Bullying in Child and Adolescent Psychiatric Training: The Need for Identification and Prevention

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Case: A 26-year-old first-year psychiatry resident presents for rounds on her first day of a child consult-liaison rotation. She is anxious to begin the rotation because she will be working with an attending psychiatrist who is known as being difficult to please. The resident presents the case of a child in the emergency room to the attending, a second-year child and adolescent psychiatry fellow, and several medical students. The resident who is presenting the case begins to notice that the attending makes eye contact only with the fellow and then asks him to present the assessment and plan for the patient she just has presented. Using "herself as an instrument" to pick up on subtle interpersonal dynamics, the resident senses that the attending is annoyed with her and that she is not doing a good job on her first day.

Throughout the rotation, the attending often criticizes the resident and gives her consistently negative feedback in front of the group. She often feels embarrassed and inadequate. She tries harder and harder to please the attending and arrives hours early to prepare for rounds and thoroughly research her recommended treatment plans. Despite these efforts, the attending's exclusion and criticism of her continue. She works diligently to make specific changes in response to the feedback offered, but there is no change to the criticism. She begins to resent the fellow for not explicitly supporting her and for being a seemingly passive bystander. The resident continues on the rotation and, all the while, feels a sense of unease. When electronic feedback from the attending and fellow arrives at the end of the rotation, it indicates that she has received below average marks without elaboration.

At the beginning of the next rotation, the resident notices a lingering impact of the previous evaluation on her general morale and self-esteem. She feels sad, unmotivated, and is having difficulty sleeping. The resident is unclear how and if in any justifiable ways these experiences have affected her personally and professionally. She also feels she should be resilient enough to handle better her feelings regarding the entire experience.

Questions to consider:

- Do the described interactions between the first-year resident, the fellow and the child consultation-liaison attending psychiatrist represent bullying?
- What is bullying in medicine?
- What can be done in psychiatry training programs to make for all a more positive work environment free of bullying?

Bullying in the Workplace

Bullying in any workplace is generally defined as "repeated acts and practices that are directed at one or more workers, which are unwanted by the victim, which may be done deliberately or unconsciously, but clearly cause humiliation, offense, and distress, and may interfere with job performance and/or cause unpleasant working environments".[1] According to a Joint Commission review, there are many factors that can contribute to bullying, including "systemic factors" (such as the unique health care environment, which often includes high pressure, demands for productivity, and hierarchical structures that differentiate powerful players from non-powerful players) and individual factors (including one's own vulnerabilities and challenges with interpersonal and conflict resolution skills).[2]

In the literature, there exist two major forms of workplace bullying: overt and covert bullying.[3] They differ both in how they target individuals and in how they are identified. Overt forms of bullying present as more obvious examples of deliberate aggression and include humiliation and belittling in public. On the other hand, covert forms of bullying are less obvious and more insidious. Examples of covert bullying include exclusion, "freezing out" and ignoring, or excessive monitoring of work. The introductory case vignette highlights both overt forms of bullying (harsh criticism, humiliation, and belittling) and covert forms of bullying (exclusion, freezing out, and ignoring).

One of the more challenging parts of bullying is understanding the victim's subjective experience, as some people may be more likely to regard sarcasm, innuendo and negative treatment as part of their own psychological tendencies. For example, a victim of bullying may generally be more susceptible to self-blame. The victim's subjective experience may also involve a "hostile attribution bias," when, in the face of ambiguous communication, someone may assume the other is more hostile than the other intends to be.

Bullying does not just involve the dyad of the bully and the victim. Within the bullying dynamic are the bystanders who likely are aware of the bullying and affected by it, too. In this way, the team atmosphere suffers, as does each of the team's members. This is the phenomenon of "negative behavior contagion," where the impact of bullying on one individual has a potential negative effect on others. Team members may be afraid to state their opinions or concerns. In medicine, this fear to speak up can present a risk for the patient, as team members might not raise appropriate questions or notify the attending of patient safety risks. The presence of bullying within a team also affects the learning of all members of the team, as trainees might be more likely to avoid asking or answering questions due to fear of experiencing directly the same bullying they have witnessed. Dr. Shelia White, a psychologist in the United Kingdom who has researched the psychodynamics of bullying, also postulates a theory called the "life cycle theory of bullying," where these dynamics of bullying seem to repeat in one's professional and personal lives.[4] Thus, once a bully, often a bully, and once a victim, often a victim. It is not clear yet if this also is true for bystanders, as well, who may experience being both outside of and pulled into a bullying dynamic.

Bullying in Medicine

The topic of bullying in medicine came to the fore when the ground-breaking paper authored by Dr. Henry K. Silver and published in *The Journal of the American Medical Association* (*JAMA*) exposed medical education as guilty of bullying through medical student maltreatment.[5] Since then, additional studies have explored in further detail the specific forms of bullying that occur in medicine. Chadaga, Villines, and Krikorian, the authors of "Bullying in the American Graduate Medical Education System: A National Cross-Sectional Survey," surveyed residents and fellows of all specialties throughout the United States graduate medical education system to quantify participants' experiences with bullying during training.[6] Alarmingly, almost half of the respondents (48%) reported being subjected to bullying. Among the study's participants, covert bullying was the most frequently reported bullying behavior; 44% identified covert bullying as one of the bullying behaviors they experienced in the course of their training. Residents and fellows also reported experiencing destructive innuendo and sarcasm (37% of those who experienced bullying) and attempts to humiliate (32% of those who experienced bullying). Of note, 61% of respondents reported having witnessed the bullying of others, which both underscores the prevalence of bullying and suggests that hostile attribution bias, alone, cannot account for the self-reported prevalence of bullying. Of note, this study's findings for the psychiatry resident subgroup did not statistically differ from those of other specialties. Bullying is a pervasive problem throughout *all* specialties in graduate medical education—one from which, as psychiatrists, our particular training in interpersonal and group dynamics seemingly does not make us immune.

Implications for Psychiatric Training Programs

Although some may expect psychiatrists to be especially attuned to the forces that are at play in human

interactions and, as a result, possess the insight and ability to identify and prevent bullying in our education and training programs, as outlined above, this has not been shown to be the case. Although studies of workplace bullying done specifically in psychiatry training settings are very limited, there are two such studies: one of the National Health Service[7] and another done in Pakistan as a cross-sectional study.[8] These studies show that bullying behaviors in psychiatric training are pervasive. Bullying, to the likely surprise of many, is as much an issue in the workplace of psychiatrists and psychiatric trainees as it is in the workplaces of those in other medical specialties.

Our psychoanalytical training as psychiatrists may help us look deeper into the interpersonal dynamics that often are at play in bullying. Dr. White explains that Winnicott's concept of containment and the holding environment are most useful in understanding bullying behavior.[4] She sees that bullies often are trying to rid themselves of their stress and anxieties and to find someone else—frequently, the bullying victim—to act as a "container" of these negative feelings or negative projections. Trainees are vulnerable to becoming "containing" victims, particularly as they often search outside themselves for answers to inner questions such as, "Am I good enough in this role?" They are in a phase in their professional identity development that makes them inherently vulnerable to the influence of more powerful others.

When bullying does occur within our psychiatric training programs, there are consequences—personally and professionally—for the bullying victims and for our larger psychiatric training system. When residents are bullied, they report higher levels of depressive symptoms as measured by the Major Depression Inventory (MDI), including more changes in sleep and appetite, and lower self-esteem. Furthermore, bullying during training predicted increased depressive symptoms in impacted trainees both at one-year and three-years follow-up, including among those who were assessed after completion of their training.[9] Based on this information, bullying in training can have mental health implications for a longer time than the duration of training, thereby negatively affecting those who make up our profession.

Identification and Prevention of Bullying in Our Training Programs

Given the detrimental impact that bullying can have on psychiatric trainees and the overall system, we need to increase awareness of bullying in medicine. However, multiple potential barriers to doing so exist. One potential obstacle to increasing the awareness of bullying is the finding that someone who has never been bullied is less likely to recognize bullying in his or her environment than someone who has been bullied. In the GME study on bullying, 97% of those who experienced bullying also reported witnessing it, while only 29% of participants who did not experience bullying witnessed it.[6] Being subjected to bullying may "sensitize one to noticing it more frequently" in one's environment. Another possible barrier to increasing awareness of bullying in psychiatric training is the potential assumption that, because psychiatrists are trained to be aware of power dynamics in the relationships in patients' lives, we should be able to identify such dynamics in the relationships in our own lives. The extension of such thinking would be that psychiatry, as a profession, should be at a lower risk for bullying in the psychiatry training workplace, but the above-described data do not support this. Denial or ignorance of the existence of bullying in psychiatry training may "form a lattice on which it can flourish."[9] This means that if the field of psychiatry does not increase its awareness and recognition of bullying in the workplace, then future trainees will continue to have to suffer its effects.

It may be useful to extrapolate knowledge gained in other work environments about the progression of bullying in order to both raise our own awareness and take action to it. In the workplace, bullying behaviors often progress through three phases of increasing aggression: "(1) 'antilocation,' characterized by prejudicial gossip restricted to a small 'in-group' circle and 'behind the back' of the victim, (2) avoidance of the victim by the crowd and associates, and, at later and more advanced malignant stages, (3) open harassment of the victim

including discrimination, alienation, exclusion, offensive remarks and jokes."[1] Bullying can occur in stages that can progress towards more and more detrimental behaviors, and, thus, identifying these behaviors at an earlier phase can prevent the development of more overt forms of bullying. With this knowledge, gossiping or avoidance may be viewed as red flags for eroding relationships in a team or program. As a trainee, trainer, or program director, just being able to recognize these behaviors and openly talk about them can be a first step to preventing more significant bullying from occurring. The person doing the bullying may not be aware of the level of harm that is occurring from his or her actions or even recognize the actions as bullying. At the level of the program, starting a conversation with staff, faculty, and trainees about these bullying phases and the impact of bullying on trainees can be a concrete way to start to address bullying in our workplaces.

Changes can be made at both the individual and system levels to address bullying. In an article, "Creating a Culture of Mutual Respect," the authors state that many hospital policies address overt mistreatment such as discrimination, criminal activity, sexual assault or physical abuse, but that grey areas such as bullying still need to be addressed with more formal organizational structures for reporting and follow-up. These include: creating a code of mutual respect that encourages sensitivity and awareness to the causes of inappropriate behavior; establishing a system for mediating, tracking and addressing these issues; providing trainings for staff; developing a formal accountability process; and measuring the results.[10]

The AWARE study further identifies "awareness of what entails workplace abuse and how to report it" as "the first steps," but also offer other concrete suggestions as well (see Table 1).

With almost half of trainees in graduate medical education reporting experiences of being bullied, bullying in medicine and, specifically, in psychiatry training, warrants more understanding and exploration. The full impact of bullying on the performance of trainees in the health care profession still is not clear. What is clear is that bullying does occur within psychiatry training; it frequently is present in many hierarchical workplaces. In addition to studying the impact of bullying in medicine on health care and training, we need to study how to prevent it. Bullying is a problem, but, perhaps, as a field, we can better use our psychiatric training and skills in understanding interpersonal dynamics to help us identify and prevent it in our psychiatry training systems.

Table 1: Summarized Points from AWARE Study[9]

1.	Offer to residents well-being resources to counter the potential pull into bullying victim roles.
2.	Offer to staff training modules that address various aspects of interpersonal interaction. The authors specifically recommend modules on "emotional intelligence, communication, leadership skills, assertiveness training, burnout, conflict management, stress relief, etc."
3.	Ensure that those in leadership roles are "supportive, impartial, and available" to both residents and staff so that concerns can be discussed effectively.
4.	Work to support an atmosphere that "allow[s] mindful awareness of one's capabilities, encouraging seeking of help without the implication of weakness."
5.	Standardize feedback for trainees across settings.
6.	Develop with staff members in all roles an action plan to prevent bullying. Consider developing a committee to review incidents of potential bullying.

Take Home Summary

- Bullying can exist in overt and covert forms in the work place.
- There is a growing body of evidence that confirms the existence of and impact of bullying in medicine.
- Child and adolescent psychiatry trainees may be more at risk of covert bullying than of overt bullying, but covert bullying can still have negative impact on the mental health of trainees.
- Next steps need to include looking into how we prevent bullying from occurring to child and adolescent psychiatry trainees.

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