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ABSTRACT
Bystander passivity has received increased attention in the prevention of interpersonal harm, but it is poorly understood in many settings. In this article we explore bystander passivity in three settings based on existing literature: patient abuse in health care; bullying among schoolchildren; and oppressive treatment of students by teachers. Throughout the article we develop a theoretical approach that connects Obermann’s unconcerned and guilty bystanders to theories of moral disengagement and moral distress respectively. Despite differences between the three settings, we show striking similarities between processes of disengagement, indicators of distress, and the constraints for intervention that bystanders identify. In relation to this, we discuss moral educational efforts that aim to strengthen bystanders’ moral agency in health care and school settings. Many efforts emphasize shared problem descriptions and collective responsibilities. As challenging as such efforts may be, there can be much to gain in terms of welfare and justice.

KEYWORDS
bystander passivity; moral disengagement; moral distress; school; health care

Introduction

In recent years there has been increased attention to both the potential and responsibilities of bystanders to contribute to the prevention of interpersonal harm. A focus on bystanders, or witnesses, stands in contrast to a more traditional ‘victim–perpetrator’ framework, and is believed to transfer questions of, for example, violence prevention, from certain individuals to a community (Banyard, Plante, & Moynihan, 2004). Bystander intervention and people’s overall tendency to remain passive has been a field of interest within social psychology since the 1960s, but it is still poorly understood in many settings. In this article our aim is to explore bystander passivity in the context of health care and school settings, by using existing literature, and to contribute to theoretical development by connecting bystander passivity to moral disengagement and moral distress. Against this background we discuss opportunities for educational efforts that could aid and activate bystanders in these settings.
Obermann (2011) distinguishes two types of passive bystanders that neatly tie together our theoretical focus on moral disengagement and moral distress in relation to bystander passivity. Moral disengagement is what separates so-called *unconcerned* bystanders from *guilty* bystanders. Guilty bystanders remain passive but experience a moral distress and thus an empathic concern for the victim and guilt for their inaction, in contrast to unconcerned bystanders. While moral disengagement can *produce* bystander passivity, leading to unconcerned bystanders, moral distress is mostly a *consequence* of feeling forced into passivity, characterizing guilty bystanders. Below, we develop our theoretical understanding of Obermann’s bystander categories.

**Unconcerned bystanders: bystander passivity and moral disengagement**

People do not always act in accordance with their own moral standards. *Moral disengagement* refers to a set of social and psychological mechanisms by which moral self-sanction can be disengaged, which permits people to engage in inhumane conduct or remain passive as bystanders without any feelings of remorse or guilt (Bandura, 1999, 2002, 2016), i.e. being unconcerned bystanders. Bandura proposed eight moral disengagement mechanisms, which are grouped into four themes. The first theme, *cognitive restructuring*, refers to reconstrual of the inhumane behavior itself, so that it is not perceived as immoral as a result of at least one of the following three mechanisms: (1) *moral justification*, in which worthy ends or moral purposes are used to sanctify pernicious means; (2) *euphemistic labeling*, in which the inhumane behavior is labeled in a way that makes the behavior sound less negative or more respectable; and (3) *advantageous comparison*, in which the negative act seems less negative by comparing it to a worse or more negative act. The second theme is *minimizing one’s agentive role* and refers to detaching or obscuring oneself from personal responsibility through at least one of the two moral disengagement mechanisms: (1) *displacement of responsibility*, in other words, claiming that someone else is responsible for one’s negative behavior or that one’s action is stemming from authorities; and (2) *diffusion of responsibility*, in which the personal responsibility is diluted due to the presence or involvement of other people. The third theme, *distorting the consequences*, refers to a moral disengagement mechanism in which the negative or harmful effects of the inhumane behavior is minimized, ignored, or misconstrued. The fourth theme is about attributing causes of the suffering to the victims by at least one of the following two mechanisms: (1) *dehumanization*, in which the victims are stripped of their human qualities and equal values; and (2) *blaming the victim*, by believing that the victims deserve their suffering.

Two decades of empirical research have shown that moral disengagement is associated with aggressive behavior (for a meta-analysis, see Gini, Pozzoli, & Hymel, 2014). In addition, research has revealed moral disengagement as negatively associated with empathy (Hyde, Shaw, & Moilanen, 2010), transgressive guilt and prosocial behavior (Bandura, Barbaranelli, Caprara, & Pastorelli, 1996), and moral emotions (Thornberg, Pozzoli, Gini, & Jungert, 2015). Thus, the social cognitive theory of moral disengagement (Bandura, 1999, 2002, 2016) may contribute to our understanding of bystander passivity. However, bystander passivity does not necessarily imply moral disengagement; signs of moral distress show that bystander passivity should not automatically be seen as inconsiderate omissions.
Guilty bystanders: bystander passivity and moral distress

Moral distress can be defined as a state of negative feeling that a person may experience when recognizing the morally appropriate thing to do, and yet not doing so because of external constraints (Jameton, 1984). Jameton distinguishes between initial and reactive distress:

Initial distress involves the feelings of frustration, anger, and anxiety people experience when faced with institutional obstacles and conflict with others about values. Reactive distress is the distress that people feel when they do not act upon their initial distress. (1993, p. 544)

According to this definition, bystander passivity could specifically evoke moral distress of the reactive type: a person sees some form of intervention as the right course of action but does not take it because of external constraints. As examples of these constraints, Jameton mentions lack of time, power structures, or institutional policies (1984), which means that in many cases, bystander intervention implies a form of risk-taking. A prerequisite for moral distress is that a person needs to be morally engaged and to feel morally responsible and obliged to take a certain course of action (Nathaniel, 2006). Only then, will passivity be perceived as a problem accompanied by a psychological dissonance of this kind. Here lies one possible connection between moral disengagement and moral distress—through mechanisms of moral disengagement, moral distress can be diminished or avoided. If moral disengagement takes place early in a situation or even beforehand, it allows bystanders to remain passive and avoid some, if not all, of their initial or anticipated reactive moral distress. Moral disengagement can also be applied afterwards, as a way to cope with reactive moral distress (Berger, 2014). While moral distress is a sign of moral engagement and a possible indicator of being sensitive to moral questions (Austin, Lemermeyer, Goldberg, Bergum, & Johnson, 2005), frequent exposure to distress can have severe negative consequences. Studies among nurses have shown that experiences of moral distress can lead to physical ill-being and lower self-esteem (Wilkinson, 1987), as well as burnout (Sundin-Huard & Fahy, 1999). Moral disengagement can be used as a necessary evil for self-protection against such symptoms.

Bystander passivity in health care and school settings

Below, we study bystander passivity building upon existing literature in three areas: (1) patient abuse in health care; (2) bullying among school children; and (3) oppressive treatment of students by teachers. These reviews are far from complete but rather explorative, starting from our own research experiences in these fields, aiming to examine and illustrate how unconcerned and guilty bystander responses could be theoretically understood with reference to moral disengagement and moral distress. Our approach is inspired by Glaser and Strauss’ (1967) classic idea of generating theory and raising the value of individual empirical studies through the comparison of different areas. Although the explorations below are presented after our theory, both parts developed simultaneously and in comparison with each other; we refined our theoretical ideas along with our understanding of the empirical contexts.
Patient abuse in health care

In a series of Swedish studies, abuse in health care has been defined as instances that patients perceive as abusive, characterized by experiences of a lack of care, a loss of human value, and feelings of powerlessness and degradation (Brüggemann, Wijma, & Swahnberg, 2012; Swahnberg, Thapar-Björkert, & Berterö, 2007; Swahnberg, Wijma, Hearn, Thapar-Björkert, & Berterö, 2009). Here, we are interested in situations where health professionals perceive that a patient could feel abused as a consequence of a colleague’s behavior, without intervening as bystanders in such situations. In a Swedish study among health professionals it was found that intervening in situations of abuse, or even noticing violations of a specific colleague, demanded courage. It was suggested that intervening was inhibited through tacit rules, such as not confronting colleagues in front of patients, or through hierarchical hindrances (Swahnberg & Wijma, 2011). The latter is consistent with what is known about bystander intervention in medical situations with other or more general moral concerns. For example, hierarchies have also been noted as an obstacle for medical students to speak up in cases where they had moral concerns about how their clinical supervisors behaved (Dwyer, 1994). In general, ‘[t]hose at the lower end of the hierarchy are used to doing what their superiors ask of them, often without understanding exactly why, and they are not always encouraged to speak up if they have concerns’ (Colaianni, 2012, p. 436).

In a Swedish intervention project that aimed to activate bystanders in situations where they perceived that patients felt abused in health care, it was found that silence and shame were obstacles for professionals to intervene while having the role of being bystanders (Wijma, Zbikowski, & Brüggemann, 2016). Silence and shame could then reinforce the taboo status that surrounds situations that staff interprets as abuse. However, shame, being a sign of moral distress, implies that the professionals emphasized their moral responsibility. Consider the case where a midwife was torn between standing up for patients who were denied their rights, her moral concerns, and obeying a gynecologist whom she was not supposed to disturb—her external constraint (Wijma et al., 2016). She and other participants in the intervention study reported such incidents with shame, indicating that they still sanctioned themselves for not standing up for patients. The fact that shame, and not guilt, was a dominant emotion might be explained by the emphasis on group work in the intervention. Feelings of shame can indicate that witnessing a situation of abuse and the question of intervening were seen as a threat to collegial bonds rather than a shared responsibility (Wijma et al., 2016). On a structural level, an analysis of a set of ethical codes for health professionals at a women’s clinic in Sweden confirmed the lack of shared responsibility. The codes mainly point at the individual professional’s obligations and hardly make any statements about how to deal with transgressions by colleagues (Zbikowski, Brüggemann, Wijma, Zeiler, & Swahnberg, 2012).

Parallel to examples where staff continue to experience moral distress, examples of moral disengagement can be found in two Swedish qualitative studies about health professionals’ perceptions and awareness of patients feeling abused in health care (Swahnberg & Wijma, 2011; Swahnberg, Zbikowski, & Wijma, 2010). A first example is the staff’s claim that some patients are just very vulnerable, through their backgrounds, their experiences, or their conditions (Swahnberg & Wijma, 2011). As this
claim was used as an explanation, it can be seen as a form of blaming the victim, thus exonerating one’s own action or omission. A similar argument can be seen in a second example where staff explained the abuse by stressing the inevitable character of abuse or the role of structures and routines (Swahnberg & Wijma, 2011) through which staff displaced their responsibility onto compelling circumstances. A third example is the staff’s concern with themselves being abused as well (Swahnberg & Wijma, 2011; Swahnberg et al., 2010)—something that can be interpreted as a form of advantageous comparison. By comparing patients’ experiences of abuse to experiences of their own or of their colleagues, it may make the patient abuse look less bad, offering a way out toward passivity. Related to this, a fourth example is that some patients were initially experienced as being ‘difficult’, even though most of their situations were understood upon further consideration (Swahnberg et al., 2010). Although what the staff meant by ‘a difficult patient’ is not described in the study, others have described difficult patients as displaying inappropriate behavior and arousing negative feelings in the staff (Fiester, 2012; Michaelsen, 2012). It has been shown that staff risk creating emotional distance to patients they experience as difficult (Michaelsen, 2012), which could make it harder to see a patient’s suffering, thereby running the risk of dehumanization. In a recent study, Fida et al. (2015) found higher levels of moral disengagement among nurses to be associated with higher levels of counterproductive work behavior toward organization and individuals, as well as with lower levels of altruism and civic virtue. Nevertheless, explicit research using theories of moral disengagement in relation to bystander behavior is lacking in the health care context.

**Bullying among schoolchildren**

When bullying incidents occur, students who are bystanders can assume three main bystander responses: (1) defending, in other words, helping or supporting the victim; (2) passive bystander behavior, in other words, remaining passive or neutral or simply trying to stay outside the bullying situation; and (3) pro-bullying, in other words, laughing, cheering, or assisting and joining the bully (Thornberg & Jungert, 2013). Research has revealed that the frequency of bullying among students is negatively associated with defending, and positively associated with pro-bullying (Nocentini, Menesini, & Salmivalli, 2013; Salmivalli, Voeten, & Poskiparta, 2011). However, students seldom take the role of defender (Craig, Pepler, & Atlas, 2000). On a general level though, students tend to perceive bullying as wrong and feel sympathy for the victim (Bellmore, Ma, You, & Hughes, 2012; Forsberg, Thornberg, & Samuelsson, 2014; Thornberg et al., 2012).

Moral disengagement has been found to be positively associated with bullying (for a meta-analysis, see Gini et al., 2014). Among the bystander responses in bullying, moral disengagement has been positively linked to pro-bullying (Gini, 2006; Thornberg & Jungert, 2013) and unconcerned passive bystander responding (Obermann, 2011), as well as negatively associated with defending the victim (Gini, 2006; Thornberg & Jungert, 2013; Thornberg et al., 2015), and guilty passive bystander responding (Obermann, 2011). When asking students in qualitative studies, they discuss several different reasons for not intervening as bystanders to bullying (Bellmore et al., 2012; Forsberg et al., 2014, 2018; Thornberg et al., 2012). Some of the concerns could be
linked to moral disengagement (e.g., defining the situation as non-serious, blaming the victim, and transferring the responsibility to teachers and victims’ friends). Others could be associated with perceived constraints (e.g., having lower social status than the bully, friend loyalty with the bully, lack of defender self-efficacy, and bystander fear) which together with strong moral feelings (feelings of empathy and sympathy for the victim, guilt for not intervening, and moral anger) could be understood as moral distress (Forsberg et al., 2014).

Moral disengagement has mostly been examined at the individual level but a few recent studies have explored it among school students at both the individual and classroom level. Class moral disengagement (i.e., classroom mean of individual moral disengagement) has been shown to be associated with more bullying and pro-bullying (Pozzoli, Gini, & Vieno, 2012), and greater peer victimization (Thornberg, Wänström, & Pozzoli, 2017). Moreover, classroom collective moral disengagement (i.e., aggregating at the classroom level, the student perceptions of the degree to which moral disengagement is shared by classroom members) has been linked to greater aggression and passive bystanding, as well as less defending (Gini, Pozzoli, & Bussey, 2015).

Although there is a small but growing body of research on how moral disengagement might be associated with various bystander behaviors in school bullying, moral distress in the bystander is still an overlooked concept in school bullying literature. Nevertheless, in a qualitative study, Forsberg et al. (2014) introduced the concept in their analysis of students’ narratives on how to react, think, feel, and act as bystanders to bullying. Conflicted motives and situational constraints could evoke moral distress among students, when they are unable to intervene even though they have painful feelings and want to intervene.

**Oppressive treatment of students by teachers**

One of the crucial ethical conflicts reported by teachers is caused by colleagues’ ethical misconduct (Bergem, 1993, 2000; Campbell, 1996; Clark, 1990; Colnerud, 1997). The elements of the ethical dilemmas are on the one hand a wish to protect students from harm caused by a colleague, which requires some kind of intervention and, on the other, the concern for—or the fear of—the colleague and his or her response to the person who meddles. Intervening in a teacher’s professional conduct toward students is a sensitive matter and is mostly perceived as critique. Teachers participating in two Swedish studies (Colnerud, 1997, 2015) blame themselves for being cowards and leaving students without protection. They discuss several excuses for not intervening, such as the risk of making the colleague angry or feeling distressed or hurt. At the same time, they regret the moral shortcoming of not defending the students. You might say that they discovered the phenomenon that acting or not acting is a moral choice. One cannot get rid of the moral dilemma by doing nothing, since passivity also has consequences—the risk of moral distress. Due to the methods used in the Swedish studies—self-reported critical incidents—those who are morally disengaged were not caught, since they reject being involved in the colleague’s acting. While there are a handful of studies focusing on teachers’ moral distress, there are no studies in terms of their moral disengagement.
The abovementioned ambiguity among the teachers, similar to that seen among health care staff, can be interpreted as an impact of the norms of collegial loyalty, which puts pressure on the teachers who feel obliged to intervene, but refrain from doing so. The informal norms prescribe silence and passivity. The reasons given by the teachers are that teachers need to support each other and that a good atmosphere among the staff could be spoiled if they do not keep together, which might be interpreted as moral justification within the theoretical framework of moral disengagement. Furthermore, they argue that teaching is a professional practice that can be performed and interpreted in different ways, and they question their ability to decide what good teaching is for other teachers. In fact, teachers feel threatened to keep quiet, something which Campbell (1993) called collegial tyranny. In spite of this, they feel morally committed to protecting the students from the kind of practice they consider harmful to the students. One conclusion drawn from the first Swedish study was that:

social norms of collegiality bring teachers into conflict with their own conscience. Norms of collegial loyalty keep them from defending pupils against their colleagues. One interpretation of this phenomenon is that teachers reinforce the socializing task in teaching by adopting such a restrictive attitude. (Colnerud, 1997, pp. 632–633)

This is reinforced by the 'hands-off norms’ (Feiman-Nemser & Floden, 1986), according to which teachers do not have anything to do with each other’s way of performing their professional practice, which is confirmed by Ohnstad (2008).

Research on the moral dimensions of teaching, which is particularly relevant to the present subject, has pointed to phenomena such as teachers seeming to be unaware of the moral impact of their actions (Jackson, Boostrom, & Hansen, 1993) and that they run the risk of suspending their sense of moral responsibility (Campbell, 1996). Furthermore, teachers develop avoidance strategies when it comes to misbehaving colleagues (Tirri, 1999). They seem to have difficulties in defining the moral dilemmas they face, and collegial conflicts tend to remain unsolved (Husu, 2004). Furthermore, teachers lack a moral language suitable for the dilemmas they experience (Sockett & LePage, 2002).

Teaching can be described as a profession with inherent contradictions, since schools as institutions sometimes prescribe practices that are inappropriate to all or some of their students (Darling-Hammond, 1985). Hansen (2001) concludes that teachers ‘frequently find themselves torn in what to do because each option that comes to mind can be morally justified’ (p. 849). That is why the two main unions for teachers in Sweden agreed in 2001 on common ethical guidelines for teachers, as found in other countries such as the UK, for example. The guidelines, written in Swedish, state that teachers should show good collegiality, but not in a way that could result in action or negligence that could harm the students. Also, a teacher should intervene if a colleague behaves wrongly toward a student or works against a student’s rights (Lärarnas Riksförbund & Lärarförbundet, 2001). Consequently, teachers should indeed be involved in each other’s ways of treating the students. However, nothing is said in the code about how to overcome one’s scruples in relation to the norms of collegial loyalty when intervention is morally required. Thus, the dilemma still requires the individual teacher to be courageous in order not to remain passive as a bystander.
To sum up, teachers may risk ending up as passive bystanders—although with bad conscience and risk of moral distress (Colnerud, 2015). Torn between contradictory expectations by the school as an institution of socialization, colleagues’ expectations of loyalty, and the students’ need of protection against harm, they seem to fail to take sides for the weakest part.

**What is similar**

Our explorations suggest that although there is some research about bystander behavior in these different settings, some areas, such as teachers’ moral disengagement and moral distress among bystanders to school bullying, are less studied. Nevertheless, the literature reviewed demonstrates similar complexities of bystander passivity throughout these settings and emphasizes the importance of moral disengagement and moral distress. Despite obvious differences between the settings—schools and health care—there were striking similarities between the processes of disengagement, signs of distress, and the types of obstacles for intervention that bystanders identified. These similarities give rise to more general opportunities for moral education with regard to bystanders’ moral agency, which we will explore in the section below.

**Opportunities for moral education in schools and professional settings**

In this section, we discuss moral education efforts that aim to strengthen bystanders’ moral agency either by focusing on unconcerned bystanders or on guilty bystanders. Both types of passivity suggest different opportunities for educational efforts and benefit from separate discussions. Where available, we will explicate the discussion by referring to concrete educational efforts that have been conducted. Rather than here emphasizing complexities and challenges, which without question are many, we choose to present a variety of possible educational entries and the ways in which they theoretically can be framed.

**Efforts directed at unconcerned bystanders: counteracting moral disengagement**

The main problem with the unconcerned bystanders is that the interpersonal harm itself is not recognized as a moral problem. In such cases, educational efforts could be either focused on eliciting and emphasizing the moral problem, or on emphasizing bystander responsibilities.

One way to emphasize a moral problem is to make disengagement processes transparent, aiming to clear away the blur that makes the problem invisible. This could be accomplished by teaching and making students aware of the presence of moral disengagement mechanisms in: (1) historical and contemporary cases of so-called crimes against humanity, such as terrorism, attacks on minorities, torture, and genocide; and (2) classic social psychological studies like Milgram’s (1974) obedience experiments, the Stanford Prison Experiment (Haney, Banks, & Zimbardo, 1973), and a range of bystander-effect experiments (Latané & Darley, 1970). An iterative and reflective process can then be adopted in which the students examine and reflect upon the connection between these historical and contemporary inhumane cases and the social life of their own school and classroom, including the moral choices they confront individually and with their peers (Facing History & Ourselves, 1994). In the ‘No Blame
Approach to Bullying’ an early step is to make a victim’s suffering visible to perpetrators and bystanders. This step is aimed at triggering the pupils’ empathy without allocating blame to anyone, in that way increasing their moral engagement with bullying as a problem (Robinson & Maines, 1997). It may also be fruitful to reach a shared understanding of what the actual moral problem is. In a drama education model among health care staff directed at activating them as bystanders in situations of patient abuse, one valuable accomplishment for them was to actually take an ethical stance against the abuse, as a group (Wijma et al., 2016). Such an agreement could potentially diminish staff’s uncertainty about whether or not an incident was abusive or not. This approach could also be helpful to teachers, who claimed that an idea of good teaching might differ among teachers, thereby creating uncertainty about what is oppressive treatment and what is not.

Another approach could be to stress the importance of people taking an active role as bystanders in the issue at hand. This may not be self-evident in every context, especially if it is unclear how formal responsibilities are distributed or if a ‘perpetrator–victim’ framework is dominant. In the case of patient abuse, the fact that ethical guidelines hardly embrace the role of bystanders (Zbikowski et al., 2012) may create a moral climate that is very much left with a focus on perpetrators or a single responsible caregiver. To emphasize the potentiality of bystander intervention, a clinic may aim to redefine this climate and the perceived responsibilities that staff have toward patients. Compared to patient abuse, the importance of bystander intervention is much more expressed in the context of bullying in schools. For example, the Finnish KiVa anti-bullying program has been designed to reduce negative bystander behavior and increase defender behavior by fostering students’ awareness of various participant roles, empathy, self-efficacy, and anti-bullying attitudes. Evaluations have shown that the program is effective in reducing school bullying and victimization (Kärnä, Voeten, Little, Poskiparta, Alanen, et al., 2011; Kärnä, Voeten, Little, Poskiparta, Kaljonen, et al., 2011; Yang & Salmivalli, 2015). Another example of an intervention that aimed to activate bystanders as defenders is a project called ‘Creating a Peaceful School Learning Environment.’ Amongst other things, this program focused on children’s own ability to resolve issues and address root problems rather than to criticize behavior; problems of a single child were conceptualized as a shared problem, emphasizing the responsibility of each individual. One result of this project was that a systematic bully–victim–bystander approach contributed to a peaceful learning climate in schools and benefited the children’s educational performance (Fonagy, Twemlow, Vernberg, Sacco, & Little, 2005). In a similar fashion—as mentioned earlier—teacher unions in Sweden developed guidelines that emphasized the importance of teachers’ interventions in situations where colleagues behave wrongly toward students. As bystanders however, many teachers seem to display distress in such situations, which indicates that they are engaged and feel responsible, and seem much more in need of support efforts of the category below.

**Efforts directed at guilty bystanders: visualizing and reducing constraints**

When there are obvious signs of moral distress, the abovementioned approaches will be of little help in the activation of bystanders. Educational efforts in such circumstances could instead benefit from a visualization and reduction of the obstacles and constraints that prevent people from intervening. For professional organizations such as schools or clinical wards, for example, an overarching strategy could be to work on a cultural
climate that values ethical considerations and integrity, and that commends rather than silences those who speak up (Gallagher, 2011). Another strand of efforts could be directed at the bystanders themselves, and their ability to intervene against or in spite of the constraints they perceive. The drama education model among health care staff mentioned earlier built on Augusto Boal’s *Theatre of the Oppressed* (2000), and has its main focus not on disengagement, but on working with agency in situations of oppression and constraint—situations that the oppressed themselves have defined as problematic. The theater forum creates opportunities for identifying oppressive structures and allows participants to explore courses of action within these structures or even how they can overthrow these structures. Training how to get passed obstacles for action is one way to increase individual and collective efficacy among health care staff, teachers, or students. In a school setting, Barchia and Bussey (2011) found that strong collective efficacy to stop aggression, i.e., the students’ belief that students and teachers can work together to stop peer aggression, predicted higher frequency of defending behavior.

**Conclusion**

This article elicits the complexity of bystander passivity, a highlighted phenomenon within the context and prevention of interpersonal violence. By connecting Obermann’s (2011) uninvolved and guilty bystanders to theories of moral disengagement and moral distress, we were able to distinguish different forms of passivity in health care and school settings. Figure 1 summarizes how these ideas are related, as one way of understanding bystander passivity.

Central to Figure 1 are two conceptually distinct ways of understanding bystander passivity. One is passivity through moral disengagement that does not evoke moral distress and represents unconcerned bystanders. Another is passivity despite moral engagement but within constraints that can evoke moral distress and characterizes guilty bystanders. In complex social situations, these different processes are most likely intertwined, dynamic, and can be more or less contingent. However, separating them analytically provides a framework that can help others to explore bystander passivity in other settings and propel theoretical understandings of this complex, yet highly relevant phenomenon. This framework can also support ways in which bystander passivity is considered in moral educational efforts, either directed at diminishing disengagement or reducing constraints for action. Even though the ultimate aim to strengthen bystanders’ moral agency may be the same, different forms of bystanding demand distinct educational efforts in terms of ends and designs.

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**Figure 1.** Understanding bystander passivity in relation to moral disengagement and moral distress.
The majority of the studies included in our analysis build on people’s reports of their experiences of and motives for bystander action or on studies conducted in experimental settings. Future research could benefit from ethnographic work, further teasing out what being a bystander means in different practices and how this position can change, e.g., through educational efforts. Even though this article mainly included research from a Swedish context, it is comparisons between different settings that provided us with valuable analytical insights, emphasizing the importance of continued empirical explorations in various settings, alongside further theoretical refinement.

Many of the educational efforts we discussed emphasized shared problem descriptions and collective responsibilities. Adopting such a framework as an organization implies positioning each and every member as a bystander at some point, and thereby as having the potential to contribute to a safe and respectful environment. As challenging as this may be for organizations and individuals, there can be much to gain in terms of welfare and justice.

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