



Are You a Safety Bully?

Recognizing Management Methods That Can Do More Harm Than Good

By E. Scott Geller

Interpersonal bullying is everywhere these days among students and teachers in educational settings, wage workers and managers in the workplace, and families at home. Definitions of bullying have varied markedly in the literature (Einarsen, Hoel, Zapf, et al., 2011; Tehrani, 2012a), but most perspectives include these characteristics:

1) Bullying involves repeated actions toward another person that are unwelcome and perceived as negative.

2) Bullying behavior is always regarded as destructive, causing negative interpersonal and intrapersonal outcomes, including the possibility of post-traumatic stress and suicide (Einarsen, Hoel & Notelears, 2009).

3) Bullying always involves a power imbalance whereby the target of bullying (the less-powerful party) perceives an inability to defend him/herself.

4) Bullying behavior may be intentional or unintentional (Einarsen, Hoel, Zapf, et al., 2003).

Some scholars argue that bullying behavior always results from a willful and conscious desire to cause harm to another person (Olweus, 2003; Saunders, Huynh & Goodman-Delahunty, 2007; Tehrani, 2012b). No doubt, intentional bullying is likely to be more severe and distasteful than unintentional bullying, but it seems undeniable that behavior from a manager, supervisor, coach, colleague or guardian can be perceived by the victim as bullying even though the intention was not to cause harm or distress. In other words, bullying behaviors

are performed either unconsciously or as a deliberate act. This article addresses safety-related bullying that is likely to be unintentional, but nevertheless inhibits the level of safety engagement needed among workers to optimize injury prevention efforts.

Upon reading this article's title, most readers likely reacted, "No, not me, I'm never a safety bully." This article challenges such self-talk by exploring how some common characteristics of traditional safety management can be perceived as bullying and, thereby, limit workers' genuine involvement. More specifically, one might be a safety bully simply by following or supporting the cited attributes or methods. This article explains the possible associations between these approaches and bullying, and suggests corrective strategies.

Misuse of Discipline

Traditional safety discipline is generally a form of top-down control with negative consequences. Some man-

IN BRIEF

- Behavior from a manager, supervisor, coach, colleague or guardian can be perceived as bullying even though the intention was not to cause harm or distress. In other words, bullying behaviors are performed either unconsciously or as a deliberate act.
- This article addresses safety-related bullying that is likely to be unintentional, but nevertheless occurs and inhibits the level of safety engagement needed among employees to optimize injury-prevention programs.

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agers have been known to include a discipline session as part of the corrective action in response to an injury report. The injured employee gets a negative lecture from the manager or supervisor whose safety record was tarnished by the injury. This is an example of possible safety bullying. Such sessions can be unpleasant for both parties, and do not encourage personal commitment or buy-in to the company's safety mission (Sidman, 1989). Instead, the employee is simply reminded of the top-down control aspects of corporate safety, and may develop an increased commitment to not volunteer for safety programs nor to encourage others to participate.

Progressive Discipline

What about progressive discipline? Whenever the author teaches behavior management principles and procedures, some inevitable questions arise: "How should we deal with the repeat offender?" "Isn't punishment necessary at times?" "Doesn't an individual who willfully breaks the rules after repeated warnings or confrontations deserve a penalty?"

Through progressive discipline, these individuals receive top-down negative consequences, starting with a verbal warning, then written warnings and eventually dismissal (Grote, 1995). In rare cases, dismissal is the best solution for uncooperative individuals who can be a divisive and dangerous factor in the workforce.

The standard process in safety enforcement includes three steps. Often, after the third infraction, the employee is sent home for several days without pay (e.g., "Three strikes and you're out"). But the wrongdoer is not out for good. S/he is usually allowed to return, which raises a critical question: Is the person a better player upon his/her return? When employees are punished by being temporarily dismissed, it is expected they will perform better when they return. In other words, managers hope they learn something from this demeaning punishment, which one can reasonably perceive as bullying.

What About Attitude?

The type of learning that occurs after punishment depends on one key factor: attitude. If the employee is angry and does not acknowledge taking a calculated risk, useful learning is unlikely. If an employee develops negative or hostile emotions as a result of such punishment, s/he will return to the workplace a disgruntled worker who might give lip service to following safety rules to avoid further punishment, but will likely share a negative attitude with anyone willing to listen (Grote, 1995; Sidman, 1989).

Even if punishment were an effective intervention, most human error is not deliberate and not deserving of a negative consequence. Instead, management mandates, equipment or system factors must be analyzed and altered appropriately. Learning how to change these factors to reduce at-risk behavior requires open, frank discussions with those committing the errors. This is only possible when there is no threat of punishment for wrongdoing. Bottom line: The threat of punishment

stifles the process of learning how to prevent the errors that can lead to serious injury. Recall Deming's (1991) critical maxim, "Drive out fear."

Investigating to Find a Root Cause

A common myth in safety holds that injuries are caused by one critical factor, the root cause: Ask enough questions and you'll arrive at the critical factor behind an injury. Is it really possible that a single root cause is responsible for a mishap, whether a close call, property damage or personal injury?

Conducting an investigation to find a singular root cause could be considered bullying. This approach can put employees on the defensive, even preventing the disclosure of hazards or barriers to safe work practices. The term *investigation* often carries a negative connotation. The self-talk might be, "They will ask 'why' five times to find the person responsible for the injury and/or property damage." Indeed, the term investigation implies fault finding rather than fact finding.

Consider the interactive impact of environmental, behavioral and person-based factors that affect safety-related performance. Environmental factors include tools, equipment, management systems, engineering design, climate and housekeeping. Also involved are the behaviors or the actions of everyone related to the mishap. Finally, one must consider the personal, internal feeling states of those involved, their attitudes, perceptions and personality characteristics.

Given the dynamic interdependency of these factors in daily events, how can anyone expect to find one root cause of an injury? Furthermore, cause-and-effect relationships cannot be identified from the information gleaned from surveys, discussions or interviews. Such data enable only correlations.

An analysis, not an investigation, is needed to sort through this complex web of contributing factors. Using a systems approach in this analysis can help one determine which factors can be changed to reduce the chance of another injury. Environmental factors are usually easiest to define and improve, followed by behavioral factors. Most difficult to define and change directly are person-states, but many of these internal feelings can be benefitted by properly influencing behaviors (Geller, 2001; 2013; Geller & Weigand, 2005).

Setting Zero Injuries as a Goal

Setting safety mandates or expectations too high can be perceived as bullying as well. "What could be worse," Deming (1991) bellowed periodically throughout a 4-day workshop, "goals without method." Similarly, one of his 14 points for quality transformation is to "eliminate management by objectives, eliminate management by numbers, numerical goals . . . eliminate slogans, exhortations and targets for the workforce asking for zero defects" (Deming, 1985, p. 6).

Does this mean companies should stop setting safety objectives and goals? Should SH&E managers stop trying to activate safe behaviors with signs, slogans and goal statements? Should a facility stop

counting OSHA recordables and lost-time cases, and stop holding people accountable for their work injuries? No. Deming (1991) was referring to goal setting, slogans and work targets as they are currently implemented in many organizations. He was not decrying the principles of goal setting, management by objectives and activators; rather, he was criticizing their current corporate use. Substantial research supports the use of objective goals to improve behaviors, if behavior-change principles are applied correctly (Daniels, 1989; Locke & Latham, 1990).

Incorrect Goals

Holding people accountable for numbers (outcomes) they do not believe they can control is another potential source of bullying. It is a sure way to produce stress or distress (fear). However, some people will not be stressed because they will not take such goals seriously. Experience has convinced them they cannot control the numbers, so they simply ignore the goal-setting exhortations.

What does the goal of zero injuries mean anyway? Is it reached when no work injuries are recorded for a day, a month, 6 months, a year? Does a work injury indicate failure? Does the average worker believe s/he can influence goal attainment, beyond avoiding personal injury?

Several corporate mission statements specify a safety goal of zero injuries. These are examples of incorrect goal setting and can be perceived as bullying. Although injuries are tracked as OSHA recordables, employees' daily experiences with injuries (often based on conversations with peers) contribute to a belief that they cannot control injuries directly (especially those involving others). One workplace injury (perhaps as the result of another person's carelessness) reflects failure to reach a goal of zero injuries and can lead to a perception of helplessness (Seligman, 1975).

Consider the impact of this common slogan, "All injuries are preventable." It implies that workers know enough today to prevent all injuries. This could make the injured party feel like a bullying victim and think, "We know enough to prevent them all, yet I suffered one." This could stifle injury reporting and analysis with the rationale, "If they already know enough to prevent this, they don't need my input."

Consider this analogy. Will penguins ever learn to fly? No. They lack the equipment and an effective method. Similarly, a goal of zero could be viewed as impossible in a particular work culture. But the vision or target can be zero injuries or injury free. Effective goals are set on the process or the journey toward a destination of zero, and the relevant participants must believe it is possible to achieve the process goal.

Setting SMARTS Goals

Effective goals are SMARTS: specific, motivational, achievable, relevant, trackable and shared. SMARTS goal setting defines what will happen when the goal is reached, and progress toward

achieving the goal is tracked and shared with relevant participants for peer support. Feedback from completing intermediate steps toward achieving the vision of an injury-free workplace motivates continued progress. Of course, those asked to work toward the process goal must believe that the goal is relevant and that they have the skills and resources to achieve it.

Misuse of Feedback

Imagine being asked to go to the boss's office at the end of the day to receive some feedback. How would you feel? If you anticipate this session with unpleasant emotions, your boss could be a bully.

Two characteristics of feedback influence people's desire to avoid it and justify the bully label. First, negative or corrective feedback is typically given more frequently than positive or supportive feedback. In other words, most parents, teachers, coaches and supervisors use reprimands more often than praise, apparently believing people learn more from mistakes than successes. Empirical research and even common sense indicate this is untrue (Chance, 1999). Although both corrective and supportive feedback are necessary for improvement, the feedback must be behavior-based.

The second reason feedback has a negative connotation is that people often correct others without focusing entirely on their behavior. In other words, the feedback suggests the problem or error observed reflects more than behavior. A child is sloppy; a student is ignorant; an athlete is lazy; a worker is careless. Such feedback delivery is bully behavior, and substantial research demonstrates dramatic disadvantages of labeling people, even when the label is positive (Dweck, 2006).

Although easier said than done, one must separate behavior from person-factors when giving and receiving feedback. Corrective feedback is not an indictment of an individual's personality or an indicator of a character flaw. Feedback must not be related to an individual's attitude, motivation, professional competence or family history.

Feedback is only about behavior. Yes, responding well to supportive or corrective feedback can lead to better attitude, motivation, competence and even a personality state. But feedback's sole purpose is to pinpoint desirable and/or undesirable behavior. Recognizing this helps maximize the benefits of behavior coaching. There's room for improvement in most facets of life, but only by receiving and accepting behavior-based feedback can people do better (Alavosius & Sulzer-Azaroff, 1990; Geller, 1995; Sulzer-Azaroff & de Santamaria, 1980).

Behavior-Based Safety

A person who believes that most injuries are caused by employee behavior can be viewed as a safety bully. This belief could influence a focus on the worker rather than the culture or management systems, or many other contributing factors. As Deming (1991) warns, "Don't blame people for problems caused by the system."



Holding people accountable for outcomes they do not believe they can control is a sure way to produce stress or distress.

When safety programs are promoted on a premise such as “95% of all workplace accidents are caused by behavior,” one can understand why union leaders object vehemently and justifiably to such programs (Hans, 1996; Howe, 1998; Hoyle, 1998; Lessin, 1997; Smith, 1995; UAW Health and Safety Department, 1999). Claiming that behaviors cause workplace injuries and property damage places blame on the employee and dismisses management responsibility. Most worker behavior is an outcome of the work culture, the system (Deming, 1991; Geller, 1992).

It is wrong to presume that behavior is a cause of an injury or property damage. Rather, behavior is one of several contributing factors, along with environmental and engineering factors, management factors, cultural factors and person-states. Thus, when behavior-based initiatives are implemented appropriately, the question is not, “What behavior caused the injury?” but “What factors are leading people to perform the at-risk behaviors that could result in an injury?”

Training Without Education

How often is the flavor-of-the-month label attached to a new organizational program or process? If an injury prevention program earns this distinction, the SH&E professional could be acting like a safety bully. Consider how safety programs are often introduced to potential participants. A corporate official (often a safety director) learns about a new safety program at a conference or in a promotional flyer and orders the appropriate materials, including workbooks, videos and a facilitator’s guide. Sometimes, an outside consultant or trainer is hired to teach the new step-by-step procedures to certain personnel. Then, these employees demonstrate the new procedures to others on the job, and the program is implemented plant-wide.

For many, this is just another set of temporary procedures that attempts to reduce outcome numbers (recordable injuries) and make management look good. It is commonly believed that the new program will not truly reduce injuries, and will soon be replaced with another program.

This attitude occurs when people are not taught the principles or rationale behind a program, they only are shown how to implement it, then are expected to train others from this how-to perspective with no “why.” They were not educated about the research-based principles and rationale on which the program is based, and can only teach others what to do, not why they should do it. This is why Deming (1991) was critical of on-the-job training.

When people learn the theory underlying a method, they develop their own belief system to rationalize their participation. They also realize that they can fulfill a particular mission in several ways and have the ammunition needed (i.e., principles and guidelines) to alter procedures whenever demands for refinement arise. When employees contribute to process improvement, they develop a sense of ownership and empowerment to sustain the process. They become self-motivated to do the right things

for safety when they understand and believe in the reasoning behind a regulation, policy, process or training program (Lewin, 1947, 1948).

Misuse of Incentives

The disadvantages of basing financial bonuses on reactive outcomes such as an injury rate are well known, but financial incentives can also be problematic for proactive programs. Ask people what reward they would like after achieving a safety process goal and the popular answer will be money, since it is the most useful reward and can be exchanged for almost anything. However, it does not connect to safety, it is quickly spent and the special way it was earned is soon forgotten.

When the material reward in an incentive program is perceived as the primary payoff, the terms *behavior modification* and *bribery* come to mind. One might think, “I like the reward, but it’s obvious the company is trying to manipulate me.” Such tactics reflect a power imbalance and could produce perceptions of safety bullying. Incentives should only be reminders to do the right thing, and rewards should serve as supportive feedback and a statement of appreciation for doing the right thing. A reward should enhance recipients’ sense of competence and thereby increase self-motivation (Deci & Ryan, 1995; Geller & Veazie, 2010; Ryan & Deci, 2000).

More important than the type of external reward is the way it is delivered. A reward should not be perceived as a means of controlling people but as a declaration of sincere gratitude for making a contribution. This recognition should focus on the effort involved in the achievement process rather than the final outcome (Dweck, 2006). A reward that includes a safety logo or message can become an activator for the relevant safety-related behavior when displayed. It takes on greater meaning when it was designed by representatives from the target population.

Following the Golden Rule

Even the so-called Golden Rule can be perceived as bullying. Case in point: When the author was in 5th grade, the teacher called him to the front of the class to recognize him for the excellent job on homework. Afterward, three other male students beat him up on the playground. The teacher treated the author the way she wanted to be treated (i.e., the Golden Rule), certainly not the way he wanted to be treated. Perhaps she was also following the management motto, “Reprimand privately and recognize publicly.” That student did not want public recognition for academic success. At the time, such behavior was not perceived by other students as “cool,” and the result of public recognition was painful. Thus, in some situations treating others the way you want to be treated could be viewed as bullying. Instead, follow the Platinum Rule (Allesandra & O’Connor, 1996) by treating others as they want to be treated. This requires empathy.

The Value of Empathy

Empathy is not the same as sympathy. One sympathizes by expressing concern or understand-

ing for another's situation. One empathizes when s/he identifies with another person's situation and realizes what it is like to be in that person's shoes. An empathic level of awareness and appreciation is not easy to achieve, and can only be reached after minimizing the reactive filters that bias conversations, then listening intently and proactively to the other person. This means hearing every word, and looking for the feelings, passion and commitment reflected as much in body language and manner of expression as in the words themselves.

For example, when observing another's work practices, try to view the situation from that individual's perspective. When listening to excuses for at-risk behavior or for an injury, try to imagine yourself in the same predicament. What would you do under the same circumstances? Imagine what defense mechanisms you might use to protect your ego or self-esteem. When you consider action plans for improvement, think about various alternatives through the eyes of the other person.

Empathic listening, diagnosing and action planning require patience. Conversations at this level are not efficient, but they are effective. The objective is to first learn, mostly through questioning and listening, what it is like to be in the other person's situation. Then, the objective shifts to developing a corrective intervention that fits the circumstances as mutually understood by all involved in the conversation. If commitment to follow through with a specific action plan is stated, then an effective empathic conversation has occurred.

Oversimplifying Human Dynamics

Marketing posters and conference speeches often oversimplify the role of human behavior and dispositional states on workplace injuries. Indeed, the author has attended sessions in which speakers claim to provide "tools" for identifying a particular human factor that "caused" an injury (i.e., a root cause). Such oversimplification is a disservice.

More importantly, these tactics are misleading and can result in safety bullying. For example, focusing on a limited number of person traits or states as the cause of an injury can be perceived as fault-finding and stifle the search for and discovery of critical contributing factors. It can also limit or bias the interpersonal conversations needed to identify the system factors that influence human factors.

Continuous Learning & Improvement

A participant at a recent leadership retreat made the author's day with the following comment.

What a pleasure it was to hear your latest thoughts about person-to-person actively caring to benefit individuals, organizations and communities. I first became aware of your research and scholarship when attending your day-long workshop at the ASSE convention in 2002. Since then, I've read four of your books and taught my colleagues many of your principles.

This comment is shared not to brag, but rather to provide context for the rest of his comments. In



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response to these positive comments, the author replied, "It's nice to learn that my teachings are reaching others through other teachers. But since you've already read several of my recent books, much of my workshop material today was redundant, right?" The participant replied:

For sure, I understood where you were coming from and I predicted where you were going throughout that session, and it was reassuring to hear it again. But what I really liked best was learning how your perspectives, principles and application suggestions have evolved over the 10 years I've been following your work.

That last comment reflects a critical point: Practical ways to apply psychology to real-world problems have progressed significantly over the years, through empirical research and field experience. It is meaningful to have an organizational leader recognize, understand and appreciate the evolution of recommended approaches for managing the complex human dynamics of organizational and societal problems. It justifies continuous collaboration and mutual learning from researchers and consultants. In addition, it validates the need to understand the rationale behind a process and to look continuously for ways to improve.

Continuous learning prevents safety bullying. Everyone should adopt a "growth mind-set" (Dweck, 2006) and never stop learning. In fact, given the level of authority most people achieve with age, it is essential to keep up with the latest research-based information in one's domain of influence, and set the best example.

Conclusion

Optimizing the people side of organizational performance requires a continuous-learning mind-set, one that is skeptical but open to considering new evidence-based proposals for intervening on



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behalf of the welfare of oneself and others. The common safety management practices reviewed can reflect confusion and misunderstanding of the human dynamics of keeping people safe and, as discussed, could be perceived as safety bullying.

Alternative approaches can eliminate these perceptions and increase employee engagement in injury prevention. However, implementing these approaches is not easy. It requires appropriate and relevant education, training, customization, commitment, and continual evaluation and refinement. Start small and build successively. On the last afternoon of Deming's 4-day workshop in 1991, a participant asked, "Dr. Deming, you've taught us so much, and you've made it clear that so much change is needed in our work cultures. With so much improvement called for, can we really expect to make a difference in our lifetime?" Deming, then age 91, replied, "That's all you've got!"

SH&E professionals can make a difference in the critical human dynamics of work cultures, but not with quick fixes that aim for short-term gains. Before attempting to advance the human side of safety, trainers, consultants and change agents should endeavor to learn the evidence-based principles of behavioral and psychological science that can inform the development of effective interventions for improving people's safety-related behaviors. **PS**

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