management and leadership. Findings of this study show that negative work environments also relate to high workload (Trepanier et al., 2016), stressful situations (Vecik, Sarita & Altuntas, 2012) and structural disempowerment (Read & Laschinger, 2013). Organisational characteristics such as work systems, leadership, management and negative employee's relations have been confirmed to be antecedents of workplace bullying (Hutchinson et al., 2010). The findings of this research paper show that there are indeed important antecedents identified in the literature and have been examined extensively; however, the methods used to uncover these antecedents are not extensive enough – for example, most of the empirical articles in our findings only utilised cross-sectional data and more longitudinal and process models are needed.

There is also a lack of relevant research that links different work environments within the health sector. The findings of this study support the research of Trepanier et al. (2016) who found that work environments are an antecedent of workplace bullying and there is lack of information that links the different work environments and different healthcare establishments.

Horizontal bullying has been identified as one of the main forms of bullying and an insidious phenomenon in the healthcare sector environment (Yildirim, 2009; Rutherford & Rissel, 2004). This study found that horizontal bullying is widely practised in the healthcare sector (Huchinson & Jackson, 2014). For example, power relations within the sector are being used to construct and corrupt legitimate processes into authoritative personal gains (Huchinson & Jackson, 2014). Linking and understanding these power relations and/ or individuals in positions of power within an organisation's culture could be an avenue for further research or theoretical development.

Most workplace bullying studies tend to focus on nursing rather than on other healthcare professions and/ or clinical staff (Rodwell, et al., 2012). This study has found that there is a lack of research exploring workplace bullying and negative acts amongst health professionals and organisations as a whole (Cashmore et al., 2012). There is also a lack of knowledge and understanding on the antecedents and outcomes and/ or consequences of workplace bullying specifically in the healthcare sector as whole. In order for an organisation to grow, it is essential that employees are able to perform to their capacity and thereby increase in job satisfaction and productivity. In cases and situations where employees are being bullied, performance and high job satisfaction are not achieved and there is consequently no organisational growth. In order maximise performance and job satisfaction, it is vital that bullying is addressed both at the individual and organisational level through policies and practices.

The results of this study show that there is not enough knowledge and research on the costs of bullying at the organisational level. This is a valid area of research as costs can be reduced within the organisation as a whole, both in terms of employee health and paying out for bullying, if the focus is directed towards developing theories, programs, policies and strategies that deal with minimising workplace bullying within the organisation.

5.1.3 Workplace bullying in the health sectors of Australia and New Zealand

There are several reasons why bullying in the workplace continues to happen in the health sector. Firstly, there is limited training and development within management where skills and knowledge can be enhanced to develop systems that address this issue. Secondly, there is a lack of acknowledgement and appreciation of the different types of personalities and ethnic groups employed in the health sector which causes internal conflicts. Thirdly, there is a lack of strategies and policies that address the issue of bullying as well as hierarchical power relations that enable negative acts of bullying to occur continuously, thereby corrupting the system (Kelly, 2004; Hutchinson et al., 2015). There has been less attention given to these issues in Australia and New Zealand compared to other parts of the world. The majority of research on this topic has been conducted in the Scandinavia countries and other European countries (O'Driscoll et al., 2015). Such research has identified that individuals who have experienced negative acts such as bullying are deeply affected; however, having a supportive organisation and supervisors is associated with positive outcomes (Chen, Eisenberger, Johnson, Sucharski & Aselage, 2009). Leading researchers in this area have utilised the Negative Acts Questionnaire (NAQ) instrument developed by Einarsen and his colleagues to measure the level of bullying in an organisation and its outcomes (O'Driscoll et al., 2015). However, the findings of this study show that most researchers have not utilised this instrument to link individuals' experience with the organisational structure and/ or management. It is recommended that this instrument be used in further research or theoretical development in order that this area be better understood – especially in terms of linking organisational structure and individuals in a position of power within the organisational culture.

This study also found that there is insufficient knowledge or research on management training and development where skills and knowledge can be enhanced to address the issue of workplace bullying. There has also been little research that has addressed workplace bullying in terms of dealing with different personalities, ethnic groups and internal and external conflicts – as well as a lack of strategies and policies to deal with these issues. For example, from the 50 reviewed articles included in this study, only two addressed this issue within the

hospital and/or healthcare sector: Stevens (2002) developed strategies to deal with the turnover rate with a resultant drop from 28.4% to 21.9% over a three-year period. Meloni and Autin (2011) developed a Zero-Tolerance of Bullying and Harassment program within the hospital setting which after three years was shown to have contributed to an overall increase in employee satisfaction and a lowering of harassment cases.

It was also found in this study that hierarchical power relations enable negative acts of bullying to continuously occur, ultimately corrupting the system (Kelly, 2004; Hutchinson et al., 2015). For example, from the 50 reviews of workplace bullying included in this study, 13 were focused on horizontal bullying. It is obvious that power-relations and horizontal bullying are evident in this sector, with significantly negative consequences in terms of health issues and a very high turnover rate. Management and/ or leadership plays a vital role in creating a positive work environment or better place to work in. They have the power to create prevention programs, policies and strategies to deal with the issue of workplace bullying and also to follow clear processes and procedures when dealing with cases of workplace bullying – something that was not made evident in the researchers analysed in this study.

Effective legislation means requiring organisations to develop policies and strategies and processes and procedures to minimise workplace bullying and make sure that future cases of workplace bullying are being dealt with within the organisation (Very, 2008). However, the results of this study showed that there have been few reviews on updated legislations within Australia and New Zealand that address the bullying phenomenon.

This study also found that there has not been enough research on the bullying costs at the organisational level within the health sectors of Australia and New Zealand. This is an important area of study as these costs can be prevented if the focus is directed at addressing workplace bullying in terms of developing clear guidelines and processes accompanied by the right strategies and policies. At national government level, numerous European countries and a number of states with the US have enacted legislation to criminalise bullying in the workplace (Blackwood & Bentley, 2013). In the case of Australia, despite the different laws at

state level, Australia's Fair Work Act 2009 (FW Act) that deals with health and safety legislation was enforced by the federal government and the state government, and in Victoria, the Crimes Act (1958) has recently criminalised bulling (Blackwood & Bentley, 2013). New Zealand's Employment Relations Act 2000 (ERA) and the Health and Safety in Employment Act 1992 (HSE Act) are legal avenues for investigating and determining which claims can be brought against organisations or individuals for any breach of duty while at work (Blackwood & Bentley, 2013). However, at the organisational level, it is dependent on the organisation as whole to create policies and strategies to prevent bullying or to deal with incidents of bullying as they arise. However, the findings of this study show that there is not enough information on the bullying costs at the organisational level for the health sectors in Australia and New Zealand. This area is vital as it addresses the losses that companies and/ or sectors make or face in dealing with preventable costs. These costs are a huge incentive for management to create the right programs, policies and strategies that can minimise the phenomenon of bullying.

5.2. Practical implications

During the analysis of the studies chosen for this research, it became apparent that there enough up-to-date information, knowledge and research on legislations and policies that address workplace bullying in Australia and New Zealand. It is important to be informed about such laws and regulations in order for an organisation to abide by guidelines. It is also important that practitioners in this area of study are encouraged to provide more updated knowledge. Considering the harmful effects workplace bullying has on the individual level and its consequences for the organisation, legislation is required for prevention. Legislation provides a "fence on top of the cliff rather than the current litigation ambulance at the bottom" (Very, 2008, p. 10). Human Rights Law makes it illegal to discriminate (Very, 2008); however Australian and New Zealand governments need to enforce this down to the organisational level. The benefit of legislation is that the organisation is obliged to abide within the law and importantly not only prevent bullying in the workplace but develop prevention steps towards minimising this issue. In regards to the organisational level, managers are encouraged to develop and advocate prevention programs, policies and strategies within the organisation not only to prevent decreased productivity and less job satisfaction due to bullying but also to avoid dealing with third parties to cover bullying costs.

One of the findings in this study is that a negative work environment, specifically horizontal bullying, is an antecedent of workplace bullying in the health sectors of Australia and New Zealand. Horizontal bullying includes power relations where power is used to corrupt legitimate processes and where allies of bullies are allowed to control processes and promotions (Hutchinson et al., 2009). At the governmental level, legislation needs to clearly define criteria and guidelines relevant to organisational systems such as requiring organisations to effectively develop strategies and procedures whereby bullying is identified immediately and dealt with in a timely manner before harm is caused. At the organisational level, management and human resource management representatives are responsible for actively abiding by the legislative laws and being proactive in advocating these internally. They have the power to create prevention programs, policies and strategies to deal with the issue of workplace bullying before it arises and to also follow clear processes and procedures

when dealing with cases of workplace bullying when it occurs. When managers and supervisors provide social support for individual employees, the outcomes are posistive. Positive relationships with management as well as colleague support in terms of sympathy, concern and understanding is related to an increase in job satisfaction and a positive outcome in general.

5.3 Limitations

Most empirical research has several limitations. Within this study, a limitation is evident in the data collection process used. This study used six electronic databases to extract data – Web of Science, ABI/Inform, Scopus, CINAHL, PsycInfo and Medline – resulting in a high number of duplicates. For example, in the second stage of research exclusion which refined all papers into full-text, journals, articles, English language and geographical location (New Zealand and Australia), 6,685 papers were excluded, largely because of duplication. Nothing was done to minimise this limitation other than to go through all the papers and confirm those that were eligible. It is possible that within such a comprehensive review, some papers were missed. Furthermore, the pool of articles within Australia and New Zealand was not sufficiently large enough once the term ‘antecedents’ was entered as a search term in all database. For this reason, the term ‘antecedents’ was removed in order to obtain a large pool of articles. The extraction and inclusion of data was crucial to the validity of the results found in this research topic.

A further limitation of this study is the analysis and categorisation of themes which was totally dependent on the author of this study. The themes may well have been categorised differently by another researcher. This limitation was taken into consideration and in order to validate the processes taken, a clear reviewing process was established. Studies obtained were further assessed by two independent reviewers to meet inclusion and exclusion criteria. The reference list of all the publications was reviewed and checked. Therefore, the categorisation of themes can be seen as problematic but definitely only a minor limitation.

5.4 Future research

A possible avenue for further research could be first, to explore bullying in the healthcare sector as a whole within Australia and New Zealand. There is lack of knowledge and understanding on the antecedents and outcomes and/ or consequences of workplace bullying specifically in the healthcare sector as whole. While there has been a large amount of research on nursing and the consequences of workplace bullying, there is a need for information on the antecedents of workplace bullying focusing on the health sector as whole. It would be interesting to see if the results of a survey undertaken throughout the health sectors of Australia and New Zealand would provide different results. To support the retention of employees in the health sector, determining the factors involved in workplace bullying would be able to minimise this issue and at the same time predict any future occurrence. Future research that can examine antecedents and consequences of bullying in the health sector would be able provide knowledge and potentially help organisations to create work systems and processes to address this phenomenon.

Another possible avenue of research is research on bullying costs within the health sectors of Australia and New Zealand. This study could not find details regarding workplace bullying costs per employee in terms of lost work performance and/ or any legal costs at the organisational level. Qualitative research is recommended to focus on the Australian and New Zealand health sectors targeting managements that hold records of workplace bullying cases and costs that have progressed to the legal stage is vital as would address the losses that companies and/ or sectors make or face in dealing with preventable costs. The results of such a research would encourage leaders to create programs, policies and strategies that could minimise this issue and also prove that bullying costs are preventable.

Another possible avenue of research is the provision of knowledge on current legislation within the health sectors of Australia and New Zealand that addresses bullying. The analysis of existing researches showed that there is not enough knowledge on current legislation at the state and government level. This knowledge is important as it can be used as a driving

force for organisations to respond to current legislation by creating steps that address the issue of workplace bullying.

Negative work environments reflect inadequate work systems, leadership and management as well as colleagues with conflicting personalities and are antecedents to bullying (Kelly, 2004; Hutchinson et al., 2015). Negative work environments are linked to horizontal bullying and power relations within the organisation. This is an area of research that could provide useful results in the future. Antecedents of workplace bullying have been extensively discussed in the literature; however the methods used to uncover these antecedents are not sufficient. For example, most of the empirical articles in analysed in this research only utilised cross-sectional data and more longitudinal and process models are needed.

Lastly, there is lack of acknowledgement of the different types of personalities and ethnicities that can cause internal conflict leading to bullying. Within Australia and New Zealand in particular, ethnicity has a strong influence on community status relationships. The work-force has a wide variety of ethnic affiliations resulting from racial or cultural ties and therefore it is crucial that steps are taken within the health sector and any other sector to support any form of education and advocate diversity and equal opportunity. Managers and supervisors are not given enough training in dealing with these issues. A possible avenue of research is the utilisation of the Negative Acts Questionnaire (NAQ) instrument developed by Einarsen and his colleagues (O'Driscoll et al., 2015). This could be used in future research or theoretical development to link organisational structure and/ or individuals in positions of power with organisational culture.

5.5 Conclusion

This chapter examined the findings in relation to the literature. First, it examined the antecedents of workplace bullying and found that negative work environments are the most common base for bullying to occur. These negative environments refer to work systems and work environment settings. In these settings, horizontal bullying is seen to be an antecedent of workplace bullying with significant consequences for the victims of bullying, leading to low work commitment, job satisfaction and organisational productivity. The chapter also showed that effective programs or policies within organisations that address workplace bullying are able to minimise its occurrence or prevent it from happening at all. Developing effective programs and policies that address this issue can also cut bullying costs at the organisational level.

Second, this chapter revisited bullying in the healthcare sector. A high rate of bullying has been reported in this sector. The consequences of this is a continuous high turnover rate and turnover intention. The chapter also pointed out that negative work environments are reflected in inadequate work systems and heavy workloads that lead to stressful situations and horizontal bullying.

Third, this chapter revisited bullying in the healthcare sectors of Australia and New Zealand. Several reasons were identified as to why bullying in the workplace continues to happen in the health sector. These include limited training and development within management to address this issue through systems and polices. There is also a lack of acknowledgement and appreciation of the different types of personalities and ethnic groups employed in the health sector and the internal conflicts these differences can lead to. Further, there is a lack of strategies and policies that address the issue of workplace bulling and the hierarch power relations that enable bullying to occur (Kelly, 2004; Hutchinson et al., 2015). It was concluded that managers are not given enough training to deal with these issues. It was also pointed out that power-relations and horizontal bullying are evident in this sector with significant negative consequences in terms of health issues and a very high turnover rate. The chapter also discussed the lack of information on bullying costs at the organisational level within the health

sectors of Australia and New Zealand. This is a vital area of future research that could address the losses that companies and/ or sectors make or face in dealing with preventable costs. This can also push for management to create the right programs, policies and strategies that can minimise this phenomenon.

Overall, this research has contributed to the body of literature by first showing that there is lack of knowledge and understanding of the antecedents and outcomes and/ or consequences of workplace bullying specifically in the healthcare sector as whole. While there is a great deal of research on nursing and the consequences of workplace bullying, more information on the antecedents of workplace bullying focusing on the health sector as whole is needed.

Second, this research has shown that there is insufficient knowledge and research on current legislations and policies that address workplace bullying in Australia and New Zealand. It is important that an organisation is informed of these laws and regulations in order to follow the practical guidelines that they offer. It is also important that researchers in this area of study continuously seek updated information in order to assist organisations in creating steps to address the issue of workplace bullying based on legislative requirements.

Third, there is lack of knowledge and detail regarding workplace bullying costs per employee in terms of lowered work performance and/ or any legal costs at the organisational level. It is essential that this area is researched as the losses that companies and/ or sectors make or face in dealing with workplace bullying are preventable costs. Such research could also push for leaders to create the right programs, policies and strategies that can minimise the issue of bullying and thus the costs incurred to deal with it.

Fourth, managers and supervisors are not given enough training in dealing with issues of workplace bullying. A possible avenue of research method is the utilisation of the Negative Acts Questionnaire (NAQ) instrument developed by Einarsen and his colleagues (O'Driscoll et al., 2015) to link organisational structure and/ or individuals in positions of power with organisational culture.

Lastly, horizontal bullying and power relations within the organisation are regarded as antecedents of bullying. However, although these antecedents have been identified in the literature and examined extensively, the methods used to uncover these relationships have been inadequate; that is, most of the empirical articles in this study's findings only utilised cross-sectional data and more longitudinal and process models are needed.

In conclusion, this study completed a systematic review on the antecedents and consequences of workplace bullying in the Australian and New Zealand healthcare sectors (1985-2015). The study provided data, discussed the limitations of the research and recommended future research in this area. More research is necessary in order to further identify the antecedents and consequences of workplace bullying and to inform and educate managers and practitioners that 'encouraging prevention' is possible through legislation and the right programs, policies and strategies.

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