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## Horizontal Violence in the Nursing Work Environment: Beyond Oppressed Group Behavior

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# Horizontal Violence in the Nursing Work Environment: Beyond Oppressed Group Behavior

A Dissertation

Submitted to the Graduate Faculty of the  
University of New Orleans  
In partial fulfillment of the  
requirements for the degree of

Doctor of Philosophy  
in  
Curriculum and Instruction

by

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MEd, University of New Orleans, 2001

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## FOREWORD

As soon as I reported to work that morning, my charge nurse told me that I had been reassigned to the intensive care unit (ICU). In my hospital nurses were routinely moved between patient care units whenever necessary. No one wanted to be reassigned to another unit, and in order to keep things fair, a list of who had gone where and when was posted on the bulletin board. I checked the list. Then, I checked the list again. Today was my turn to be reassigned to another unit. I made the best arguments that I could to avoid going to the ICU. I did not feel comfortable leaving my home unit. The critically ill patients in ICU needed an intensive care nurse. They needed someone experienced. I was new. I was terrified. However, it was my turn and I had to go.

As I took each step towards the intensive care unit, my feelings of inexperience and lack of confidence grew until I was close to tears. I took a deep breath and opened the ICU doors. I walked into a very loud and fast paced unit. I was wearing the standard hospital nurse uniform of white dress, white stockings and white nursing shoes. The ICU nurses were in surgical scrubs. They wore green pants with green tops and jackets. They wore athletic shoes. They did not wear a "Hello, my name is..." badge on their collars. Their identification badges swung from their waistbands with a pair of hemostats and a roll of surgical tape. If anything needed taping or clamping, they were ready. The difference between my prim white hospital floor uniform and their relaxed green surgical scrub wear could not have been more striking. I was not part of their world.

I stood at the desk waiting for someone to notice that I was standing there. They were all busy with their patients and no one noticed me. Should I interrupt them? Who was I

supposed to take care of back here? I did not know what to do. After what seemed like an eternity, I finally caught someone's attention and I introduced myself. I told the nurse my name and from which floor I had been reassigned. Maybe she would understand that I was scared and help me. She looked me up and down and muttered, "I can't believe they sent us *this*." She did not ask me if I knew how to care for intensive care patients. She did not ask me anything.

She turned away and, shaking her head, she slid behind a curtain drawn across a patient room to talk with another nurse. "You aren't going to believe *what* they sent us." She said it loud enough for me to hear. She said it loud enough for everyone to hear. The other nurses in the unit stopped what they were doing and looked at me standing alone by the desk. I felt humiliated. I wanted to go home. I said nothing. The curtain that the first nurse had slid behind suddenly screeched open. The first nurse stood there with her hand on her hip and her head cocked to one side looking at me. A second nurse stood next to her and, after looking me up and down several times, she turned to her colleague and said, "They sent us *that*?" Within just a few minutes I had been called a "this," a "what" and a "that." All I could think of was how bad I felt at that moment. I wanted to leave but that was not an option.

Why was this happening? I did not want to be back there. This was not my idea. Somehow I managed to get through the rest of the 12 hour shift in the ICU. It was an excruciatingly unpleasant experience and shifted my view of nurses a bit. Where were the nurses I had so admired? Was this the reality shock my nursing school instructors had talked about? What happened? What had I done wrong? Why were they so mean to me? They did

not want me there. I did not want to be there. If I left, I could be charged with patient abandonment. I felt trapped. How had this happened?

In spite of this distressing introduction to intensive care nursing, I was drawn to the patients and families in the ICU. I eventually made critical care my practice specialty for many years. As I gained experience and confidence, I enjoyed working with and being a part of a team of nurses who were doing their best for the critically injured and ill. Although I never called a nurse from another unit a “what” or a “this” or a “that,” interpersonal conflict was rampant within and between patient care units. I could never figure out why these negative behaviors between nurses seemed to flourish in our work environment. Although I had not forgotten how devastating it was to be the target, patient care was my priority, and I did not take the time to think about what may have been driving these hostile behaviors.

Many years later, I was admitting a patient who had arrested on another floor to the ICU. Whenever a patient arrests in a hospital, there are a lot of people doing a lot of things all at the same time. All of this activity around one patient is loud and often appears, if you are not accustomed to these events, frantic. Patients do not arrest on the medical-surgical floors very often, and when they do, it is stressful for the nurses and the other staff involved. The priority is to get the patient to the ICU where the staff have the resources and experience to manage these emergencies.

The patient, whom I was admitting, had been successfully resuscitated by the floor nurses and code team personnel. Someone had saved his life, and now I was admitting him to the ICU. As I hooked up my monitors and adjusted the intravenous medications, I asked the patient’s nurse what had happened upstairs. She began to tell me details of the patient’s



admission and subsequent hospital course. I asked what had happened again, and she continued her report. We were speaking different languages. She was giving me report on the *patient*, and I was asking for report on the *event*. I rolled my eyes, waved my hand at her and said, “Never mind, I’ll figure it out myself.” I then turned away from her and went back to caring for the patient.

I continued with the post-arrest protocols. I was analyzing the patient’s heart rhythm, breathing pattern and kidney function. I turned around to look at one of the intravenous pumps and saw the patient’s nurse looking through the window into the room. Her eyes were on her patient, and her look of concern for this gentleman stopped me cold. This was her patient. He had arrested, and she had been there to rescue him. She had managed to get him down to the critical care unit alive, and I had dismissed her as though her knowledge of the patient meant nothing. She had tried to tell me what had happened in her world before she and her patient were both brought into mine. As I looked at her, I remembered how I felt when I had been dismissed as a “what” and a “that” so many years before. I had just done the same thing.

I was fortunate that her concern for her patient had overridden her reaction to my rude and disrespectful comment. If she had left, I would not have realized what I had done. I washed my hands, walked out of the room and apologized for my inconsiderate and unprofessional behavior. She told me that it was okay. She said that she understood that things were hectic. She said that I could forget about the incident, but I never did. This event

rekindled my interest in horizontal violence between nurses at work. I was not the first or last target of this destructive behavior, and I was not the first or last perpetrator. This study is a result of those two events from my own experiences.

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## **ABSTRACT**

The United States has been experiencing a nursing shortage since the mid-1990s. The shortage is expected to deepen as the provisions of the 2010 Patient Protection and Affordable Care Act are enacted. Horizontal violence is a negative phenomenon in the nursing workplace that contributes to difficulty in recruiting and retaining nurses in hospitals. Horizontal violence has been described as a form of mistreatment, spoken or unspoken, that is threatening, humiliating, disrespectful or accusatory towards a peer. The effects of this nurse on nurse aggression can be devastating for the nurse involved and also for the patients under the nurse's care.

Nursing and social science literature have advanced oppressed group behaviors as a motivating factor driving this phenomenon in nursing. Workplace stress has also been implicated in these negative behaviors. This study used a grounded theory approach to examine how nurses explain, through semi-structured and open ended interviews, the phenomenon of horizontal violence in the nursing workplace. The primary outcome of this study was a small scale theory focused specifically on horizontal violence in the nursing work environment. The theory that emerged from this analysis was that horizontal violence can be influenced by other environmental factors beyond oppression theory. The results from the data indicated that these behaviors, described as horizontal violence may, at times, be employed as a method of manipulating the care environment in an effort to enhance patient outcomes while maintaining group or individual perception of security through a sense of environmental control.

Nurses, Nursing Shortage, Nurse Retention, Bullying, Nurse-to-Nurse Interactions, Workplace  
Violence, Patient Safety, Oppression, Stress, Grounded Theory, Alliances

## **CHAPTER ONE**

### **Introduction**

The stereotypical media image of a nurse standing at a desk holding a clipboard in what Tisdale (2007) called the “beautiful hospital” bears little resemblance to reality. Hospital nursing is a fast paced, mentally and physically demanding endeavor. In most U.S. hospitals, the typical shift is anywhere from twelve hours upward depending on patient needs. During this time the nurse is managing sick patients on tight schedules for multiple treatments and interventions. Time must also be found to document each assessment, intervention and follow-up observation which adds to the nurse’s work load. Long hours can cause fatigue and increase the risk of patient care errors (Geiger-Brown & Trinkoff, 2011; Scott, Rogers, Hwang & Zhang, 2006; Trinkoff, Johantgen, Storr, Gurses, Liang & Han, 2011). In the interest of patient safety, even the most exhausted, stressed and distracted nurse must complete all assigned tasks with little tolerance for error.

Adding to the challenges of providing patient care, for many nurses, workplace aggression is a frequent event (Brown & Middaugh, 2009; Farrell, Bobrowski & Bobrowski, 2006; Murray, 2009). This aggression takes various forms from physical assault, threatening behaviors and verbal abuse (Jackson, Clare & Mannix, 2002; Winstanley, 2002). Hostile interactions directed at nurses in the workplace come from patients and their families (e.g., Alexy & Hutchins, 2006; Lechky, 1994; Lynch, Appelboam & McQuillan, 2003; Roche, Diers, Duffield & Catling-Paull, 2010), poor relationships with physicians and other hospital staff (e.g., Azoulay et al., 2009; Nelson, King & Brodine, 2008; Rosenstein, 2002) as well as between nursing colleagues.

Hospital staff relationships are damaged by disruptive and abusive behavior. These negative behaviors also pose a threat to patient safety (Ditmer, 2010; Pennsylvania Patient Safety Authority, 2010; The Joint Commission, 2008). Abusive behavior between nurses and other hospital staff can and does result in increased stress levels, frustration, loss of concentration, reduced team collaboration and breakdown in communication (Rosenstein & O'Daniel, 2005). Nurses report that aggression between nurse colleagues, called horizontal violence, is the most emotionally devastating of all the forms of workplace aggression (Farrell, 1999).

### Horizontal Violence

Horizontal violence has many names in the nursing literature. The phenomenon is known as horizontal violence or hostility, lateral violence or hostility, disruptive relationships, bullying, peer mobbing, intra-staff aggression, intrapersonal workplace aggression, nurse on nurse aggression, sabotage, verbal abuse and infighting. All of these terms are used to describe disruptive and damaging behavior between nurse colleagues in the workplace. For the purposes of this study, I am using the term horizontal violence to describe these negative nurse-to-nurse interactions. I am defining horizontal violence as any non-verbal or verbal non-physical behaviors that result in the recipient feeling personally or professionally isolated, threatened or attacked. Horizontal implies that the behavior is initiated by a nurse or nurses towards another nurse whether practitioner or student. This definition of horizontal violence would include behavior between charge nurses, staff nurses, nurse faculty/instructors and student nurses. The term horizontal violence in nursing describes hostile and aggressive behavior between nurse colleagues (Duffy, 1995).

This definition does not consider the intent of the behavior but focuses only on how the behavior is received by the target nurse. The behaviors include, but are not limited to, belittling, shouting, accusing, disparaging remarks made to the target nurse or to others about the target nurse, facial gestures such as eye rolling and raised eyebrows, withholding information, snide comments, the silent treatment, public criticism, the unnecessarily difficult patient assignment, undermining, in-fighting, scapegoating and bickering. Horizontal violence includes any behavior that results in the target nurse feeling isolated, devalued and under attack. The target nurse may feel a loss of confidence and self-esteem (Nazarko, 2001). The main theme is damaging behavior between nurse colleagues. Although attempts are made to control these negative interactions in the hospital the behaviors continue to occur (e.g., Hutchinson, Jackson, Wilkes & Vickers, 2008; Johnson, Phanhtharath & Jackson, 2010; Katrinli, Atabay, Gunay & Cangarki, 2010; The Joint Commission, 2009).

### *Effects of Horizontal Violence*

Nurses report that horizontal violence, also described as nurse against nurse aggression, is the most emotionally devastating of all the forms of workplace aggression (Farrell, 1999). Nurses who are targets of these negative behaviors report reduction in confidence or self-esteem (Evan, Bell, Sweeney, Morgan & Kelly, 2010; McKenna, Smith, Poole & Coverdale, 2003). Walrath, Dang & Nyberg (2010) reported that disruptive behavior is a distraction that can jeopardize patient care. Abusive behavior can and does result in increased stress levels, frustration, loss of concentration, reduced team collaboration and reduced information transfer between patient care providers (Rosenstein & O'Daniel, 2005). Job dissatisfaction and nurse attrition can be expected to follow (Vessy, Demarco & Defazio, 2010). Negative clinical

outcomes as evidenced by increased errors, increased patient morbidity and mortality are more likely in an environment of this type (Institute for Safe Medication Practices, 2009; Pennsylvania Patient Safety Advisory, 2010; Roche, et al., 2010). In the interest of patient safety and nurse well-being, investigation into the phenomenon of horizontal violence remains a legitimate undertaking for researchers.

### Oppressed Group Behavior

Horizontal violence between nurses has been studied under various labels for more than 30 years. The phenomenon is well documented in the nursing literature (e.g., American Nurses Association, 2011; McKenna, et al., 2003; Walrath, Dang & Nyberg, 2010). When researchers attempt to explain horizontal violence in nursing, they most often turn to the oppressed group behavior model introduced by Freire in the 1970s (e.g., Fletcher, 2006; Freshwater, 2000; Hedin, 1986; Matheson & Bobay, 2007). Freire (2007) based his model on behaviors he observed in members of the Brazilian working class whom he believed were dominated and oppressed by a more powerful European privileged class.

In Freire's (2007) model, oppression is characterized by assimilation, marginalization, self-hatred, low self-esteem, submissive behaviors and horizontal violence. The values of the powerful group (the oppressors) are internalized by the oppressed while the oppressed group's own values are rejected. The oppressed group members attempt to assimilate into the powerful group by adopting the values of the powerful. With successful assimilation of the powerful group's values, the oppressed become marginalized.

Marginalization results from the oppressed no longer feeling part of their own group while, at the same time, believing that they will never truly belong to the powerful group.

They feel alienated from both groups. Feelings of marginalization are thought to lead to self-hatred and low self-esteem. Fear of retaliation from the powerful group leads to submissive behaviors. Self-hatred, low self-esteem and submission lead to anger. Submission and fear prevent the anger from being directed at the powerful group members. The anger is therefore directed towards members of the oppressed own group in the form of horizontal violence.

Nurse against nurse aggression has historically been attributed to oppressed group behavior (e.g., Cox, 1991; Duffy, 1995; Fletcher, 2006; Hedin, 1986; Roberts, 1983).

Researchers assert that nurses, as a group, are oppressed by more powerful groups such as organized medicine or hospital administration (Ashley, 1976; Group & Roberts, 2005). Nursing is described in the literature as a support service that is exploited for the benefit of organized medicine (Duffy, 1995; Fletcher, 2006; Hedin, 1987; Longo & Smith, 2011; Roberts, 1983). Systematic exploitation and oppression of nursing as a group is believed to result in nurses disliking themselves and other nurses related to their powerless state. A lack of regard for self and for other nurses is believed to ultimately result in horizontal violence.

Studies describe aspects of horizontal violence in the nursing workplace and ascribe the behaviors to oppression and the effects of subjugation. Research has established that these negative behaviors occur in the workplace (Hutchinson, et al., 2008; Katrinli, et al., 2010) and that hostile work environments contribute to the nursing shortage (Aiken, et al., 2001; Jackson, Clare, & Mannix, 2002; Simons, 2008) which in turn may place patient care at risk (Rosenstein & O'Daniel, 2005).

Nursing literature examining nurse-to-nurse workplace interactions supports the presence of behaviors ascribed to oppressed groups such as horizontal violence. However, the

research is not as clear in demonstrating that these behaviors are a consequence of oppression and not another dynamic (Matheson & Bobay, 2007). Oppressed group behavior has provided some understanding of horizontal violence between nurses at work, but the theory does not recognize other environmental issues found in the nursing workplace that may contribute to the phenomenon (Alspach, 2007; Hutchinson, Vickers, Jackson, & Wilkes, 2006).

The evidence indicates that the majority of working nurses will experience horizontal violence at work sometime during their careers (Aiken, et al., 2001; Rosenstein & O'Daniel, 2005; Sofield & Salmond, 2003; Young, 2011). In 1983, Roberts attributed these long standing negative behaviors between nurses to oppression. Oppression of nurses continues to be identified as a driving force behind horizontal violence in nursing (King-Jones, 2011; Longo & Smith, 2011).

Current scholarly discussion of horizontal violence in nursing demonstrates continuing interest in constructively managing this negative phenomenon in the work environment. Nurse researchers assert that oppression of nursing as a group has been a pervasive influence on negative behavior between nurses at work. This one dimensional explanation cannot truly account for a complicated behavior dynamic that occurs between nurses practicing across different cultures and healthcare delivery systems (Abe & Henly, 2010; Aiken, et al., 2001; Hutchinson, et al., 2010; Lee & Saeed, 2001; Uzun, 2003). Although social oppression of nursing as a profession has been the prevailing explanation for over 30 years, horizontal violence continues to occur between nurses at work. An alternative or additional explanation is needed to understand behaviors that the evidence demonstrates is damaging to the nurses and patients involved in these events.



## Purpose of this Study

Nurse researchers have attributed horizontal violence to oppression of nursing as a profession. Scholars have examined horizontal violence and developed the theoretical connection between these behaviors and oppression. The purpose of this study was to listen to the stories that nurses told about horizontal violence and to develop an alternative explanation for horizontal violence based on the perspectives of the individuals involved in these events. Researchers believe that oppression drives these negative behaviors. This study examined what the nurse participants believed were influences on horizontal violence.

Although oppressed group behavior has provided some understanding of horizontal violence, other environmental factors may contribute to the phenomenon. Numerous descriptive studies have provided a strong base of evidence supporting the existence of horizontal violence in the nursing work environment (e.g., Aiken, et al., 2001; Cox, 1991; Rosenstein & O'Daniel, 2005). The evidence strongly suggests that this behavior is destructive to nurses and, ultimately, a threat to patient care. With horizontal violence identified as a threat to patient safety, it is important to examine what nurses involved in these events believe may be contributing factors.

Grounded theory methodology was chosen for this study because it is a research method in which theory emerges from the data rather than using the data to support existing theory. This study used the grounded theory approach to analyze data obtained through interviews with nurses who had experienced horizontal violence in the workplace. The aim was to reveal the theoretical propositions implicit in the data and to enhance understanding of

horizontal violence, a long standing and disruptive phenomenon in the nursing workplace, from the nurse participants' perspective.

### Study Questions

The questions in this study were broadly worded in order to allow the participants to discuss whatever aspect of horizontal violence was important to them. The intent was to allow for an open-ended exploration of the participant's experience with negative nurse-to-nurse interactions in the work environment. I was interested in soliciting each participant's interpretation of his or her experience (Charmaz, 2006) with horizontal violence. Two main questions drove the data collection. My first question was how the nurses described horizontal violence in their work environments. The second question focused on what factors, from the nurses' perspective, contributed to the incidence of horizontal violence.

As noted earlier, quantitative studies have verified that horizontal violence between nurses occurs in the workplace and also provides information on the consequences of these behaviors. Less is known about how nurses interpret these events. The main purpose of my questions was go beyond the oppressed group behavior explanation for horizontal violence in the nursing workplace. Qualitative methods are well suited for exploring complex behaviors grounded in the context within which the behaviors, such as horizontal violence, occur.

### Definition of Terms

For the purpose of this study, the following terms are operationally defined as follows:

#### *Acute Care Environment*

An acute care environment is an area within a hospital that provides acute medical, surgical and nursing care to patients needing continuous observation and treatment. This

designation is used in this study in place of more identifying hospital unit labels (e.g., Emergency Department, Medical-Surgical Care Unit, Post Anesthesia Care Unit) to maintain participant confidentiality.

#### *Alliance/Clique*

An exclusive work group formed within the boundaries of the larger work group. Qualification for membership in the alliance/clique is based on informal, and often unspoken, standards established by the group members themselves.

#### *Horizontal Violence*

Any non-verbal or verbal non-physical behaviors that result in the recipient feeling personally or professionally isolated, threatened or attacked. Horizontal implies that the behavior is initiated by a nurse or nurses towards another nurse whether practitioner or student.

#### *Interdependence*

Interdependence is defined as a mutual dependence upon and between group members for task completion or outcome achievement.

#### *Nurse*

An individual duly licensed by their respective state board of nursing to educate and treat patients related to various medical conditions. (definition adapted from United States Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, 2010-2011).

#### *Oppression*

Oppression is defined a systematically applied injustice based in “coercively enforced inequality or diminished choice” (Cudd, 2005, p. 22).

### *Organized Medicine*

The term organized medicine is used to describe a dominating social force systematically maintaining control of nursing roles and range of practice while profiting from nursing labor (Group & Roberts, 2001). Historically, the medical profession, through organization and professional closure, has maintained control over care provided by nurses (Ashley, 1976; Witz, 1992).

### *Patient Care Unit*

An area of a hospital designed for the treatment of patients with specific conditions and staffed by personnel trained and skilled in managing these conditions (e.g., critical care unit, emergency care unit, medical care unit, post-surgical care unit).

### *Relational aggression*

Relational aggression is a term used to describe bullying behaviors that may result in relationship damage through psychological and emotional harm. Behaviors associated with horizontal violence and relational aggression are similar (e.g., gossip intended to damage reputations, social exclusion, isolation) although relational aggression is not limited to people on the same professional level such as with nurse-to-nurse aggression.

### *Stress*

Stress relates both to an individual's perception of the demands being made on them and to their perception of their capability to meet those demands (McVicar, 2003). Stress in this study is defined as a state of mind during which the individual's judgment determines that the environmental and/or internal demands tax or exceed the resources required to manage them (Holroyd & Lazarus, 1982).

## Summary

Research has established that the nursing workplace can be described as a sometimes hostile environment related to poor relationships between nurses, physicians and other hospital staff members. All disruptive hospital relationships are difficult and a possible threat to patient safety. However, horizontal violence (nurse-to-nurse aggression) has been found to be the most difficult for nurses to manage. Horizontal violence is reported to result in increased stress, frustration and loss of team collaboration which can ultimately result in negative patient outcomes.

Nursing has been described as an oppressed group and horizontal violence has been attributed to the effects of oppression. Oppressed group behavior has provided some understanding of horizontal violence but fails to recognize other environmental issues that may contribute to the phenomenon. As social environments such as health care and the practice of nursing have become more complex, a one dimensional explanation for a complicated behavior dynamic such as horizontal violence suggests a gap in our understanding of the phenomenon. Even after many years of examining oppression in nursing, horizontal violence continues to occur in the patient care environments across different cultures and healthcare delivery systems.

Research indicates that horizontal violence can ultimately affect the quality of patient care and nurse well-being. Although horizontal violence has been attributed to oppressed group behaviors, recommendations for decreasing social oppression of nursing have not been successful in controlling these deeply entrenched and widespread negative behaviors (e.g., Hutchinson, et al., 2008; Johnson, et al., 2010; Katrinli, et al., 2010; The Joint Commission,

2009). An alternative or additional explanation is needed to understand and manage behaviors that the evidence demonstrates is damaging to the nurses and patients involved in these events. The purpose of this study was to enhance understanding of negative nurse-to-nurse interactions through the stories of nurses who have experience with the phenomenon of horizontal violence in the nursing workplace.

## CHAPTER TWO

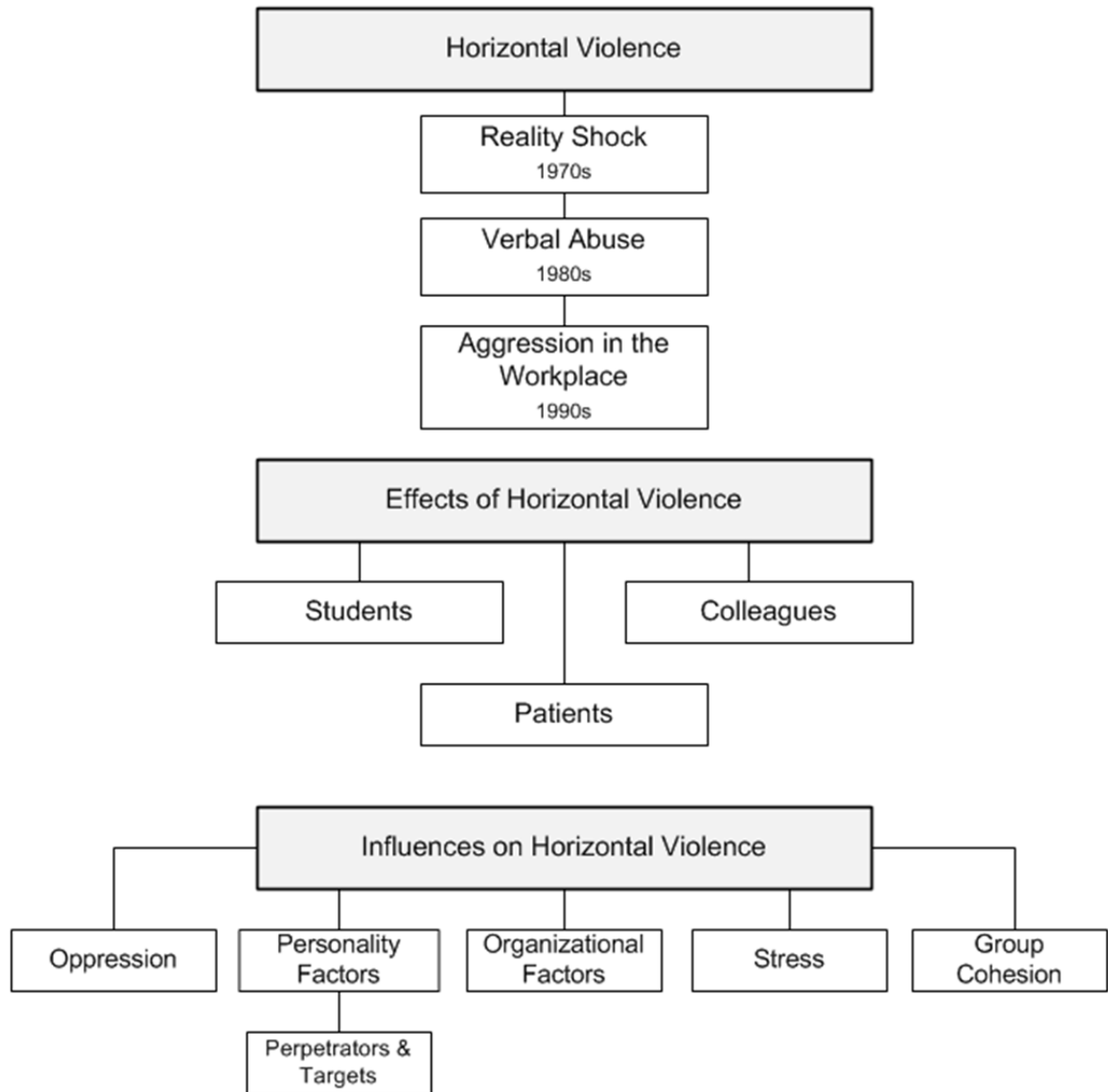
### LITERATURE REVIEW

#### Introduction

The purpose of this chapter is to present the literature as it relates to horizontal violence in the nursing work environment. The phenomenon of horizontal violence or nurse-to-nurse aggression in the workplace has been discussed in the professional literature for many years. Through these years, horizontal violence has been described and discussed using different terms. Horizontal violence has been described as a component of what was known as *reality shock* in the 1970s. Negative interactions between nurses at work have been labeled disruptive behaviors, relational aggression, bullying, intra-staff aggression and nurse-to-nurse hostility. These different labels are used to describe the same behaviors that are now labeled horizontal violence. Although horizontal violence will be described according to the different terms used in the literature, all of the different labels used in examining the phenomenon refer to the same construct.

During the 1970s, the term *reality shock* was used to describe negative interactions between nurses at work. Verbal abuse of nurses, a component of horizontal violence, was examined by researchers beginning in the 1980s. From the 1990s to the present, researchers have continued to examine the incidence and effects of horizontal violence in the nursing workplace as well as developing explanations for these negative behaviors between nurses. After a discussion of the behaviors examined in horizontal violence research, the sections that follow will discuss individual, environmental and social factors that have been implicated as influences on horizontal violence in the nursing workplace (see Figure 1).

Figure 1. Organizational Chart of Review of Literature on Horizontal Violence





## Horizontal Violence

### *Defining Horizontal Violence*

There is no agreement in the nursing literature on a definition of horizontal violence as encountered in the nursing work environment. The lack of definition makes the actual incidence of horizontal violence in the nursing workplace difficult to determine. A significant measurement challenge is the number of terms used to describe these behaviors. As previously noted, researchers have focused on what they call horizontal hostility or violence, lateral hostility or violence, disruptive behavior or relationships, relational aggression, bullying, peer mobbing, intra-staff aggression, nurse on nurse aggression, sabotage, verbal abuse and infighting, workplace violence, workplace aggression, nurse-to-nurse hostility, hostile action, problematic behavior, internal occupational violence and interactive workplace trauma. All of these labels refer to the phenomenon of horizontal violence. Hockley (2000) notes that reluctance to use standardized language when discussing this phenomenon can make discussion and possible resolution difficult. Standard nomenclature could facilitate research and enhance understanding of this phenomenon (Crawshaw, 2009).

The hostile behaviors with the labels noted above include, but are not limited to, belittling, shouting, accusing, disparaging remarks made to the target nurse or to others about the target nurse, facial gestures such as eye rolling and raised eyebrows, withholding information and snide comments. Other behaviors include the silent treatment, public criticism, the unnecessarily difficult patient assignment, failure to assist a colleague when needed, undermining, in-fighting, sabotage, scapegoating and bickering. These negative behaviors can be covert or overt, verbal or non-verbal. The number of different terms used to

describe the behaviors associated with horizontal violence can make cross comparisons difficult. The table that follows illustrates the number of different labels applied to behaviors identified as horizontal violence in the literature (See Table 1).

Table 1.  
*Behaviors Described in the Literature as Horizontal Violence*

<b>Author</b>	<b>Subject group</b>	<b>Behaviors Described as Horizontal Violence</b>
Cox, 1987	Registered nurses in hospital setting (US) <i>n</i> = 478	Verbal abuse defined as language pattern that causes harm
Curtis, Bowen & Reid, 2007	Second and third year nursing students (Australia) <i>n</i> = 152	Being neglected and ignored. Verbal reprimands in front of colleagues. Treated with disrespect.
Dellasega, 2009	Literature review	Spreading rumors, the silent treatment, using humiliations and put downs, failure to support a colleague, intimidation, eye rolling, name calling, smear campaigns
Dunn, 2003	Registered Nurses (US) <i>n</i> = 145	Sabotage, constant criticism, silent treatment, gossip, exclusion from unit activities, negative references, termination without cause
Farrell, 1999	Staff nurses and university nurse lecturers (Australia) <i>n</i> = 270	Rudeness, abusive language, humiliation, failure to defend, refused help, spreading rumors, unjustified criticism, silent treatment, stealing credit for your work, excessive scrutiny
Hutchinson, Vickers, Wilkes & Jackson, 2010	Staff nurses (Australia) <i>n</i> = 26	Isolation & exclusion, intimidation & threats, belittlement & humiliation
McKenna, Smith, Poole & Coverdale, 2003	Registered Nurses in first year of practice (New Zealand) <i>n</i> = 551	Learning blocked Undervalued Threat of repercussions for speaking out Emotional neglect Lack of supervision and support Rumors
Stanley, Martin, Michel, Welton & Nemeth, 2007	Staff at metropolitan hospitals (US) <i>n</i> = 663	Rudeness, withholding information, lack of support, sabotage
Walrath, Dang & Nyberg, 2010	Registered Nurses in acute care hospital (US) <i>n</i> = 96	Behaviors categorized as incivility, psychological aggression

Except for physical violence, which is rare between nurses in the workplace (Dellasaga, 2009; Hader, 2008; Khalil, 2009), what these behaviors have in common is a disruptive and damaging form of interpersonal interaction that can threaten nurse retention and patient safety.

### *History of Horizontal Violence*

#### *Reality Shock*

Negative interactions between nurses at work have been of interest in the nursing literature for many years. In 1974, Kramer introduced the concept of *reality shock*. The term reality shock was used to describe the conflict between role expectations as a new nurse and the reality of the nursing work environment. An experienced nurse would be subjected to the same reality shock when moving to an unfamiliar work unit. Becoming a member of the professional work group requires a period of social integration during which the nurse must earn acceptance from the established staff by passing a series of tests based on the group's internal and informal standards (Schmalenberg & Kramer, 1976).

Although horizontal violence is not specifically addressed in the reality shock literature, Schmalenberg and Kramer (1976) discuss interactions between nurses that result in feelings of frustration, anger, rejection and "moral outrage" (p. 38). The authors also suggest that resolution of reality shock includes tools for conflict resolution such as affording students opportunities for classroom practice in "dealing with clashes" (p. 43). This focus on conflict resolution suggests that horizontal violence was, at least, part of the reality shock phenomenon.

## *Verbal Abuse*

Verbal abuse, a component of the reality shock phenomenon, was identified by Curtin in 1980 as a threat to communication, patient safety and productivity. Horizontal violence was not a term used in 1987 when Cox investigated the incidence and effects of verbal abuse in the nursing workplace. Staff nurses ( $n = 421$ ) and nursing directors ( $n = 57$ ) completed surveys on the prevalence and sources of verbal abuse in the workplace. Nursing directors (77%) and staff nurses (82%) reported experience with verbal abuse in their practice. Although the term horizontal violence was not used in this study, both groups of nurses identified nurse coworkers, among others, as sources of verbal abuse. The author also found that verbal abuse in the workplace was a significant influence on a nurse's decision to leave the organization. In this early study, Cox did not speculate as to what conditions may be contributing to verbal abuse in the workplace.

Sofield and Salmond (2003) examined the connection between verbal abuse and intent to leave the organization. Nurses ( $n = 461$ ) from a multisite medical center were asked if they had experienced a verbally abusive incident within the past month. Ninety-one percent (91%) indicated that they had been verbally abused in the past month. Less than half (42%) of the respondents believed that these abusive incidents had been triggered by a stressful event. Physicians were the most frequent perpetrators, followed by patients and their families. Approximately 25% of the nurses reported being verbally abused by a peer. The effects of this workplace violence were reported as decreased morale, productivity and quality of patient care. The nurses also reported increased workloads and, perhaps most significantly, an increase in patient care errors.

### *Cross cultural studies*

Horizontal violence in the form of verbal abuse is not a uniquely American phenomenon. Two studies done in Turkey (Uzun, 2003; Öztunç, 2006) found that nurses there also report being targets of verbal abuse. Uzun (2003) collected data from 467 nurses practicing in various clinical settings in three hospitals. Data from a 23-item questionnaire were evaluated using frequency and descriptive statistics. The analysis revealed that 86% of the nurses reported experiencing verbal abuse in the past 12 months. Most of the nurses (92%) believed that verbal abuse affected their morale and caused a decrease in productivity. Anger was the most frequently reported emotional response (58%).

Öztunç's (2006) study was descriptive in nature and used a questionnaire with closed and open ended questions that were developed "on the basis of information in the literature" (Öztunç, 2006, p. 361.) Although the author does not state what information in the literature was used, the results were similar to other studies. Öztunç found that the majority (80.3%) of respondent nurses ( $n = 290$ ) in this Turkish study reported being subjected to verbal abuse in the workplace. Sources of verbal abuse included patients, families, physicians and other nurses. Anger was again the most frequently (50%) reported emotional response to verbal abuse. It is interesting to note that the majority of nurses (82%) reported that they had not learned in school about verbal abuse and how these incidents should be handled in the healthcare setting. In both Öztunç's and Uzun's studies, the most frequent emotional response to verbal abuse was anger on the part of the nurse. Whatever the source of verbal assault in the nursing work environment, it is reasonable to conclude that angry nurses are not the most

effective caregivers; nurses themselves believed that horizontal violence affected the care provided.

### *Aggression in the Workplace*

In 1997, Farrell published the results of a mixed methods study focusing on two main questions. The first question focused on what nurses report when asked about aggression in the workplace and the second question focused on the extent and importance nurses attach to these experiences. Farrell's subjects were nurse educators ( $n = 9$ ) and nurses who were practicing in the clinical environment ( $n = 20$ ). Farrell describes what I am defining as horizontal violence as intra-staff aggression. Intra-staff aggression is further defined in this study as "aggression by nurses towards nurses" (Farrell, 1997, p. 503). The majority of respondents said that "intra-nurse aggression was a frequent occurrence" (Farrell, 1997, p. 503). All of Farrell's respondents thought that this form of aggression was more upsetting and difficult to deal with when compared to other forms aggression in the workplace such as patient to nurse aggression or physician to nurse aggression.

Farrell published a follow up study (1999) to the 1997 research noted above. In the follow up study, Farrell expanded the number of nurse participants ( $n = 270$ ) and again found that nurse-to-nurse to nurse aggression was described as more distressing than patient to nurse or physician to nurse negative interactions at work. Farrell suggests that aggressive behavior between nurses at work may be related to violating unspoken, but expected, rules of the work relationship (e.g., accepting a fair share of the work, respecting another's privacy, cooperation, standing up for co-worker in his/her absence). In this study, work relationship

dynamics were suggested as an influence on aggression between nurses as opposed to oppressed group behaviors.

### *Effects of Horizontal Violence*

#### *Student Nurses*

Where does horizontal violence start? “Nurses eat their young” is a well-known phrase in nursing (e.g., Bartholomew, 2006; King-Jones, 2011; Roberts, 1983). The phrase implies that that experienced nurses do not treat their new colleagues well. Student nurses are especially vulnerable to horizontal violence.. A student nurse’s unfamiliarity with the workplace and dependence on staff can place him or her in a vulnerable position to become an easy target for aggression (Johnson, 2010). Longo (2007) found that students are frequently “put down” (p. 178) by staff nurses. Students were also humiliated, spoken to in a sarcastic manner and talked about “behind their backs” (p. 178). Longo found that a significant percentage of victimized students do not report the incident to their instructors.

Experienced nurses behaving in an aggressive, unsupportive, humiliating or intolerant manner towards nursing students or new graduate nurses is the basis for the statement “nurses eat their young.” In Longo’s (2007) study, 72% of the students surveyed believed that the statement, “Nurses eat their young” was true. When students see these negative behaviors modeled by experienced nurses, the behaviors may be viewed as an acceptable way to interact with other nurses in the workplace. The author concludes that nursing instructors need to be sensitive to horizontal violence in the clinical areas and make their students aware that these behaviors are not acceptable. Further, Longo argues that staff nurses need to consider the

system-wide impact of their interactions with students and the role it may have in perpetuating horizontal violence in the workplace.

Curtis, Bowen and Reid (2007) reported nursing students' ( $n = 152$ ) experiences of horizontal violence in a similar manner. Data included basic demographic data and solicited written responses to five open ended questions. The data collected from the open ended questions were analyzed using thematic analysis. A majority of the students (57%) reported that they had experienced or witnessed horizontal violence while in the clinical areas. A majority (90%) of the respondents who experienced or witnessed horizontal violence said that it would influence their career and/or their employment choices. These authors note that the data collected provided evidence that merely witnessing horizontal violence can be distressing for students. The authors suggest that training students to constructively manage horizontal violence is one way to break the cycle of horizontal violence in the workplace.

Thomas and Burke (2009) analyzed narratives ( $n = 221$ ) that described nursing students' experiences with horizontal violence in the clinical area. The original assignment asked the students to describe anger experienced related to their classes or clinical experiences. From these narratives, those describing horizontal violence in the clinical area were analyzed and coded using content analysis. Although the students were asked specifically about anger, the results were similar to other studies focused on nursing student experiences with horizontal violence. The participant students in this study described feeling unwelcome, unwanted, ignored, and humiliated by the staff nurses in the hospital. One recommendation offered by the authors was to add education on managing abusive events to the curriculum in order to "prepare students for the inevitable" (p. 230). Although the authors do not explain what "the



inevitable” is, the recommendation for education to manage abuse in the workplace suggests a pervasive abusive environment.

### *Staff Nurses*

The risk of exposure to an abusive environment continues after student nurses graduate and begin their nursing careers. Horizontal violence is reported by both student and practicing nurses. The American Nurses Association (2011) found that reports of horizontal violence are similar in nursing students (53%) and staff nurses (56.9%). Although the effects of horizontal violence on students and staff nurses have not been directly compared, targets of aggressive behaviors from both groups have reported physical and emotional problems such as sleep disorders, poor self-esteem, low morale, depression and impaired personal relationships (Curtis, et al., 2007; Purpora, 2005; Randle, 2003).

Exposure to horizontal violence can result in anxiety, weight changes and exacerbation of previously controlled conditions such as hypertension or irritable bowel syndrome (Faminu, 2011). Randall (2001) studied the effects of bullying in adulthood and states that targets of bullying may develop autonomic reactions (e.g., feeling out of breath, blood pressure changes) muscle manifestations (e.g., backache, neck pain), cognitive reactions (e.g., inability to concentrate, irritability, sensitivity) up to and including post-traumatic stress disorder. Target nurses have increased absenteeism and are at risk for resigning from the organization or leaving the practice of nursing (Woelfle & McCaffrey, 2007).

McKenna, Smith, Poole, and Coverdale (2003) studied the experiences of nurses in their first year of practice. These authors state that the first year in nursing is an important “confidence-building phase” (p. 91) in a nurse’s career. This quantitative descriptive study

used anonymous surveys mailed to first year nurses in New Zealand ( $n = 1169$ ). The response rate was 47% ( $n = 551$ ). Only information on interpersonal conflict among nursing colleagues was requested. The results were similar to other studies. First year nurses reported being subjected to interpersonal conflict involving their colleagues across all represented nursing specialties. These first year nurses reported feeling undervalued (58%), unsupervised (46%), blocked from learning experiences (34%) and emotionally neglected (34%). The respondents reported feeling distressed (38%) and fearful of repercussions for speaking out (20%).

The authors report that nearly half of the events described by the first year nurses were not reported to nursing management. Only 12% of those who described an experience with horizontal violence received assistance in the form of counseling or debriefing. The authors recommend primary intervention in the form of education and training because the majority of respondents did not receive training to “enable them to cope with adverse staff relationships” (p. 96). This study of first year nurses in New Zealand adds to the international literature on horizontal violence in nursing.

Walrath, Dang and Nyberg (2010) examined hospital nurses’ ( $n = 96$ ) experiences with disruptive behavior. The authors’ definition of disruptive behavior includes the behaviors associated with horizontal violence. When asked to describe the impact of disruptive behavior, nurses said that these behaviors negatively affected morale and caused distractions, which can lead to patient care errors. These participants also said that disruptive behavior in the workplace caused problems with nurse retention. Forty-six of the nurse participants (48%) stated that they knew of nurses who had changed units or departments to escape disruptive

behaviors including those associated with horizontal violence. Thirty-four percent (34%) stated that they knew nurses who had left the organization because of disruptive behavior.

### *Patients*

In the previously mentioned study (Walrath, et al., 2010), a nurse participant stated that someone who is psychologically aggressive and uncivil in the workplace may not “turn it off when they go into the patient’s room” (p. 112) leaving the patient vulnerable to the effects of negative behaviors. Patients may also feel the effects of horizontal violence related to the distraction these hostile interactions create in the workplace. No nurse, physician or other health care provider wants to make mistakes that can potentially harm a patient. However, if the team members are distracted or cannot work together, patients may be at risk.

Rosenstein and O’Daniel (2005) examined the effects of disruptive behavior, which includes horizontal violence, on the quality of patient care. The authors’ goal was to assess perceptions of physicians, nurses and other hospital care providers on disruptive behavior’s effect on professional relationships and how these behaviors may affect patient care. In a departure from previous disruptive behavior studies which focus solely on physician behavior, these authors also examined the incidence and effects of nurse disruptive behaviors in the workplace. Data was collected using surveys sent to a convenience sample ( $n = 1,509$ ) of practitioners (nurses = 72%, physicians = 27%, administrators = 1%) at the authors’ hospital system.

A majority (86%) of the nurses and almost half of the physicians had witnessed a disruptive incident in the workplace. The majority (68%) of all respondents said that they had witnessed disruptive behavior on the part of a nurse. Ninety-four percent (94%) of the sample

believed that disruptive behavior has a potentially negative effect on patient outcomes. More than half of the nurses (68%) and the physicians (60%) saw a link between disruptive behaviors and adverse patient care events which are defined as negative patient outcomes. Although the majority of respondents thought there was a link between disruptive behavior and adverse events, only 17% of that group said that they knew of an adverse event that had actually occurred related to disruptive behavior. Of the 17% who knew of a specific event, 78% thought that the adverse event could have been prevented.

In this study, both nurses and physicians were identified as perpetrators of disruptive behavior in the clinical environment. Respondents recognized that negative (disruptive) behaviors at work can increase the risk of adverse patient care events. Results of this study indicated that disruptive physician or disruptive nurse behaviors can present a risk to patients. However, these data rely on respondent perceptions of the effects of disruptive behaviors on patient outcomes and not actual adverse incident data. Hospital reports of adverse patient care events are legally protected and the data are restricted. The possibility of litigation against the hospital and any involved practitioners makes it difficult to obtain specific instances or identifying details related to patient care errors. However, survey information on staff perceptions of patient risk provides information on what the respondents believe about the topic. This study is important because it focuses on the behaviors of both physicians and nurses.

#### Influences on Horizontal Violence

Horizontal violence has historically been attributed to oppressed group behavior (Cox, 1991; Fletcher, 2006; Hedin, 1986; Matheson & Bobay, 2007; Roberts, 1983). These

researchers assert that nurses, as a group, are oppressed by more powerful groups such as organized medicine<sup>1</sup> and hospital administrators. The oppression results in nurses disliking themselves and other nurses because they are powerless against the oppressor. This lack of regard for themselves and for other nurses ultimately results in horizontal violence.

Oppressed group behavior has provided some understanding of horizontal violence (e.g., Cudd, 2005; Freire, 2007; Roberts, 1983) but the theory fails to recognize other environmental issues found in the nursing work environment that may contribute to the phenomenon. The nursing workplace is a multidimensional environment and the phenomenon of horizontal violence has more than one element influencing how nurses interact with each other. The following sections will review the influence of oppression, individual personality factors of perpetrators and targets of horizontal violence, organizational factors, stress, and group relationships on horizontal violence in the nursing workplace.

### *Oppressed Group Behaviors*

In 1983, Roberts argued that negative behaviors between nurses in the workplace were related to nursing, as a profession, being an oppressed group. Behaviors resulting from widespread oppression and subjugation of one group by another more powerful group have been described in colonized Africans (Fanon, 1963), African-Americans (Carmichael & Hamilton, 1967) and South Americans (Freire, 2007). In *Pedagogy of the Oppressed* (2007), Freire describes a two-tier society which includes the socially advantaged and powerful oppressor and the socially disadvantaged oppressed. Freire believed that education was used to solidify the social power of the ruling class (the oppressors) by teaching values that support the position of

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<sup>1</sup> The term organized medicine is used to describe a dominating social force systematically maintaining control of nursing roles and range of practice while profiting from nursing labor (Group & Roberts, 2001).

the oppressor. Oppression of any group whether based on race, religion, nationality, gender or other category is defined as a systematically-applied injustice based in “coercively enforced inequality or diminished choice” (Cudd, 2005, p. 22).

In Freire’s model, oppression is characterized by assimilation, marginalization, self-hatred, low self-esteem, submissive behaviors and horizontal violence. The values of the powerful group (the oppressors) are internalized by the oppressed while the oppressed group’s own values are rejected. The oppressed group then feels marginalized when, despite what may appear to be successful assimilation of the powerful group’s values, the oppressed recognize that they will never truly belong to the powerful group. The oppressed will never belong to the powerful group because some factor, whether it is race, gender, religion, education, economic status or other differences, will always keep them separated.

#### *Nursing as an Oppressed Group*

Nurse researchers have used Freire’s (2007) model for oppressed group behaviors to analyze negative behaviors between nurses; they assert that these behaviors arise from oppression in the workplace (e.g., Fletcher, 2006; Freshwater, 2000; Hedin, 1986; Matheson & Bobay, 2007). According to the authors, nurses, as a group, are subject to various potential sources of oppression. The majority of practicing nurses are female (US Department of Health & Human Services, 2010) and therefore are at risk of oppression based on gender (David, 2000; Lee & Saeed, 2001). Nursing continues to be seen as subservient to the medical profession (Boykova, 2011; Duchscher & Myrick, 2008; Rees & Montrose, 2010) leaving nurses, as a group, subject to oppression based on hospital power hierarchies. Researchers have also identified

sub-oppression of other nurses by nursing management as these higher status nurses attempt to assimilate into existing hospital power hierarchies (Roberts, Demarco, & Griffin, 2009; Street, 1992).

Nursing as a profession is thought to be oppressed based on gender and occupation (Mooney & Nolan, 2006). They remain separate from the powerful medical group and ultimately do not even feel part of their own group after rejecting nursing's core values. Feelings of marginalization are believed to ultimately lead to self-hatred and low self-esteem. Fear of the powerful group's ability to retaliate against opposition to their authority leads to submission. Self-hatred, low self-esteem and submission lead to an anger that is manifested through horizontal violence as members of the oppressed group take their frustrations out on each other. The table that follows lists some of the research studies examining horizontal violence as a manifestation of oppressed group behavior (see Table 2).

Table 2.

*Horizontal Violence as a Manifestation of Oppressed Group Behavior in the Nursing Literature*

Author	Method	Data	Sample	Conclusion
Cox, 1991	Quantitative, description, correlation and chi-square analysis	Questionnaire, 100 items, forced choice	$n = 1,168$	Low self-esteem, low assertiveness & low sense of control over practice ( <b>oppressed</b> behaviors) associated with low perceived ability to handle verbal abuse encountered in nursing work environment. Behavior described but not related to surrounding circumstances.
Curtis, Bowen & Reid, 2007	Mixed method - Demographic percentages and content analysis of emergent themes	Survey - closed and opened ended questions followed by informal discussion	$n = 152$	Nursing students experience horizontal violence. Nursing as a profession is considered <b>oppressed</b> . The definition of nursing's role and power creates a system that supports horizontal violence. Behavior described but not related to surrounding circumstances.
Dunn, 2003	Quantitative descriptive, correlation possible relationship between perceived sabotage & job satisfaction	Briles' Sabotage Savvy & Index of Job Satisfaction questionnaires	$n = 145$	Author states study was done to describe the effects of <b>oppression</b> & displays of horizontal violence. Study measured perceived sabotage & job satisfaction. Sabotage not related to overall job satisfaction. Behavior described but not related to surrounding circumstances.
Embree & White, 2010	Concept analysis	Published literature	n/a	Origins of nurse-to-nurse lateral violence include <b>oppression</b> .
Freshwater, 2000	Exploratory	Literature	n/a	<b>Horizontal violence</b> in nursing a result of unexpressed conflict within an <b>oppressed</b> group.
Hedin, 1986	Critical theoretical approach to case study	Interviews	No information on sampling methods	Evidence of <b>oppressed behavior in nurses</b> related to examples of oppressed group behavior, oppressor behaviors, and subjugation of the oppressed, banking concept of nursing education.



Table 2. *continued*

Author	Method	Data	Sample	Conclusion
McCall, 1996	Feminist methodology	Interview	<i>n</i> = 5	Nursing education not valued. <b>Oppressive behaviors</b> related to collusion and acquiescence of nurses. Participants describe "the dark side of nursing." (p. 31)
Powers, 2002	Discourse analysis	Articles and books published on nursing diagnosis	n/a	Nursing diagnosis sustains conditions of social domination, limits autonomy and responsibility and <b>oppresses</b> individuals and groups.
Rather, 1994	Phenomenological	Interviews	<i>n</i> = 15	"Schooling for <b>oppression</b> " used to prescribe thoughts, values and behaviors of returning BSN nursing students.
Whitehead, 2010	Descriptive	"recent survey" (p. 20)	Not identified	The nursing profession is <b>oppressed</b> on two social fronts. Nurses are mainly women and as such, in line with feminist theory, the entire profession (including those men within it) is subjugated in the same unjust way that women are within society.

Nurses have been portrayed as oppressed in past academic literature. Katz (1969) categorized teachers, nurses and social workers as semi-professionals. The author used the term semi-professional to describe teachers, nurses and social workers as "new professions whose claim to the status of doctors and lawyers is neither fully established nor fully desired" (p. v). At the time of publication (1969), women dominated all three of these "semi-professions" and the majority of physicians and lawyers were men.

As semi-professionals, nurses were said to accept that the physician has control and ownership of patient related knowledge and this inequality in knowledge ownership has diminished nursing's status (Katz, 1969). Katz asserts that although the nurse is able to translate physician knowledge into specific patient care tasks, the physician remains the "ultimate guardian of knowledge about the patient" (p.59). The nurse's subservient position is illustrated by the following:

The nurse is expected to react with moral passivity to her knowledge of happenings in the hospital. Doctors' mistakes are not to be discussed---not with doctors, nor with hospital administrators, and least of all with patients and outsiders in the community. While her own mistakes can be drastically censured with the hospital, exposure of those by physicians is strongly tabooed, and the nurse herself helps enforce the taboo (Katz, 1969, p. 59-60).

Katz provides a sociological view and therefore presents a snapshot of the socially constructed status of nurses in the 1960s. Nurses making mistakes would be "drastically censured" while physician mistakes would be hidden. This historical view supports the concept of nursing as an oppressed group during the time of the study.

Roberts (1983) reported that nurses lack accountability and control over the nursing profession. She discussed the process of internalization of a controlling and powerful group's ideals and behaviors. For Roberts, the authoritative group is the medical profession and the

subjugated group is nursing. Internalization of the medical profession's values by nursing leads to marginality, self-hatred and low self-esteem. Eventually, the oppressor (physicians) and the oppressed (nurses) both lack respect for the oppressed group's (nursing) culture which leads to more self-hatred in the oppressed (nursing). Lack of respect for nursing and a feeling of powerlessness lead to infighting and horizontal violence between nurses.

Roberts (1983) states that nurses are oppressed because they find it "natural to think of themselves as second-class citizens" (p. 27). If nurses think of themselves as second class citizens, it may be that the belief is more a result of oppression rather than the cause. Dunn (2003) added to the discussion of nurses as an oppressed group by noting the lack of autonomy, accountability and control over the profession of nursing by nurses. These concepts are aligned with Freire's (2007) model of oppressed groups. Dunn states that, "it is not surprising to observe frequent acts of sabotage within the nursing profession because women comprise at least 90% of the nursing profession" (p. 978). Dunn acknowledges that nursing, as a profession, needs to address horizontal violence in the workplace if recognition as a partner in patient care delivery is to occur.

McCall (1996) used a feminist methodology to document reports of horizontal violence in the nursing workplace. The author explains her methodology as an attempt to identify oppression through dialogue with participants who have experiences to share. McCall's participants ( $n = 5$ ) believed that gender, education and adoption of the victim role were the reasons for continued oppressive behaviors in nursing. Adoption of the victim role appears to be a result of an oppressive environment and a manifestation of oppression, rather than an explanation for continued oppressed group behaviors.

McCall does not provide selection criteria or information on where the data was collected. Statements or questions used to initiate the dialogue with participants were not included. McCall's conclusion that middle management in the nursing department was threatened by a well-educated group of nurses is supported by a statement on gender disparity in the society at large. However, McCall's research is important because she collected data from nurses about their experiences with horizontal violence and emphasized gender's continued influence on the nursing workplace in the mid-1990s.

Roberts (1983), one of the first nurse researchers to connect horizontal violence in the nursing workplace with oppressed group behaviors, suggested in 2000 that liberation from oppression requires acknowledging internalized oppression. Her argument is that some of the difficulty nursing has experienced in taking control of their own destiny is related to internalized beliefs of their own inferiority. Roberts suggests that empowerment involves understanding the cycle of oppression and internalization of the oppressor's values. This suggestion is closely aligned with Freire's conscientization which he believed was the first step in liberation from oppression (2007). Roberts identifies the oppressor as organized medicine and the medical model, although she does not elaborate on what the medical model entails and how it differs from nursing.

Lending support to Freire's assertion that education is used to solidify social imbalances, Hedin (1986) published an incident analysis on oppressed group behavior in West German nurses. In Hedin's study (1986), the oppressors were West German government administrators who had eliminated an experimental education program for nurse educators. The program, titled *"The development and testing of a three year university course of study for instructors in*

*the health professions,”* (p. 53) had been funded through the national government. The program’s stated objective was to upgrade nursing by upgrading the education of nursing instructors. The program was unique in that this was the first time nursing instructor education was provided at the university level in West Germany. Hedin argued that government administrators eliminated the education program in order to stifle “anything that might foster critical thinking in the oppressed” (p. 55). The author also argued that non-continuation of the experimental program demonstrated societal constraints on the nursing profession’s growth and development in the Federal Republic of Germany. Hedin reported that nurses were not able to obtain a university education even if desired. An environment as described by Hedin certainly could have stifled critical thinking and supports the concept of oppression. Hedin also reported that nurses in West Germany were divided and engaged in horizontal violence although no details on the types of behaviors were given. Group division and internal hostility are behaviors associated with oppressed group behavior.

In an attempt to validate oppressed group behaviors in nursing, Matheson and Bobay (2007) reviewed the literature and found that the existence of these behaviors in the work environment has been well documented. However, the authors also found that attributing the behaviors to oppression was not as well supported. The concept of oppression of nursing as a group has been discussed by many researchers but the evidence presented describes behaviors believed to be associated with oppressed groups without developing a connection between the behaviors and oppression.

### *Medical and Nursing Professional Values*

Internalization of the medical profession's values and rejection of nursing values are fundamental components of nursing's oppression. The American Medical Association (AMA) states that competent care and upholding the best interest of the patient are core values in the practice of medicine by physicians (AMA, 2009). Nursing values are more difficult to define. Wilson-Barnett (1998) notes that nursing values fall within the categories of holistic, individualized and practical patient care. Wilson-Barnett proposes that in addition to the practical tasks associated with patient care, the core values of nursing are based on respect for the patient as an independent actor who has inherent worth and the right to self-determination.

Shaw and Degazon (2008) also highlight respect for the patient as a unique individual with inherent worth and dignity as nursing values. The authors list the following as core professional nursing values: (1) altruism, (2) patient autonomy, (3) human dignity, (4) integrity and (5) social justice. Horton, Tschudin and Forget (2007) conducted a literature review to identify core values in professional nursing. Their review included 32 studies and found 34 different terms used to describe nursing values in the literature which are categorized as patient focused, personal and clinical nurse related values and institutional/business focused values. These categories and associated values are presented in Table 3.

Table 3:  
*Core Nursing Values*

Patient	Nurse/personal	Nurse/clinical	Institution/business
Person focused	Courage	Sound knowledge	Teamwork
Privacy	Obligation	Clinical competence	Management
Creativity	Moral attitude		Economic returns
Patient choice	Judgment		
Continuity	Individualism		
Personhood	Positive acknowledgement & personal achievement		
Relationships	Compassion		
	Making a difference		
	Versatility		
	Altruism		
	Nurturing		
	Integrity		
	Supporting & empowering individuals		
	Reciprocal trust		
	Harmony		
	Self-sacrifice		
	Hard work		
	Control		
	Diversity		
	Self-protection		
	Aesthetics		

Source: Horton, K., Tschudin, V. & Forget, A. (2007). The value of nursing: A literature review. *Nursing Ethics*, 14(6), 716-740.

The nursing values in the table above emphasize respect for the individual's right to self-direction and professional integrity which is similar to the AMA's values of competent care and best interest of the patient (AMA, 2009). A major difference between the two sets of values is that the AMA does not address personal characteristics such as courage, moral attitude, compassion or harmony in their broadly worded medical values focusing on the best interests and care of the patient. Nurses and physicians both claim ownership of protecting the patient's dignity and right to competent care. Horton, et al., (2007) suggest that the difficulty in defining nursing values may be a result of intraprofessional disorganization related to oppression. If a fundamental component of oppressed group behavior is the rejection of the oppressed group's values and assimilation of the oppressor's values, the unanswered question remains one of defining which nursing values are being rejected in favor of organized medicine's values (Baumann, Deber, Silverman & Mallette, 1998).

Although distinct differences between the professional values of physicians and nurses are not clear, oppressed group behavior has provided some understanding of horizontal violence in nursing. However, the theory fails to recognize other environmental issues that may contribute to the phenomenon (Alspach, 2007; Hutchinson, et al., 2006). Oppression of nursing as a group is not the only factor to consider when examining the phenomenon of horizontal violence in the workplace. Negative interactions occur between individuals in many environments. Personality factors of both perpetrators and those targeted for hostility have both been examined as possible contributing factors in negative interactions between individuals in the work environment.



## *Individual Personality Factors*

### *Targets of Horizontal Violence*

Horizontal violence occurs between individuals in the workplace. There are at least two points of view related to each of these incidents. It is important to examine the characteristics of the perpetrators and the target nurses involved in the behaviors. In order to examine those who may be targeted by horizontal violence, Strandmark and Hallberg (2007) interviewed nurses who identified themselves as bully victims ( $n = 22$ ). Using grounded theory methods during their analysis, the authors found that bullying in their participant group was believed to be triggered by power struggles. Once the perpetrators and their targets locked into a power struggle, they became more and more engaged in the conflict. Interestingly, people who saw themselves as strong and competent felt they were targeted because of their strength. Others who saw themselves as vulnerable and sensitive said that they were targeted because of their vulnerability. Both of these groups believed that they were bully targets because of completely different characteristics. Targets of bullying may be those caught in power struggles without regard to their individual characteristics. The authors conclude that an environment where bullying is tolerated results in uncertainty, frustration and increased stress among the people involved. They also suggest that strong leadership is required to manage these types of conflicts in the workplace.

Targets of horizontal violence were also the subject of a Scandinavian study focused on bully victims ( $n = 72$ ). In a study that used survey data and cluster analysis, Glasø, Matthiesen, Nielsen & Einarsen (2007) found that the victims (targets) were “more anxious and neurotic and less agreeable, conscientious and extravert than non-victims” (p. 317). The cluster analysis,

however, indicated that although victims display less emotional stability than non-victims there is no general victim personality profile. There is no discussion of whether the noted emotional characteristics such as anxiety are an antecedent or consequence of being a target of workplace aggression. Being the target of horizontal violence in the workplace is a very personal experience which makes attempts to develop a typical target profile difficult.

### *Perpetrators of Horizontal Violence*

#### *Triggers*

Attempts to develop a typical profile of perpetrators of horizontal violence are as complicated as defining the typical target of horizontal violence. As previously noted, Walrath, et al., (2010) investigated nurses' experiences with disruptive behavior using focus groups. The authors asked the participants ( $n = 96$ ) to discuss what they believed were triggers for horizontal violence and other disruptive behaviors in the workplace. The participants identified fatigue, hunger, lack of information needed to care for a patient and high patient volume as triggers to hostile and disruptive behaviors. An interesting finding was that these nurses also identified a perceived lack of competency in new nurses as an intrapersonal trigger for disruptive behavior. The intent of the study was to develop a structure to organize and describe disruptive behaviors. Therefore, the authors did not expand on the finding of perceived lack of competence as a trigger for horizontal violence between nurses in the workplace.

#### *Perpetrator profile*

Perpetrators were the focus of Dellasega's (2009) discussion of what she labels relational aggression. The author used the term relational aggression to highlight the

aggressive nature of these relationships. The author categorizes perpetrators into various types of nurse bullies ranging from what the author describes as elitist, experienced and highly specialized nurses to those who are resentful or envious of others and nurses who form cliques intended to exclude and isolate other nurses. The descriptions of different types of nurse perpetrators have a wide range from the elitist nurse who is described as a “supernurse” (p. 54) through nurses who are envious of “what others have” (p. 55). A typical and recognizable perpetrator profile does not emerge from these descriptions. Although Dellasega does not provide definitions for these categories and some labels (e.g., resentful, envious) are open to interpretation, the author does provide suggestions for controlling negative behaviors. Suggestions include providing consequences for negative behaviors and constructive conflict management education.

In 2011, Dellasega published a book on relational aggression (horizontal violence) between nurses. In the book, the author points to jealousy and envy as an important perpetrator characteristic. Perpetrators are described as harboring resentment towards other nurses who hold advanced degrees, have received promotions or practice in a specialty area. Dellasega connects this jealousy to internalized oppression which results in members of the oppressed group trying to keep each other down. This behavior is compared to “crabs in a pot” (p. 61). Dellasega asserts that horizontal violence can be viewed as an attempt to keep group members down because one person’s success is bad for the rest of the group.

Dellasega suggests that self-esteem is an important factor in relational aggression and offers a self-assessment to determine professional self-esteem. The author points to low self-esteem as a contributing factor in those who are involved in relational aggression (horizontal

violence). Zapf and Einarsen (2003) suggest that high rather than low self-esteem is noted in perpetrators of workplace aggressors. High, but unstable, self-esteem can be threatened by unfavorable external feedback. These researchers suggest that workplace aggression may be an attempt to maintain a favorable view of oneself in the face of negative input. The authors also note that social incompetence and an inability to reflect upon the consequences of one's own actions contribute to the perpetrator profile. Interestingly, these authors also report that participants who admitted to bullying behaviors described themselves as lacking in self-esteem. These different perspectives highlight the difficulty in categorizing personality traits and behaviors through self-reporting. People frequently have an interest in presenting themselves in the best possible light especially if there are social or legal sanctions in place to prevent unacceptable behaviors in the workplace.

The difficulty in identifying a typical target profile or typical perpetrator profile was also noted by Coyne, Smith-Lee, Seigne, and Randall (2003). In their study, participants ( $n = 288$ ) used a questionnaire to identify themselves or others as targets or perpetrators of workplace bullying. The researchers also examined differences in personality between the two groups as compared to a control group. The self-identified targets of workplace bullying were found to have problems managing personal criticism, were easily upset, saw the world as threatening, were more anxious and tense and more suspicious of others when compared to the controls (Coyne, et. al, 2003). The authors found that self-identified perpetrators of workplace aggression were more likely to have difficulty managing personal criticism, were easily upset and saw the world as threatening when compared to the controls. Both self-identified targets and self-identified perpetrators presented characteristics in common.

Based on the results of the above studies, the evidence suggests that perpetrators and targets of workplace aggression do not fit into identifiable profiles. It seems difficult to support the concept that horizontal violence, which has been reported across different cultures and health care delivery systems (e.g., Abe & Henly, 2010; Farrell, Bobrowski & Bobrowski, 2006; Johnson, 2009), is related to specific perpetrator or target personalities traits. Although personality traits belonging to both perpetrators and nurse targets may contribute to negative interactions between nurses, Lewis (2006) argues that these events are mostly environmentally mediated. Each individual and experience must be evaluated within the specific interpersonal and organizational contexts in which the behaviors occurred.

#### *Organizational Factors and Horizontal Violence*

Organizational factors such as downsizing, a competitive culture, poor work design, lack of job control and individual performance based reward systems may increase the risk of aggressive behaviors between coworkers. Zapf and Einarsen (2003) note that the organization's micropolitical culture may foster behavior aimed at protecting one's own interests and position. The authors assert that this behavior is not the same as bullying or horizontal violence, although the actions may have similar negative consequences for others in the workplace. Zapf and Einarsen suggest that what appears to the targeted individual or to witnesses as bullying behaviors may, in fact, be behaviors focused on advancing other personal or position based interests.

In 2010, Katrinli, Atabay, Gunay and Cangarli found that nurses ( $n = 232$ ) believed that horizontal peer bullying (horizontal violence) may not be irrational behavior related to individual personality factors. These nurse participants indicated that horizontal violence may

be a deliberate attempt to improve the perpetrator's standing through better performance appraisals, better task assignment, promotions and increased allocation of valued work related resources. It is possible that in a competitive environment, behaviors associated with horizontal violence (bullying) are not necessarily irrational but perhaps part of a "competitive strategy" (Katrinli, et al., p. 616).

Other research outside of nursing suggests that organizational structure itself may passively encourage horizontal violence as an unsanctioned method of personnel management. Salin (2003) suggests that higher rates of horizontal violence or bullying behavior in public organizations could be related to difficult and complex processes required to terminate public employees. Because of complicated bureaucratic rules involved in employee dismissal, management and staff may resort to bullying (horizontal violence) to pressure problematic employees into voluntarily leaving the organization (Salin, 2003). The question becomes what organizational characteristics could result in an employee or group of employees feeling that they have to use an unsanctioned method of personnel control rather than depending on legitimate action from administration?

### *Stress*

#### *Sources of stress*

Another possible explanation for horizontal violence between nurses at work could be the effects of stress in the workplace. Nursing research examining different patient care environments consistently identifies common sources of stress that nurses must manage while at work. Workload, time constraints and emotional demands are frequently cited in the

research on nurse stressors. The table that follows summarizes results from selected studies identifying sources of stress in the nursing work environment (see Table 4).

Table 4.  
*Perceived sources of stress in the nursing work environment*

Author	Method	Sample	Source of stress
Berland, Natvig & Gundersen, 2008	Interviews, focus groups	$n = 23$	Increasing job demands; time constraints; lack of control over patient care decision; lack of social support; unpleasant work environment
French, Lenton, Walter, & Eyles, 2000	Expanded Nursing Stress Scale	$n = 2,280$	Role conflict; work overload; dealing with multiple conflicting demands of the workplace
Gelsema, van der Doef, Maes, Akerboom & Verhoeven, 2005	Questionnaire	$n = 807$	Work overload; time constraints; physical demands
Hillhouse & Adler, 1997	Questionnaire	$n = 260$	Death; workload; conflict with physicians & other nurses; work load
McGibbon, Peter & Gallop, 2010	Ethnography	$n = 23$	Emotional demands from patients/families; prolonged presence in care environment
McGrath, Reid & Boore, 2003	Questionnaire	$n = 171$	Too little time to perform care; scarce resources; emotional demands of patients; unpleasant work environment
Salomé, Martins & Espósito, 2009	Phenomenological approach	$n = 14$	Fatigue; exhaustion; workload; lack of resources
Wu, Chi, Chen, Wang & Jin, 2010	Questionnaire	$n = 2,613$	Role conflict; responsibility; social support; self-care; nurse-patient relationship; chronic disease

### *Work environment*

Responsibility for the care of sick patients can be stressful. However, nurses develop strategies to manage patient care requirements while working within prescribed time constraints (Bowers, Luring & Jacobson, 2001). In addition to patient care responsibilities, the work environment itself can create additional stress and increase the risk of patient care error. Gurses and Carayon (2007) surveyed nurses ( $n = 272$ ) from seven hospitals to determine the most frequently encountered environmental performance obstacles. These nurses cited distractions related to a hectic workplace (40%) and crowded work environments (37%). The nurses also stated that they frequently encountered problems obtaining needed resources (e.g., medications, patient care supplies, equipment). A noisy workplace was also cited by 46% of the participants as a frequent performance obstacle.

### *Noise*

Pope (2010) examined the level and source of noise in the patient care areas and found that the studied areas were “as noisy as a busy office” (p. 2469) with peak decibel levels frequently as high as 100 decibels measured by noise dosimeter. The noise from a motorcycle or outboard motor is approximately 100 decibels (Industrial Noise Control, 2010). Identified noise sources included talking, shouting, hospital paging, noise from equipment including all of the bells, alarms and other electronic alerts associated with the use of hospital technology.

The association between noise and perceived stress related to noise was examined by Morrison, Haas, Shaffner, Garrett and Fackle (2003) through questionnaires, audiograms and biological evidence of stress related responses. In this study ( $n = 11$ ), noise was found to correlate with several measures stress such as increased heart rate and annoyance ratings.



Noise in the workplace has been found to create distractions, decrease concentration and negatively affect working memory (Belojevic, Jakovljevic, Slepcevic, 2003). Elevated noise levels can affect communication between nurses which may increase the risk of patient care errors (Choiniere, 2010).

### *Manifestations of Stress*

Stress in the nursing work environment has been discussed in the nursing literature for years. Feelings of anger, tension and anxiety in response to workplace stressors were reported by nurses in an intensive care unit (Cassem & Hackett, 1972). In 1979, Smith and Selye discussed the physical responses to stress and what they believed were possible pathophysiologic manifestations of stress, ranging from emotional exhaustion to diabetes, hypertension and heart disease. The authors connected chronic stress in nurses to a decrease in the quality of patient care and cautioned nurses to manage their stress for the sake of their patients.

In 1990, Breakwell listed some of the characteristics of nursing that were considered stressful. Long hours, heavy workloads, lack of autonomy, and non-supportive relationships with nursing colleagues were all associated with feelings of nursing related stress. Breakwell identifies some of the manifestations of stress as hostility, defensiveness and feelings of powerlessness and worthlessness. Hostility and feelings of powerlessness are also identified as manifestations of oppression (Dunn, 2003; Freire, 2007; McCall, 1996; Roberts, 1983).

A literature review by McVicar (2003), listed the manifestations of stress in the nursing work environment. Pessimism, negative attitudes and lack of self-esteem are identified as possible expressions of stress. Depersonalization and disengagement are listed as

manifestations of severe stress (termed distress). Lack of self-esteem and negative behaviors are also implicated as manifestations of oppression (Dunn, 2003; Freire, 2007; McCall, 1996; Roberts, 1983).

Stress can cause physical changes and emotional distress. Stress also has a negative influence on job satisfaction. In 1993, Blegen published a meta-analysis looking at variables associated with job satisfaction. Their analysis indicated that job dissatisfaction was most strongly related to stress. Fourteen years later, in another meta-analysis, Zangaro and Soeken (2007) again found that job stress was strongly correlated with job dissatisfaction (effect size,  $-.43, p = <.001$ ).

Cluster analysis was used by Hillhouse and Adler (1997) to assess stress, burnout and symptoms in a group of hospital nurses ( $n = 270$ ). The authors found that the sources of stress in nursing included heavy workloads, poor communication, poor social support, emotional demands of patients and families, experience with death and separation and a constantly changing work environment. The majority of participants (69%) reported high levels of perceived stressors. Interestingly, this study also revealed that the more time that nurses were able to spend with patients the lower the reported levels of perceived stressors.

#### *Unrelieved stress - burnout*

Unrelieved stress can lead to burnout. Burnout is defined as a response to chronic emotional and interpersonal stressors on the job and manifests as exhaustion and cynicism (Maslach, 2003). Although burnout has been discussed for many years in the nursing literature, there is no comprehensive model or theories to use when examining burnout in nurses (Jennings, 2008). Even without a comprehensive model of nurse burnout, it is likely that

cynical and exhausted nurses may struggle to deliver the high quality care that their patients require. Burnout has been associated as a threat to nurse retention (Harwood, Ridley, Wilson & Laschinger, 2010; Meeusen, Van Dam, Brown-Mahoney, Van Zundert & Knape, 2011).

### *Coping with Stress*

There is more research documenting stress in nursing than information on how to constructively manage the stress associated with nursing. Dewe (1987) identified some of the strategies that nurses use to cope with work stress. Data was collected through questionnaires ( $n = 2,032$ ) and classified stress coping strategies as direct action or palliative coping strategies. Direct action strategies are directed towards dealing with the problem or source of the stress. Examples of direct action are referring matters up the hospital hierarchy, working faster to complete required tasks and attempts to prevent the stressful situation from arising. Examples of palliative strategies include making an effort to relax, crying, getting angry and smoking more. Reliance on crying, smoking or getting angry does not, as Dewe points out, offer much of an advantage when dealing with stress. The author suggests hospital administrators develop and provide supportive structures to remove negative features of nursing while promoting the positive features.

### *Stress across cultures*

Boey (1999) examined the contribution of personality, coping and family support to the ability to manage stress in nursing. Questionnaires were sent to nurses working in public hospitals in Singapore ( $n = 1,043$ ). It is interesting to note that common work stressors for the nurses in Singapore include inadequate staffing, work overload, awareness of tremendous responsibility and interpersonal conflicts. These are the same work stressors identified in the

United States (Aiken, et. al., 2001), Canada (McGillis-Hall & Doran, 2007), France (Poncet, et. al., 2007), Turkey (Uzun, 2003, Öztunç, 2006) and Sweden (Glasberg, Norberg & Söderberg, 2007).

The evidence suggests that nursing is perceived as a stressful occupation across different cultures and healthcare delivery systems.

What factors are protective against stress? Boey (1999) found that self-esteem was considered an important personal resource in managing workplace stress. Enhancing professional skills and knowledge was found to be a better defense against stress when compared to cognitive type coping mechanisms such as acceptance or looking at the positive side of stressful events. Enhancement of professional skills and knowledge may help the nurse feel more in control of the ever changing situations he or she encounters on a daily basis. Becoming a more skilled and competent nurse is also beneficial for the patients.

Most practicing nurses will experience stress in the workplace. Some nurses will leave the profession but many will remain in the hospital environment to care for patients. In an examination of who remains in nursing, Burgess, Irvine and Wallymahmed (2010) used questionnaires to collect data from a convenience sample of intensive care nurses ( $n = 46$ ). The authors conclude that personality traits such as openness and extraversion are associated with lower levels of perceived stress. They suggest that recruitment of staff members that have these traits may result in improved nurse retention. The authors do not offer suggestions for lowering perceived stress levels in current staff.

For nurses who are current staff members and do not fit the suggested personality profile of openness and extraversion, the question becomes what protective factors can be employed to counteract what research has identified as stress in the nursing work

environment. One suggestion for managing chronic stress is affiliating with social groups at work to reduce the perception of environmental risks (Taylor, Klein, Lewis, Gruenewald, Gurung & Updegraff, 2000).

### *Group Cohesion*

Although not specifically investigated as a protective factor against stress at work, nurse group cohesion has been investigated as a factor in overall nurse job satisfaction. Adams and Bond (2000) found that nurses' ( $n = 834$ ) sense of cohesion with their nursing colleagues was one of the best predictors of job satisfaction. In a later study, Kovner, Brewer, Wu, Cheng and Suzuki (2006) found that in their sample of nurses ( $n = 1,538$ ), work group cohesion and peer support was associated with increased job satisfaction. The authors raised an interesting question when they asked whether work group cohesion could be influenced by hospital management or policy. Group cohesion and social support in the nursing workplace may provide greater access to needed resources, assistance with the workload and emotional support when necessary (Ko, 2011).

Social support in the context of stress and coping was examined by Schwarzer and Knoll (2007). Social support can influence one's ability to cope with environmental stressors which can, in turn, increase a sense of self-confidence in the ability to manage the stressor. The authors also found that this increased sense of self-confidence is a proactive component in the social support relationship. A sense of self-confidence may help to maintain and even cultivate more social support. Confidence in the ability to handle a stressful situation can generate problem solving strategies which, in turn, may lead to continuing social support (Schwarzer & Knoll, 2007). In the patient care unit, group cohesion and social support of nurse peers can be

a positive self-perpetuating cycle of increasing self-confidence and job satisfaction (AbuAlRub, 2004). Self-confidence, job satisfaction, group cohesion and support may increase the quality of patient care.

### Summary

Horizontal violence has been discussed in the nursing literature for many years. The evidence indicates that the majority of working nurses will experience horizontal violence in the workplace. Horizontal violence as a concept includes, but is not limited to, behaviors such as verbally abusive communications, workplace sabotage, difficult patient care assignments, social isolation, and negative non-verbal gestures such as eye-rolling or raised eyebrows. Although nurses recognize that these negative behaviors in the workplace can put patient care at risk, the behaviors continue to occur.

Horizontal violence is not an isolated phenomenon that can be separated from the influences of the work environment. Influences include the effects of oppression, organizational factors, personality factors of perpetrators and target of the horizontal violence, stress in the workplace and group dynamics. Studies examining personality traits of both targets and perpetrators of horizontal violence in the nursing workplace suggest neither group fits into existing profiles. Although personality traits may contribute to horizontal violence, organizational characteristics may increase the risk for workplace aggression between nurses. Horizontal violence may not be irrational behavior but part of a strategy to manage the workplace rather than depending on legitimate action from administration and management.

Stress can manifest as lack of self-esteem and negative behaviors at work. The literature identifies multiple sources of stress in the nursing workplace but there is less research

on successful management strategies. Personality factors such as high self-esteem and extraversion have been found to be protective factors in managing stress. Group cohesiveness and peer support have also been found to be protective against stress, thereby allowing for increased problem solving and improved quality of patient care.

Horizontal violence has been attributed to oppression of nurses as a group by the more powerful medical group and hospital administrators. There is historical evidence to support the concept of nursing as an oppressed group and the theory continues to be the prevailing framework used to examine horizontal violence in the nursing workplace. Oppressed group behaviors have provided some understanding of this negative phenomenon in the nursing workplace. Research has documented the incidence and prevalence of horizontal violence in nursing but less known about the circumstances that surround these disruptive behaviors.

In conclusion, the evidence indicates an ongoing interest in horizontal violence as an identified threat to the quality of patient care and nurse well-being. After many years of scholarly discussion and suggestions for change, these negative behaviors continue to occur. An alternative or additional explanation is needed to constructively manage behaviors that are damaging to the patients and nurses involved in these events. Researchers believe that oppression of nursing as a profession drives these behaviors. This study examined nurses who have experienced horizontal violence and what they believed influenced the occurrence of horizontal violence in the workplace.

## **CHAPTER THREE**

### **METHODS**

#### Introduction

Quantitative, qualitative and mixed methods research methodologies each take different approaches in collecting and analyzing data. The approaches are different but each method is, ultimately, grounded in data (Glaser, 1999). Grounded theory, the method chosen to examine the phenomenon of horizontal violence in the nursing workplace, is a qualitative method used to generate new theory where theory may be lacking or no longer fits. Grounded theory is also useful for enhancing and expanding existing theory when the theory may not answer the question adequately (Creswell, 2007). When the research question focuses on actions and interactions within groups, grounded theory can be used to develop explanations for what may be occurring between actors in a specific setting and context (Morse, Stern, Corbin, Bowers, Charmaz, & Clarke, 2009).

#### Rationale for Qualitative Design

Quantitative research has provided a foundation describing the frequencies, trends and relationships associated with horizontal violence in the nursing workplace. These studies have provided ample evidence that these negative behaviors occur, are long standing in the workplace (e.g., Cox, 1987; Curtis, Bowen & Reid, 2007; Dunn, 2003; Embree & White, 2010; Katrinli, et al., i, 2010; Stanley, et al., 2007) and that survey respondents perceive that this behavior is a threat to patient safety (Rosenstein & O'Daniel, 2005). The evidence supports the existence of these negative interactions between nurses in the workplace. For me, the question evolved from description to the search for explanations. What do nurses think were



the triggers for these behaviors? Researchers have suggested that nursing is an oppressed group and that these negative behaviors are manifestations of the oppressed state. The goal of this study was to develop theoretical propositions that could narrow the gap between prevalence and description of the types of the behaviors as documented in the literature and generate possible explanations for the phenomenon.

The meaning that people ascribe to social interactions and their explanations for why they respond in different ways in different contexts can be difficult to capture using quantitative measures. The qualitative design is well-suited to examine phenomenon by hearing from the individuals involved and allowing them to share their stories and reflections (Bitsch, 2005). Qualitative research is an appropriate approach to examine interaction between people when the interactions are setting and context dependent. The critical question to be examined by this study was what circumstances, from the nurse participants' perspective, are associated with episodes of horizontal violence in the workplace? The rationale for a qualitative design, and particularly grounded theory methodology, lies in the type of data obtained from nurses reflecting on their experiences with negative interactions between colleagues in the workplace.

### Grounded Theory

Grounded theory research is specifically designed to generate, enhance or expand theory from the data rather than using data to verify existing theory. The choice of the grounded theory method for this study did not happen quickly. My education and professional experience have been deeply influenced by quantitative research. In health care, randomized controlled trials are the standard to which research outcomes are held. Evidence is rated on,

among other criteria, how close the design comes to the randomized controlled trial model. If the research question is focused on causal connection or efficacy of a particular treatment in a target patient population, quantitative design is the logical choice (Nicholls, 2009). I tried to fit my question within the quantitative framework because it was more familiar to me. However, my goal was not to verify the existing theory of oppressed group behavior and its relationship to horizontal violence in nursing. My hope was to generate theoretical propositions beyond this concept as an explanation for horizontal violence in the work environment and expand understanding of a long standing phenomenon in nursing. Grounded theory methodology fit the needs of my study.

### *Classic Grounded Theory*

Grounded theory is a method used to study process and is itself a process that has developed and evolved since its introduction in the 1960s. The classic grounded theory methodology was introduced by Glaser and Strauss in the late 1960s. Both social science researchers, their approach blended Glaser's systematic quantitative expertise with Strauss' qualitative field research background (Hallberg, 2006; Stern, 2010). The grounded theory methodology was intended to provide a systematic way to analyze qualitative data that would meet the standards of the dominant positivist orientation of the time. Glaser and Strauss offered a methodology that emphasized using data to discover concepts and hypotheses rather than using data to verify existing theory (Glaser & Strauss, 1967). Grounded theory is useful for understanding situations where understanding may be incomplete or when existing theory does not, or no longer, fits.

### *Symbolic Interaction*

Grounded theory originates from symbolic interaction which has its foundation in George Herbert Mead's analysis of social interaction. Mead felt that social action should be addressed as a complex whole "something going on" (Morris, 1934, p. 7) expanding the view of behavior beyond simply stimulus and automatic response. Blumer, a student of Mead's, focused on the concept of self and how this self-concept leads to meaning and self-directed behaviors (Cheniz & Swanson, 1986). According to Blumer, human behavior results from interpretations of the objects and events encountered in the environment (Blumer, 1969). Symbolic interaction focuses on the meaning that people place on the events that occur in daily life. How these events are experienced is influenced by the meanings that things have for the people involved. These meanings are developed through the social interactions that people have with each other.

The three central themes of symbolic interaction are meaning, interpretation and social action (Snow, 2003). People attach symbolic meanings to objects, other people and themselves and they transmit these meanings through interaction (Howard, 2000). Meaning is not inherent in the objects themselves but is the result of interpretation and reinterpretation. Therefore, the meaning of each thing is fluid and adjusted as new information is processed (Ward, 2003). In a social group, individuals are likely to align their behavior with the others in the group. This alignment behavior is dependent upon shared meanings between group members (Urquhart, 2001).

Nurses, as with other groups, have shared meanings that are sensitive to place, time and context. Patient care units are typically segregated by type of medical and nursing services

required (e.g., orthopedic, obstetric, pediatric). An alarm in one unit may herald an emergency while an alarm in another unit may merely indicate the end of a treatment. These two alarms, which may sound similar, elicit different responses related to meanings shared between group members.

### *Reformulated Grounded Theory*

In the years since publication of Glaser and Strauss' classic grounded theory methodology, the methods used to develop grounded theories have evolved and diversified. Glaser and Strauss went their separate ways when Strauss published an updated version of grounded theory with Juliet Corbin (Corbin & Strauss, 1990). Corbin and Strauss' 1990 reformulated version was written to provide their students with guidelines for conducting grounded theory research. Glaser subsequently published his own works explaining his views on developing grounded theories and, at times, critiquing how other writers presented the principles of the methodology (Glaser, 2002; Glaser & Holton, 2004; Walker & Myrick, 2006). However, as Morse noted, "Science changes, develops and usually improves over time" (Morse, et al., 2009, p. 17). Corbin explains that grounded theory is a way of thinking rather than a formula and leaves the details of how the study is actually done to the researcher as long as the methods include theoretical sampling, constant comparison and asking questions (Morse, et al., 2009).

### *Constructivist Grounded Theory*

My choice for this study was constructivist grounded theory as advocated by Charmaz (2006). Constructivist grounded theory assumes that multiple realities exist and acknowledges participant and researcher experience and viewpoints in the construction of data and the

development of theory (Charmaz, 2006). From the constructivist perspective, knowledge, being socially constructed, is interpreted through the actor's way of knowing and does not have a universal objective reality. The reconstructed experience that is shared by the participant is simultaneously being reconstructed by the interviewer. Post interview transcription and analysis of the data involves deeper reconstruction on the researcher's part as he or she searches for overt and tacit meanings. The interviewer is an integral part of the research experience. Charmaz (2006) notes that constructivist grounded theory acknowledges that the researcher enters and is affected by the participant's world. Constructivist grounded theory regards the data as constructed and the analysis as an interpretation rather than an objective point of view (Morse, et al., 2009).

The common ground between Glaser's classic grounded theory (2002), Corbin and Strauss' (2008) more prescribed and structured reformulated version and Charmaz' (2006) constructivist grounded theory is the generation of concepts and theory derived from the data as the goals of the research. Each type of grounded theory includes theoretical sampling techniques, asking questions, coding, constant comparison and analysis of the data until the core variable emerges. The core variable accounts for the concern or issue that emerges from the data by explaining behavior surrounding the phenomenon of interest. These strategies enhance the development of a theory based on the phenomenon of interest, conditions, context and consequences (Creswell, 2007). The researcher is ultimately responsible for choosing the version of grounded theory that best fits the study.

## Literature Review

Throughout the evolution of grounded theory as a research methodology, there has been considerable debate regarding the role of existing research and its influence on developing a grounded theory. Glaser and Strauss, the two developers of grounded theory methodology, were originally in favor of a literature review prior to beginning a grounded theory study. They stated in their original publication that the theories in existing research can become “almost automatically a springboard or stepping stone to the development of a grounded formal theory” (Glaser & Strauss, 1967, p. 79). Strauss stated in the third edition of the book he wrote with Corbin (2008) that a literature review done early in a grounded theory study could have several advantages. In the reformulated version of grounded theory, a literature review is recommended to increase theoretical sensitivity which can assist in question and sampling strategies as well as provide secondary sources of data (Corbin & Strauss, 2008; McGhee, Marland & Atkinson, 2007).

Glaser, after parting ways with Strauss, stated that an extensive literature review before the development of core categories violates grounded theory’s premise of theory emerging from the data (Glaser & Holton, 2004). Glaser states that knowledge of existing theory could inhibit an open approach to the data and decrease theoretical sensitivity (Glaser & Holton, 2004). In 2009, Glaser reiterated his stance on not reviewing the literature in the area of the proposed research to avoid preconceptions.

Opinions continue to differ on whether a review of the literature should be done in the area of interest before beginning a grounded theory study. Schreiber and Stern (2001) note, pragmatically, that few researchers approach a study without being familiar with the research

related to the topic of interest. The argument that prior knowledge of existing theory can be difficult to set aside has validity. However, prior knowledge also can provide increased sensitivity by highlighting gaps in current knowledge. A familiarity with the theories and issues surrounding the phenomenon of interest increases the ability to interpret rather than merely report the data as it is received (Robson, 2002). Urquhart (2001) offered a compromise on the literature review question by suggesting that the researcher become familiar with the literature, but strive to avoid imposing preconceived ideas from the literature onto the data.

In this study, the question of avoiding prior knowledge from the literature on horizontal violence in nursing was not possible. I had become familiar with the nursing literature on horizontal violence through my academic and professional work before I had come to a final decision on my research methodology. I am also familiar with current discussion in some of the social science and education literature on the phenomenon of negative interactions among colleagues in the work place. There is always the risk that existing theories may influence a researcher's perspective. However, I believe that in this study my familiarity with the literature on the topic was an advantage. Without knowledge of current theory, it would have been difficult for me to develop a focus for my research. My review of the literature exposed what I believed to be a possible gap in the existing theory. My knowledge of existing research provided a foundation that enhanced my search for alternative explanations for horizontal violence, a long standing negative aspect of the nursing work environment.

#### *Influence from the Literature*

Based on my review of nursing and other relevant literature and my personal experiences with horizontal violence at work, I brought biases about these negative behaviors

to the study. The primary bias identified was my reaction to the theory that oppression was a singular driving force behind these hostile behaviors between nurses at work. At that time, I did not think I was oppressed and that opinion influenced my evaluation of the theory. A second bias I identified was what I saw as a relationship between horizontal violence in the nursing workplace and the stressful nature of nursing work.

Warnings about the stressful nature of nursing began when I was in nursing school. Throughout my years of practice I have heard my colleagues complain of feeling stressed. I have complained of feeling stressed. Stress and burnout, a form of severe and unrelieved stress, have been and continue to be a frequent topic of discussion in the nursing literature (e.g., Fimian, Fastenau & Thomas, 1988; McKay, 1978; Moustaka & Constantinidis, 2010; Rowe & Sherlock, 2005; Ulrich, Taylor, Soeken, O'Donnell, Farrar, Danis & Grady, 2011). Stress is acknowledged as an almost unavoidable part of nursing and I had developed a tentative connection between the stress of nursing practice and negative interactions between nurses at work.

### Role of the Researcher

Informal interviewing is a basic element of nursing practice. Nurses ask patients, family members, and other healthcare providers questions in a variety of settings in pursuit of information needed to optimize the process of care planning. In nursing practice, information is gathered to guide intervention and questions are asked to implement and evaluate the effects of those interventions. After reviewing patient admission information, I usually have an idea of how to ask the right questions to find what I need to know. In this study, I did not know what I was looking for and had to move out of my comfortable position as patient care provider



into the role of novice researcher. I had considered oppression as the influence behind these negative nurse-to-nurse interactions. However, I was not comfortable with a one dimensional explanation applied across different cultures and healthcare delivery systems. On a personal level, I did not see myself as oppressed or dominated in my practice environment although I knew that members of oppressed groups may be unaware of their oppression. I had to accept that I could be experiencing this lack of awareness. I respected the efforts of the nurse researchers who had worked to bring attention to this phenomenon in the nursing work environment. I also had respect for the work that had been done to validate the oppressed group behavior theory in the literature. For me, the missing piece was what circumstances the nurses themselves would say were driving these negative behaviors.

Throughout this study, I was the lens through which the data was gathered and interpreted. I entered the study with experiences and subjectivities that I recognize. However, I also acknowledge that I may also have unrecognized subjectivities. My participants came to the study with their own experiences and subjectivities. Their stories were their personal interpretations of past events. In constructivist grounded theory research, the aim is for an interpretive understanding of the data. My advantage and challenge in interpreting the data collected from nurses is that I am also a nurse. Being a nurse is an integral component of both my professional and personal identities. My participants were nurses and were all aware that I was also a nurse. I believe that being a nurse was an advantage in several ways. I understood the language, situations and contexts that my nurse participants were discussing. I also felt that my participants felt comfortable talking about events that, as a nurse myself, I could understand. There are intricacies of patient care that are difficult to explain to someone

unfamiliar with nursing practice. I felt that this ability to relate as a nurse was an advantage. Interestingly, I found this same sense of familiarity to be challenging and uncomfortable at times. When my participants asked what I thought of something, I had to sort out what I thought as a nurse colleague from what I thought as the interviewer. There were times that I would deflect a question by repeating part of their previous answer. I also used repeating part of their answer as a form of verbal memoing that cued me during tape transcription that the statements had triggered strong feelings in me during the interview.

As a registered nurse, I practiced in the critical care environment of a metropolitan hospital. I have been the target of horizontal violence in the workplace. I have seen my colleagues targeted by this behavior. At times I intervened to protect the target nurse. I have also witnessed this behavior without intervening to help the target nurse. I have, with and without my colleagues, been the perpetrator. Interestingly, I did not see any of us behave this way outside of the work environment. I did not consider myself a bully or abusive person. I did not consider my colleagues bullies or abusive people.

I am a part of the nursing world. My experience as a nurse provides knowledge of subtexts, networks and connections within the culture of professional hospital nursing that cannot be eliminated from my analysis. Because of my knowledge of the nature nursing work, I believed that the participants would be comfortable speaking to someone who understood and could relate to the rewards and pressures of the patient care environment. However, as each participant reconstructed their experiences to tell their story, I was interpreting the information through my own perspective. My interpretations have been influenced by my role as a novice

researcher, my role as part of hospital nursing culture and my own experiences with horizontal violence in the workplace.

### Research Question

The primary research question for this study was what nurses identify as circumstances in the work environment that may influence horizontal violence between nurses at work. The purpose of this study was to go beyond identifying and documenting the prevalence of the behaviors in the nursing workplace and attempt to understand the circumstances surrounding the behaviors. The evidence indicates that the majority of working nurses will experience horizontal violence in the workplace during their careers. What did nurses believe contributes to this phenomenon? From the nurses' of their experiences with horizontal violence, I learned about the situations in which the behaviors occurred.

### Institutional Review Board Approval and Confidentiality Measures

Approval was obtained from the Institutional Review Board (IRB) at the University of New Orleans prior to beginning the interviews (see Appendix A). Participation was voluntary and those who agreed to participate in the study signed a written consent form (see Appendix B). I explained that participation could be terminated at any time without penalties of any sort. I also explained that that my study would not identify specific nurses, their employers or patients. Participants were identified only as nurses and by two letters which they drew (one letter each from two separate envelopes) before beginning the interview. The first letter was permanently removed from its envelope after being drawn and therefore could not be chosen again. The second letter was returned to its envelope. I used this method to avoid pulling the same set of two letters for different participants. I told the participants that their workplace

would be only be identified as "an acute care environment" as this designation can be used to describe any unit in all short term and long term acute care hospitals in the United States. In order to facilitate free conversation, I explained that I would carefully edit any potentially identifying information in the transcript to protect their privacy.

Transcripts were identified only by the initials pulled by the participant before the interview. Their names were not included. No one saw the transcripts except for me and members of the dissertation committee. The digital folders containing the audio files and transcripts were stored on an external portable drive and password protected. The data will be kept for three years. After that time, all data will be deleted from the external drive and the drive will be reformatted. No other identifying information about the participants was gathered. There was no deception involved in this study. Participants were aware that they were participating in a research study and that they would be tape recorded. Participants were advised that other than a slight risk related to recalling unpleasant memories no adverse outcomes were anticipated. Contact information for the IRB committee was provided in case a participant wanted to discuss any concerns.

### Sample and Sampling Procedures

For this grounded theory study, the initial sample was identified by purposive sampling. I was interested in locating nurses who had experienced horizontal violence between nurse colleagues in the workplace and soliciting their participation in the study. The criteria driving the choice of first round participants were experience with the phenomenon of interest and an ability and willingness to discuss these experiences with me. According to Denscombe (2003), selection of the initial group can be based on reasonable expectations of obtaining relevant

information related to the research topic. The best participants for a grounded theory study are those who have experienced the phenomenon under investigation (Morse, 2010). I chose to restrict my participants to individuals who were working or had worked in an acute care hospital. The individuals from this group were chosen because the literature notes that nurses working in these environments are theoretically subject to work stress, oppression and horizontal violence. Individuals, who agreed to participate, were chosen based on their ability to contribute to an increased understanding of the experience of horizontal violence in the workplace.

The central criteria for selecting participants were their knowledge of and experience with the phenomenon of horizontal violence in the nursing work environment. The initial participants, chosen for their ability to provide examples of the phenomenon of interest (horizontal violence), included five nurses. Of these five, two were unable to participate which left an initial sample of three practicing nurses. During these initial interviews, I asked the participants if they knew of someone else who had experience with nurse-to-nurse horizontal violence in the workplace who may have interest in participating in the study.

Snowball sampling is method of identifying participants through people who know other people who may have a story to share (Creswell, 2007). My initial plan was to request names of potential participants from my first three nurses. I would then call the prospective participants and ask if they would be interested in participating in the study. However, after reviewing the sensitivity of my topic, it was recommended that I ask my first round participants to contact the potential second round participants and inform them of the study. If these nurses were interested they were asked to call me. This process was adopted in order to protect

disinterested parties from exposure. Using this method, people who do not want to participate were not exposed and eliminated any pressure they may have felt to agree to participate if I had called them first. Through purposive and snowball sampling, I conducted a total of 17 interviews that were tape recorded and transcribed verbatim by me.

The snowball sampling through the first round participants was influenced by theoretical questions arising from initial coding and comparisons of the first data sets. Statements related to different nursing specialties (e.g., medical-surgical nursing, intensive care nursing, operating room nursing), education levels (e.g., associate, baccalaureate, master's degree), and gender led me to ask the participants to consider if they knew nurses who could and would speak from these perspectives.

#### Participants

Participant characteristics and comparison data on gender, age and education from the National Sample Survey of Registered Nurses (US Department of Health & Human Services, 2010) are listed below (see Table 5).

Table 5  
*Participant Characteristics*

Characteristic	<i>n</i>	(%)	NSSRN 2008
Gender			
Female	15	(88.2%)	93.4%
Male	2	(11.8%)	6.6%
Age Range			
30-39	6	(35.3%)	35.3%
40-49	9	(52.9%)	25.5%
50-59	2	(11.7%)	29.2%
Education			
Diploma	3	(17.6%)	13.9%
Associate	1	(5.8%)	36.0%
Bachelor	7	(41.2%)	36.8%
Master	6	(35.3)	12.3%
Position			
Staff	6	(35.3%)	
Charge	2	(11.7%)	
Education	4	(23.5%)	
Support	1	(5.8%)	
Administration	4	(23.5%)	
Total	17		

The National Sample Survey of Registered Nurses (NSSRN) is conducted every four years and provides statistics on those with current licenses to practice registered nursing in the United States (U.S. Department of Health & Human Services, 2010). In 2008, men in nursing comprised 6.6% of the nursing population. I have included the NSSRN data for information purposes and not in an attempt to establish representativeness. My sampling decisions were directed by the need to talk to nurses who had experience with horizontal violence.

Although I did not choose the participants with representativeness in mind, the gender mix of the participants was not substantially different from the general population of nurses. With 11.8% ( $n = 2$ ) male participants, the study mix was close to the NSSRN sample of nurses. The study group varied from the 2008 NSSRN sample in age. Over half (52.9%) of the study participants were between the ages of 40 and 49 as compared to 25.5% of the 2008 NSSRN

sample in the same age group. My participants were purposively chosen for their experience with horizontal violence and their ability to discuss and reflect on these experiences. I believed that nurses with experience would be the best informants for this study. These initial informants subsequently brought other experienced nurses to the second round of interviews. The NSSRN sample has a higher percentage of nurses between the ages of 50 and 60 (29.2%) as compared to the study group (11.7%). This may be related to the NSSRN sampling all nurses who hold current licenses in the United States regardless of employment status, while my group of participants not only held current licenses but were also currently working. The education level of the study participants was also different from the 2008 NSSRN sample. The two largest differences were in the associate and master's prepared participants. Associate degree nurses comprise 13.9% of the NSSRN sample. In my group, 5.8% held associate degrees. My group also had more master's prepared nurses (35.3%) as compared to the 2008 NSSRN sample (12.3%). I believe that these differences were also influenced by initial selection and subsequent recruitment of study participants that had experienced the phenomenon of interest and also had interest in and the ability to describe and reflect on these experiences.

#### Data Collection

After obtaining signed and informed consent, interviews were conducted at the time and place most convenient for the participants. Some of the interviews were conducted in restaurants, coffee shops and participants' homes. One interview was conducted, per the participant's request, in a parked car. Another interview was conducted in a shopping mall early in the morning before the stores opened for the day. I met the participants wherever they felt most comfortable.



Data was collected through tape recorded interviews which were scheduled for 45 minutes because of participant schedule requirements. Most interviews were ended on time although some participants did agree to continue past the allotted meeting time. I had developed an interview guide with questions to initiate the conversation and keep things moving if necessary (see Appendix C). However, I found that the participants were willing to share their stories and reflections with little, if any, prodding from me. I was impressed with their candor and ability to reflect on their experiences.

### Memoing

Throughout the data collection and analysis process as my personal form of memoing I would note my impressions. Repeating a participant's question to me was my form of a recorded verbal memo or cue that did not interrupt the interview in an obvious manner. Immediately after an interview, if I had a skeptical or negative impression I would make a note and ask myself why this piece of data had led to this reaction. If I felt particularly positive about something I followed the same process and made a note of the positive feeling. I also recorded my impressions and would later transcribe these ideas on to the reverse side of the appropriate transcript. With these notes and the recorded cues I was better able to reflect on ideas that made particular impressions on me as I interpreted my data. An example of a field memo is presented below:

I am hearing the same things from people. Patient care concerns. Safety. Common experiences with bad behavior. Sitting there listening and UJ says that not talking about this issue is like closing a dirty wound. The image brought to mind was so powerful. Festering. Said one nurse would be shocked to know how she was sabotaging the patient care by hiding supplies. Perhaps my bias working, but I doubt that. I think that people who hide things so that they are ones controlling the resources know what they are doing. Nurses are very willing to ascribe positive motives to others.

## Data Analysis

The grounded theory approach requires that analysis begin as soon as data is collected. I recorded my thoughts as a form of memoing to keep from losing ideas between the interview and typing the transcript. My coding process began with the first interview. After the first transcript was printed, I transferred my recorded thoughts to the transcript and began initial coding. In grounded theory, coding is how the data is analyzed (Corbin & Strauss, 2008). Initial coding consists of looking for meaning in each segment (word or sentence) of data rather than attempting to fit the data into preexisting categories such as oppressed group or stressed group behaviors.

The first coding decision I made was to use single words as my unit of analysis. However, after looking at single words for many hours I found that single words were not saying the same thing when separated from each other. Single words were not able to convey the experiences the nurses described and thereby lost their meaning. My unit of analysis progressed from single words to phrases and sentences. I looked for keywords to identify key phrases and sentences while also identifying context. As the interviews were coded, each was compared with the other. The process of constant comparison is an important element in developing a grounded theory (Wuest, 2010). Codes from one data set were compared to the other data sets. The codes from the interviews were then grouped into categories. The core categories emerged from the categories and the theory emerged from the core categories. The process was not linear in nature, but circular as data was collected and compared with previous data, codes and categories.

## Value Assessment

Quantitative methods have well established criteria against which to judge the research methods used and the results obtained. One time tested method to evaluate validity of quantitative design is replication. Replication of similar results supports the validity of a previous study. In contrast, replication in qualitative research can be problematic. In this grounded theory study, the data was the participants' interpretation of past events. People change. Settings change. Stories change in the retelling as people focus on different aspects of an event. A change in focus can result in a change in perspective. It would be difficult, if not impossible to recreate the exact circumstances of data collection in this study.

For example, several participants said that they had not experienced horizontal violence in the workplace and then went on to describe being the target of threats of physical violence, isolating behaviors and witnessing humiliating events involving co-workers. I found it remarkable that participants would tell such vivid stories about behaviors that, initially, they felt they had not witnessed or experienced. Each participant ultimately recognized the behaviors in their stories. If asked again, they may no longer feel that they had no experience with these behaviors. New participants could be recruited but they would have different experiences and their own individual interpretations of the events. Another researcher will also bring his or her own experiences and interpretations to the study. There are different realities associated with each episode of horizontal violence including, but not limited to, witness reality, target reality and perpetrator reality.

Difficulty in replication of grounded theory research does not, in itself, weaken the validity of a study's results (Hammersley, 1990). I hold a constructivist and interpretive point of

view which acknowledges that although little knowledge is certain, research conclusions can be assessed for reasonableness and plausibility based on our existing understanding.

Reasonableness and plausibility are, however, subject to individual interpretation. To further complicate quality assessment in qualitative research, standards for conducting and evaluating qualitative research are broad and vary depending upon the specific method used. In the table that follows, I have listed selected qualitative evaluation criteria that has been published in the literature (see Table 6).

Table 6:  
*Selected quality measures for evaluating qualitative research*

Author (Year)	Suggested Quality Measures
Altheide & Johnson (1994)	Information about researcher, methods, setting, participants, analysis and interpretive processes Ethical accounting – noting that all knowledge is based in individual perspective
Charmaz (2006)	Credibility Originality Resonance Usefulness
Glaser & Strauss (1967)	Fit Understandability Generality Control (applicability)
Hammersley (1990).	Are the findings plausible? Is there practical application to practice? Social relevance of the research is dependent upon the audience
Lewis (2009)	Triangulation Negative cases Researcher reflexivity Member checking Thick rich description Peer debriefing

Table 6. *continued*

Author (Year)	Suggested Quality Measures
Mays & Pope ( 2000)	Triangulation Member checking Clear account of the process of data collection and analysis Reflexivity Attention to negative cases Fair dealing
Miles & Huberman (1994)	Acknowledgement of researcher bias Have things been done with reasonable care? Truth value – do the findings make sense? Are they credible? Were any competing hypotheses considered? What is the level of usable knowledge offered?
Popay, Rogers & Williams (1998)	Illumination of subjective meaning, contexts and actions Theoretical or purposeful sampling Adequate description Data quality Theoretical and conceptual adequacy

There is no universally accepted set of criteria for judging the validity of qualitative research and many of the published quality assessment measures are open to interpretation. Whether findings make sense is, for the most part, determined by the audience. Lewis (2009) notes that final judgment of validity rests with the research consumer. Glaser and Strauss (1967) described a grounded theory as one that fits the area to which it will be applied, makes sense and is usable in everyday situations. Glaser and Strauss (1967) also describe a theory as being abstract enough to be usable in different daily situations but caution that a theory should not be too abstract as to lose applicability. The theory properties recommended by Glaser and Strauss, including fit, understandability, generality and applicability, each have multiple meanings.

Reasonable, usable (Miles & Huberman, 1994) and fair (Mays & Pope, 2000) are also terms that are open to interpretation. Whether a description is adequate (Popay, Rogers & Williams, 1998) is a judgment reserved for the reader. One common assessment standard is

the need to acknowledge that each researcher brings a different set of experiences and interpretations to their study. As noted earlier, I am a nurse and I believe, within the limits of my own personal and clinical experience, that I have some understanding of the complexities of the nursing workplace. I have also experienced horizontal violence as a witness, target and, as previously described, a perpetrator. My experiences, although not to be considered data, do provide me with an insider's point of view when discussing the nursing work environment.

### *Credibility*

A study is considered credible if the descriptions and interpretations presented are recognizable by the readers (Sandelowski, 1986). If the reader has experienced the phenomenon described, they should be able to recognize the situation from the descriptions provided. If they have not experienced the phenomenon, the study can be judged as credible if the reader recognizes the phenomenon after have read about it in the study. This standard, however, is also open to interpretation as each person experiences and remembers and an event within their individual perspectives. Recognition is personal. Interpretation is also personal. Chiovitti and Piran (2003) recommend using the participants' own words to enhance credibility. Using the participants' own words can reduce the potential for distorting their intended meaning. I have used my nurse participants' voices as often as possible to make transparent any unintended distortions in my interpretations.

### *Triangulation*

Triangulation is a validity measure that looks for commonalities or differences between different sources of information. Different data sources, different theories, different methods or perspectives from different investigators are types of information that can be used for

triangulation (Creswell & Miller, 2000). The concept of triangulation is that other independent measures agree or at least do not contradict the findings of a study (Gillis & Jackson, 2002).

Triangulation is based on the acceptance of a “superior explanation against which other interpretations can be measured” (Barbour, 2001, p. 1117). Triangulation is a valuable tool when working within the positivist perspective and with quantitative data sets. Triangulation of independent measures assumes that it is possible to compare different accounts. To compare quantitative and qualitative studies results would be problematic.

Comparing results between qualitative studies could also be difficult. Interview data, focus group data and observation study data may be similar but may each be dissimilar enough to complicate attempts at direct comparison (Barbour, 2001). However, comparison of interview data, different theories and other research literature can be employed to examine validity of the study results. Examination of different perspectives can develop a wider explanation of the phenomenon under study. Triangulation is also a method for enhancing researcher reflexivity (Mays & Pope, 2000). Although no theory, method or data source can explain, on its own, the complexities of social behavior, together they can increase understanding of what we believe about a phenomenon (Hoque, 2006). I was able to use different theories and explanations in the literature to analyze my results and recognize when the data was leading me through common or divergent pathways.

#### *Member checking*

Member checking involves taking data and interpretations back to the participants in the study so that they can confirm the credibility of the account. Data was provided in the form of verbatim transcripts sent to the participants. Each person was asked to review the transcript

of their own interview. No participant was given the opportunity to review other interviews. Because the second round of participants was recruited by the first group, many of the nurses knew each other. I did not feel it was appropriate to share transcripts between participants. Sharing transcripts had a potential for violating confidentiality that I was not willing to risk.

A copy of each participant's transcript was sent to them for their review. The nurses were told that if they read something that they no longer felt comfortable with or found some potentially identifying information they wanted removed, I would edit the transcript as they requested. Each person was advised that they could edit their transcript as they saw fit. I told them that they did not have to give me an explanation for any requested changes if they did not want to do so.

I met with available participants to discuss the transcripts. I wanted to give the participants an opportunity to correct errors or challenge what they felt may not represent what they had wanted to say. I also wanted to provide the nurses with an opportunity to provide additional information. No one asked me to remove, add or edit any part of their transcript.

### *Reflexivity*

Reflexivity is an awareness of how the researcher's experiences and perspective may influence the research process (Robson, 2002). Reflexivity also addresses the potential for the researcher-participant relationships to influence the interaction and data collection. This awareness should be explained in the research narrative so that the reader can judge if, or how much, the researcher's perspective is affecting data interpretation. However, it should also be acknowledged that reflexivity is dependent upon the level of researcher awareness and may be



partial. Charmaz (2006) suggested that researchers be as open as possible about past experiences and how these experiences influence their present perspective.

There were no power gradients to influence my data collection or analysis. We met to discuss horizontal violence as peers. If any power gradient existed, it was on the participant's side, as without their agreement to donate their time to talk with me, I would not have been able to move forward with the interviews. All of the participants knew that I was a nurse with bedside care experience similar to their own experience. We had all experienced or witnessed horizontal violence in the workplace. I felt that my relationship with the participants was one of an insider. I was a nurse talking to nurses about a much discussed phenomenon in the practice environment.

I have provided information on my background as a nurse and my experiences as a witness, target and perpetrator of horizontal violence in the workplace. I brought preexisting ideas about oppressed group theory as an explanation for horizontal violence between nurses at work to the study. I had done a lot of research about these behaviors and had personal experience with the stresses associated with hospital nursing practice. I began the study believing that the nurses would reject one theory and embrace the other. They did neither. As they talked and shared their experiences and perspectives, they took me in a direction I had not previously considered as I began to analyze the data.

#### *Peer Review*

I took advantage of the experience and knowledge of my nurse colleagues. Throughout the process as I developed different explanations, I would ask for feedback from expert nurses in the clinical, administrative and academic environments. Through electronic and telephone

communication, I was able to discuss my findings and developing theory with a recognized expert in the area of oppressed group behaviors in nursing and associated horizontal violence. I discussed my developing explanations with nurse experts in the area of patient care quality management, nursing education and hospital nursing management. I discussed the decisions I had made during the data collection, coding and developing categories. I was also able to discuss how my own subjectivities could be influencing my interpretations of the data. These nurses were not involved in the interviews and we could discuss my findings on a peer level. Sometimes they would validate my thinking and sometimes they would offer another perspective to consider.

### Summary

For this grounded theory study, the initial sample was identified by purposive sampling. I was interested in locating nurses who had experienced negative interactions with nurse colleagues and were willing to discuss these experiences with me. Snowball sampling recruitment through the efforts of the first and second round participants was influenced by theoretical questions arising from initial coding and comparisons of the data sets. Statements related to different nursing specialties (e.g., medical-surgical nursing, intensive care nursing, operating room nursing), education levels (e.g., associate, baccalaureate, master's degree), and gender led me to ask participants to consider if they knew nurses who could and would speak from these perspectives. Data was obtained through one to one interviews that were transcribed verbatim by me. Data were coded and categorized. This process resulted in the emergence of a small scale theory focused specifically on horizontal violence in the nursing work environment.

## CHAPTER FOUR

### RESULTS

“Nothing is as powerful as a story. Stories are a means of truth telling. If we have had a similar experience, the story resonates with us at the deepest level, and there is comfort and validation as we realize that others share our experience.” (Bartholomew, 2006, p. 7)

#### Introduction

The purpose of this study was to generate theoretical propositions beyond the concept of oppressed group behaviors as an explanation for horizontal violence in the nursing work environment. Nursing literature has advanced oppressed group behaviors as a motivating force behind these negative behaviors in the workplace. Nurse scholars have provided explanations for horizontal violence by analyzing the behaviors within the oppressed group behavior framework. The main questions of this study focused on what nurses who had first-hand experience with horizontal violence as a witness, target or perpetrator believed to be explanations for these negative behaviors between nurses at work. This intent of this study was to examine the phenomenon of horizontal violence from the nurse’s point of view and develop possible explanations outside of oppressed group behavior.

The theory that emerged from the data was that these behaviors, described as horizontal violence, may at times be employed as a method of manipulating the care environment in an effort to enhance patient outcomes, while maintaining group or individual perception of security through a sense of environmental control. Conditions and context were identified through the constant comparison method of analysis. Also identified were strategies used by the nurses to manage perceived threats to the quality of patient care as well as threats to their own group and individual self-concepts and identities as competent care providers.

The next section begins with an introduction to each participant and their responses to my primary question related to their experience with horizontal violence in their own work environments. Research indicates that the majority of working nurses will experience horizontal violence in their work environment (e.g., Aiken, et al., 2001; Cox, 1991; Rosenstein & O'Daniel, 2005). The nurses who participated in this study were chosen purposefully based on their experience with horizontal violence and their ability to reflect on those experiences at work. Each participant had been involved, either as witness, participant or target, in horizontal violence. Although the participants had exposure to horizontal violence in common, their individual experiences were different. My analysis began with the transcript of the first interview and continued as subsequent interviews were transcribed and analyzed using the grounded theory method of constant comparison.

### Participants

The nurses who participated in this study all had experience with horizontal violence at work. They were experienced nurses and able to reflect on the events and consider the context and conditions associated with negative nurse-to-nurse interactions in the workplace. I am using direct quotes to preserve their voices and allow each of them to be heard. Their own words will illustrate how they individually perceived horizontal violence. I believe that the direct quotes used throughout this chapter are the best way to allow the reader to “hear” and understand what the participants were saying. Following a brief introduction to each participant, I will present their verbatim quotes on horizontal violence. Directly following their statements will be my initial interpretations of the data. To maintain confidentiality while also

identifying which participant is speaking, each person is identified by the two letters that they drew for themselves at random before each interview began.

In order to introduce each participant, the following transcript excerpts represent their answers to my initial question about their experiences with horizontal violence. The excerpts that follow are in alphabetical order for presentation purposes only and do not reflect the sequence of interviews in real time.

*AB*

AB has practiced in several different patient care environments and brought a wide range of experience to the interview. She currently provides direct patient care in a specialty environment with an established group of care providers. I met AB at a restaurant chosen by her because it was close to her workplace. The restaurant was busy but the background noise was not loud enough to be distracting. During our interview, AB spoke candidly about her experiences with horizontal violence in the workplace. She was able to discuss witnessing events as well as being a target of horizontal violence.

I've seen where nurses demean, personal demeaning, co-workers in professional situations that aren't necessarily warranted as far as taking care of the patient. It will be more of a personal attack and it may be on them according to what they did professionally and/or if they just don't like the way they acted or responded toward them.

Like, oh, you're accusing me of trying to bully? That's not it. It's just that what I think, I feel it's the truth and I should be able to say it. (Regardless) if it hurts their feelings, if it's true, all that aside, they feel they have a right to say it.

Horizontal violence is seen as "more of a personal attack" if the behaviors are not related to the patient care. Negative nurse-to-nurse interactions may be judged as warranted based on how

the target nurse is “taking care of the patient.” Within this context, the perpetrators believe a difference exists between being a bully and defensible behaviors that are grounded in “truth.”

AB described her feelings of isolation and lack of confidence when she was a target of negative behaviors such as the silent treatment. She also said that she used the silent treatment which would place her in the position of a perpetrator. However, she said that she did not use the silent treatment as a method of isolating other group members, but as a way to maintain her focus on patient care during times of conflict in the workplace. She placed the silent treatment, an isolating behavior which is categorized as horizontal violence, within the context of what she believed was in the best interest of the patient.. For AB, her use of the silent treatment is a method to avoid conflict and maintain group integrity.

Now, sometimes I’ve given the silent treatment and I’m not happy to say it. But, because if I don’t think that a person I’m working with responded appropriately to an issue or a situation or a patient, I’m not one that’s willing to confront them right away. So, as a result, in order for me to, kind of like, maintain my shift and do what’s in the best interest of the patients and the group, I will just be silent and do my work.

*AH*

AH has practiced nursing in several different states, different healthcare delivery systems and in different specialty patient care areas. She has held regular full time staff positions as well as practicing nursing as a travel nurse. Travel nurses are contracted through an agency to fill temporary work assignments in hospitals throughout the United States. Because of this experience, AH has a perspective that encompasses a number of different work environments. She also has a sense of independence in her practice that has been cultivated from being the outsider during her years as a travel nurse. AH discussed witnessing and being

the target of horizontal violence in the workplace. She also was able to reflect upon times when she was the perpetrator of negative behavior.

Nurses can be petty. All the places I've worked and with my travel nursing particularly I've seen nurses gang up and get a traveler fired. She (a travel colleague) felt like she was more like an assault victim. She was in shock. She was crying.

These nurses in this (unit) just decided they didn't like her. One coerced all of them into complaining to the nurse manager. They got her fired.

An influential member of the established work group was able to get the other members to work together in order to eliminate the traveling nurse. AH describes the target nurse's experience as similar to an "assault victim." AH also described working in hospital units in which all traveling (temporary) nurses were subjected to what she believed to be consistently unfair assignments. Unfair assignments are a form of horizontal violence involving inequitable work distribution.

#### *BE*

I met BE in an area of that she had chosen for our interview. Although we were in a private area with the door closed, we were interrupted several times. We left that area and went to a restaurant and continued our discussion without further interruption. BE has a wide range of experience across different areas in the hospital. She has practiced in medical-surgical and specialty nursing areas. BE related past episodes of horizontal violence in which she was the target nurse. BE also discussed in detail witnessing negative behaviors between nurses. She was able to reflect on possible motivation of the perpetrators. BE did not relate any instances in which she, specifically, was the perpetrator of horizontal violence.

While BE said that some horizontal violence in the workplace could be related to personality differences, she also believed that some of the isolating behaviors were based on competence assessments made by the established group when a new nurse enters the work environment.

You don't fit in. Whether you're just not fast enough to catch on to the way things are done wherever you're at. Or whether you...you just don't fit with the rest of the personalities. You just don't fit into the clique or whatever. You're alienated.

Should the group decide that the target nurse does not meet their formal or informal inclusion criteria, that nurse would be alienated and isolated from the support of the work group. These isolating behaviors can result in the target nurse leaving the work unit.

You're pretty much having to do, instead of getting the help of the team or the pack you're kind of like left on your own to do things. Sometimes you're made to feel inferior. Sometimes it's even verbal assault.

Yes, so that person is kind of alienated until they just can't do everything by themselves and they're out of here.

Alienation is used to manipulate a targeted nurse out of the group. The target nurse is isolated, excluded and denied group support and assistance in an environment that has a high level of interdependence between multiple team members for optimum outcomes.

#### *EC*

I met with EC early in the morning at a shopping mall before any of the retail stores opened. EC was on her way to a family gathering later in the day and felt strongly enough about participating in the study that she was willing to meet me very early in the morning before she was scheduled to meet the other people in her party. We found a bench in a wing of the mall away from the main entrance so that we would not be interrupted by other patrons crossing the mall to enter an coffee shop that was open. EC has been practicing in specialty



care areas for over 20 years. She is a direct patient care provider. She has witnessed horizontal violence and acknowledged that she had been a perpetrator.

I've never been deliberately mean to anybody, but ah...I will offer to assist them but if they're not willing to learn or they think that they know everything, then I, by no means, encourage them to stay.

Passive methods of isolation (e.g., "...I, by no means, encourage them to stay.") can be just as effective in removing someone from the workgroup as direct action. These covert tactics also have the advantage of deniability if confronted by the target nurse or management. EC has also been a target of horizontal violence. She described being the target nurse and the importance of group support during the experience.

Because, seriously, for several months there it was like every day it was like, my God, what have I done now? But when other people started telling me, what is up with that, I was okay, I'm not crazy.

In EC's experience, support of the established work group mitigated the effects of the negative encounters. The group can rally together to run someone out of the work environment or rally together to provide professional and emotional support. These protective functions of the group can make the effort required to maintain group relationships worthwhile.

#### *FF*

I met FF at a private residence. FF has practiced in specialty areas for many years. She has experience in providing direct patient care and in all aspects of managing specialty care units and the nurses that work there. FF described horizontal violence as occurring "all the time" in her environment. She then reconsidered and changed the description from "all the time" to "almost daily."

FF talked about perpetrators of horizontal violence in the nursing workplace. She described the behaviors and what she believed was the motivation influencing the perpetrators.

Because they definitely give bad assignments and play with people's minds. I think they do. Well, they're accomplishing the protection or the admiration or the whatever of their friends or the people that they're not screwing with. The people that are their friends. They're protecting them.

(This nurse will) be partial to those particular people and screw the other people. So that's what she's accomplishing.

Protection is provided to "their friends" through better assignments for group members and heavier workloads assigned to nurses not in the group. Nursing standards of care require assigning each patient to the nurse whose skills match the patient's needs (Alspach, 2006) rather than assigning patient care based on group alliances.

Research related to horizontal violence in nursing discusses the many negative effects of these behaviors such as damaged self-esteem, increased stress and threats to patient safety. However, FF shared what she believes are necessary and sometimes positive effects related to what is classified as horizontal violence in the patient care environment.

It does definitely relate to if you're a good nurse or a good caregiver. Sometimes people don't belong. It's not bullying when someone doesn't belong in the environment.

I think it not a kindness to treat them mean but somebody has to see and somebody has to say that person doesn't belong in this environment. You know?

Not everyone fits well into every different environment. This is true of nursing or any other profession. Published standards of care are available to healthcare providers and the public. However, there is no published definition for "good caregiver" because each patient care environment is different and each patient requires individualized care planning. Without

an accepted definition, the question becomes how the group determines that a nurse is not a “good caregiver.” The target nurse would be likely to perceive behaviors intended to remove them from the group because he or she “doesn’t belong in this environment” as bullying and horizontal violence.

So you can’t pull the bully clause there. The clique is sometimes right. It just takes somebody who can figure out that they need to go someplace else.

TM: And if I were the person who did not fit, I would see this as bullying?

Yes. You would.

### *HB*

After working in hospitals for close to ten years, HB has moved into a different environment. HB specializes in team member management and conflict resolution. HB’s perspective was one of reflection now that she is no longer working in a hospital. HB describes a target nurse as an outcast who can find it difficult to work without team support in an environment where cooperation between nurses is needed for optimum care outcomes.

They are the person that people zero in on. This is where you have a lot of negative interactions and the bullying as you are labeling it now. I have definitely seen that.

The intent is to never have that person who is outcast as a member of the group. So the outcast person has a choice. The choice comes down to I’m either going to stay and stick it out and not be 100% engaged and happy in my job or I am going to go elsewhere...in my experience, they go elsewhere.

HB believed that the established work group develops a set of standards against which a new nurse is measured. The group does not allow a new member to join the group unless there is a fit with these standards. She has heard nurses justify their negative behaviors towards others nurses because “they weren’t a fit.” As mentioned earlier, there is no standard definition for “good caregiver.” There is also no standard definition for “good fit.” These

determinations are based on informal and unwritten standards of the individual work group. The group was willing to work with fewer nurses during the shift (short-staffed) in order to maintain their informal criteria for inclusion and exclusion. Although group dynamics may remain stable through these negative behaviors, working with less than the optimum number of nurses is not in the best interest of the patients or the nurses.

### *KM*

I met KM at a restaurant for her interview. The place proved to be too noisy for recording and KM suggested that we hold the interview in her car. After moving to the car, we started the interview. KM has been a nurse for over 15 years. She has practiced in the clinical environment, at the administration level and also as a nurse educator. KM had experience in another field before she entered nursing and therefore was able to bring a non-nursing as well as a nursing perspective to the discussion. She described the negative behaviors she witnessed between nurses as an “eye opener” because she had not experienced this type of interaction between colleagues in her non-nursing work environment. KM discussed witnessing horizontal violence as well as being a target nurse. KM was thoughtful and at times would pause as she considered her answer before responding to a question.

KM described being a witness to horizontal violence when she was new to nursing.

When we first started I remember one nurse picking on another nurse just aggravating her. anything he could do to just get under her skin. He would call her names and whatever in front of anybody. Thought he was being cute. And one day he picked her up and put her in the garbage can. Because he always used to say how skinny she was and scrawny and how can you expect to take care of a patient and turn a patient and he said, "Look, I'll show you." and picked her up and put her in the garbage can.

KM said that although she believed that the supervisor was aware of this incident the supervisor's response was that “he just walked off.” Passive acceptance on the part of

leadership can normalize negative behaviors in the form of horizontal violence in the workplace. Without sanctions, the behaviors can continue unchecked.

KM described witnessing another nurse being targeted by horizontal violence.

I think they thought that she didn't fit in. That she didn't know what she was doing and that she wasn't taking care of the patient right so they just outcast her. And they rode her until she finally just resigned.

They made her do it (provide care) by herself or wait or she would be the last person that got help to change the bed and change everything on the patient because they said that she didn't belong there.

Although KM, FF and HB practiced in different hospitals, they all described isolating behaviors intended to manipulate a nurse into leaving the workgroup if perceived by the established group as not “taking care of the patient right” or that the target nurse “didn’t belong there.”

#### LA

LA has experience in public hospitals, private hospitals and home care nursing. She has direct patient care and administrative experience. LA told me that she had been having a “bad week.” At the beginning of the interview she seemed a bit nervous but as she began to talk about her experience as a Licensed Practical Nurse (LPN) and then as a Registered Nurse (RN) nurse she was able to bring a hierarchical perspective to horizontal violence in the nursing workplace. She said that she did not see negative behaviors between nurses when she worked as a LPN. She felt that during that time “everybody helped you.” After she earned her nursing degree and began practicing as a RN she described environments where she has since experienced what she believes was horizontal violence at work. As she spoke, her slight nervousness seemed to dissipate and she was able to reflect on the meaning of some of her experiences.

So that person has an inside person. And since I don't have inside people, it always made me feel like why couldn't I have information? That would have been good information for me to know. ... But, it's just the sharing of information. Your information is limited and sometimes you feel that you're in the dark because you don't have...you're not in that clique and you don't know the people who know what's really going down. That's how I perceive it.

The established work group has control of information which increases the power of the group. Access to information is an important resource and controlling the flow of inside information can keep outsiders "in the dark" and therefore marginalized. LA was the first of the participants to acknowledge information as a resource in the work environment.

#### *NP*

Before we began, NP reminded me that she had another appointment and wanted to get started as soon as possible. NP spent many years in a highly specialized area of nursing. This area, much like other specialized areas in hospital, cares for patients who are, at times, in critical condition. The unit is fast paced and very dependent on teamwork in order to provide patient care. NP described being a perpetrator of horizontal violence.

I worked at a big, the (public) hospital so that when you got these patients in, they were sick, they were emergencies. And I need this a long time ago and where are you? You are outside doing what? And that kind of thing. But there can be times when you are not happy with yourself. So it's...and I am very aggressive. And sometimes maybe I'm mean. But I have to get my job done.

NP explains behavior that could leave her "not happy" with herself in the context of emergency patient care. She also described her experience as a target of horizontal violence when she began as a new member of an established team. She said that she resigned five days later.

It's hard going to a (specialty unit). I went to one in (city) and five days later I resigned. It was awful. The doctors were rude. The staff didn't give a lick about you and I had never worked in an (unit) that was like that.

Practicing in a new environment without the assistance and support of the established work group is very difficult. NP was an experienced specialty nurse and recognized that she was not going to easily fit in with that particular group of nurses. Rather than attempt to work herself into the group, her decision was to leave after five days.

*PW*

PW has been a nurse for over 15 years. She has held positions as a staff nurse providing direct patient care, charge nurse, nurse manager, and hospital supervisor. She has also held an administrative position overseeing all aspects of patient care delivery. She first noticed negative nurse-to-nurse interactions during her hospital orientation when she was a new graduate nurse. PW shared her experience as a target of horizontal violence in the workplace. She was also able to share her experiences in which she was in a position to manage these behaviors between nurse colleagues.

(As the new staff member in orientation) They did not know me and, you know, they stop talking when you come into the lunch area. Don't invite you to sit down and have lunch with them or anything.

When a new staff member is exposed to the silent treatment and isolating behaviors, the message is that an established group exists and that acceptance into the group is not automatic. PW said that with time she “won them over in the end.”

As a manager, PW noticed that, at times, the group would “work on trying to get people fired.” She also noticed that the established group would lodge complaints against a target nurse concerning behavior that the members found acceptable from each other. PW spoke of how she managed complaints about target nurses and how she tried to determine which complaints were valid. She then shared a story about when she had been targeted by her own

work group after she had accepted a new position and was leaving the unit. Even after almost ten years, PW was emotional when telling this story.

They didn't talk to me. They didn't throw me a going away party. Didn't say congratulations. Didn't say anything. I spent my last day on the job there crying.

It still hurts my feelings. I thought they were my friends. Obviously, it still gets to me. I got over it and had good cordial working relationships again. They acted, I guess after a little while, that nothing had ever happened. But, it always....I don't know...I remember. I remember.

Another participant had mentioned the possibility of a group turning on its own members, "especially if a situation arises, they will get singled out" (AH: 14-3). PW gave a first person account of this phenomenon. The situation here may have been the anticipated change in group dynamics with PW's departure from the unit. In this case, the target nurse (PW) was not only isolated and alienated at the time but the negative memory has lingered for years.

#### *QM*

Nursing is QM's second career. QM said that although, "I just stumbled into this (nursing)," caring for patients was "something I really wanted to do for the rest of my life." Having experience in another occupation, QM was able to bring a non-nursing perspective to our discussion of horizontal violence between nurses at work. QM found some positives in the group dynamics of nursing alliances. QM saw a protective element in belonging to a group and having team members that have proven to be reliable in a sometimes unpredictable nursing environment.

QM's previous non-nursing background provided a perspective with which to reflect upon behaviors he encountered between nurses at work. His initial impression of the



interactions between members of a specialty unit was that they had little restraint in their personal exchanges.

Upon hitting a (unit), what I found out was...or what I thought I recognized was that, well, these were very very aggressive personalities in (unit). They had very little, if any, limitation in their interpersonal reactions.

QM shared an experience in which he was the target of horizontal violence.

She yelled at me. Told me I didn't know what I was doing. Criticized my...just really attacked me. And ah...so...ah...I, oh...of course it flew all over me. I had to get up and leave because I got too mad too fast. So I just walked away.

QM explained that that when he returned and attempted to defend himself he was dismissed by the other nurse who had been working in the patient care unit for some time and was a member of the established work group. Dismissal by an established unit nurse implies a hierarchy and the authority to dismiss another nurse. Dismissal also implies that the information QM had to share was not important to the other nurse who minimized his status and contribution to the team. When QM reported another experience with horizontal violence in the unit to hospital administration, the nurse manager dismissed the behavior.

So I went to the nurse manager. The way I addressed it was, what was the story because it seemed...well, I felt kind of attacked that day. She says, "Oh, that's just the way she is. Don't worry about it."

Passive acceptance of these negative behaviors and a lack of sanctions is a form of tacit approval and does not address the concerns of either the target nurse or the perpetrator. Both sides have a story and may each have valid concerns. Horizontal violence continues unchecked in this type of environment.

*SD*

SD has been nursing for many years. There are other nurses in SD's family. SD has been a direct care provider in medical and surgical nursing. She also has experience as a charge nurse, supervisor and in nursing education. SD shared her reflections on horizontal violence between nurse colleagues as well as between nursing students and staff nurses.

HR gets frustrated when someone leaves for something that (HR) doesn't find out about until it's too late. Something that has gone on and on.

SD described an example of horizontal violence that although the incident had been reported to management, it had been too late to change the outcome (personnel loss). She questioned why the behavior was tolerated for so long before someone made the report.

People said it had been going on for weeks. Why didn't somebody speak up? Why did you all tolerate it for these weeks? I think some of that behavior, I don't know if it has become expected.

When horizontal violence becomes an accepted part of the hospital's work culture the behaviors continue unchecked. By not taking action in response to horizontal violence the unspoken message is acceptance.

*TT*

TT has experience in direct patient care in various hospital settings including critical care and specialty areas. She moved from direct bedside care into nursing management overseeing the care provided by other nurses. TT also has experience in nursing education. TT described her experience with horizontal violence as a target and what she has witnessed in the workplace. TT was able to reflect on the effects of horizontal violence on the nurse involved as well as possible effects on the patients.

TT described witnessing horizontal violence in the form of isolation and failure to help a colleague.

You might have a patient that wasn't doing well and if they didn't like the individual, they just wouldn't help them or only when the patient was in a full crisis situation would ultimately go in to help the patient but it wasn't in any way being supportive of their peer.

Although horizontal violence may be directed at another nurse, refusing assistance to a colleague can have a negative effect on patient care. TT believed that perpetrators see assisting the ostracized nurse as support for the nurse versus caring for the patient. Ostracism of a target nurse crosses over to the patients under that nurse's care.

If that nurse (target) has to leave the floor for an in-service or a meeting I've noticed that those patients suffer because the other nurses that are supposed to be covering tend to see it as help for the nurse rather than help for the patient.

#### *UJ*

UJ has practiced nursing in several patient care areas including specialty care. UJ has practiced as a member of a hospital based established staff nurse workgroup and has also practiced as a contracted temporary outsider through a nursing placement agency. UJ's perspective on horizontal violence between nurses includes this range of experience. He was able to discuss his experiences as a target nurse and had witnessed horizontal violence in a variety of settings. UJ was able to offer a perspective on how this disruptive behavior may affect patient care.

UJ described covert and overt hostility between nurses at work.

Everything from the just kind of being snippy towards the newcomers to the full out, not just talking bad behind people's back that you see, but also people talking bad to them. Like, why did you do it that way? That is wrong. What do you think you're doing?

UJ discussed information as an important resource in the work environment. LA had also mentioned that she had seen control of information used to reinforce status within the group

I've worked with quite a few nurses over the years that don't share information with students or even the new people. I guess they think they got caught with something so everybody needs to get caught with it.

The failure to share information because “everybody needs to get caught with it” implies an ingrained and almost cultural component of horizontal violence in the nursing workplace. The concept of allowing a nurse colleague to provide care to a patient without needed information is difficult to reconcile with required professional nursing standards for patient advocacy and care. UJ believed that horizontal violence in the nursing workplace was a negative influence on patient care.

The whole nurses backstabbing, back biting, eating their young, being nasty to each other, whatever it is that you want to call it definitely impacts patient care. Because not only is it emotionally upsetting for the nurse on the receiving end which puts them into a negative frame of mind (but it) distracts them from patient care which needs to be the focus.

VZ

Although she has an extensive experience across the continuum of patient care in the hospital and home environments, VZ described herself as “basically a med-surg nurse<sup>1</sup>” VZ said did not notice horizontal violence at her first job. She described the nurses at her first hospital as working well together as a team. She also said that she may not have noticed horizontal violence there because she was new and kept her attention on her patients.

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<sup>1</sup> Medical-Surgical (med-surg) nursing includes the nursing care of adult patients whose conditions or disorders are treated medically, pharmacologically or surgically outside of the critical care or specialty units.

VZ began to notice horizontal violence between nurses at work when she left her first position and began working in a different hospital. She described witnessing horizontal violence directed at others.

That's where the ostracism takes place (within established workgroups). That's where you have the people who say, I'm the X nurse therefore I'm above everybody else. And we, as X nurses, gang up and treat everybody else a certain way and they'd better accept it. You see it in high school. You see it in junior high school. That's what it is. It's that kind of behavior.

VZ described an incident in which she was a target of horizontal violence after beginning work in a different unit. As the new nurse, she believed she was abandoned when she needed help.

The very first week, I was left alone in a code.

TM: Alone?

By the staff. Well, I called a code and my own (group) didn't really help. And, so...I mean everything turned out okay. It was a (type of) code and we got the patient back. But, that is the power of the ostracism.

This was another story in which an ostracized nurse believed that the ostracism crossed over to the nurse's patient care. Assisting with the patient care may be seen as assisting the nurse rather than assisting the patient.

*WM*

I met with WM at a restaurant. There was a fair amount of background noise but it was not loud enough to interfere with our discussion. WM has been nursing for many years. She practiced in the hospital specialty environments and said that, during those years, she was focused on patient care and did not notice hostile interaction between nurses. In WM's current work environment she witnesses horizontal violence between nurses "daily."

It's always...it seems like there's always someone that can stir up a lot of commotion. When that person is removed from the situation, it seems that things are a little bit calmer. But then, if they leave then someone else comes in and they kind of...they just cause commotion. They want to be in charge. They have to say negative things about the other people. Just stir up a lot of (trouble).

WM described two powerful group members who used strong tactics to increase their respective levels of influence with the other group members. WM believed that the conflict between these coworkers decreased the group's ability to function (provide care).

*YE*

YE and I also met at a restaurant. This restaurant was very quiet and we were able to spend some time talking about nursing in general before we started the interview. Before we began the interview, YE apologized for what she believed was a misunderstanding on her part over the topic of the study. She said that she did not have experience with horizontal violence at work. She agreed to discuss events she may have witnessed between other nurses and we began the interview.

After only a few minutes, YE began to talk about physical altercations she had witnessed between nurses at work. This was the first report of horizontal violence in the form of physical confrontation that I had heard during the interviews.

I've been where people have had fist fights over the patient. Like a male and female and they spit at each other, oh, yes.

Horizontal violence is almost always non-physical in nature. Before we were finished, YE had talked about different times when she had, in fact, been a target of horizontal violence when she was at work. YE described experiencing the silent treatment. She then told a story of being physically threatened by her coworkers.

She proceeds to tell me that I am nothing but (nurse) and she is (nurse). She was a graduate of (school) and I had no business...she actually.... We went into this little room and she really just chews me out and (name) stands in front of the door so that I can't get out. ... You are holding me against my will and I want to leave this room. So she let me out. I was a nervous wreck. So (name) started going around telling in front of all the patients...

TM: In front of the patients?

In front of the patients. Um-hmm...saying (name) was going to kill me when I left to go to my car. ... Oh my God, I was so scared.

YE reported this incident to hospital leadership and believed that the situation was addressed appropriately to maintain her safety and the safety of the patients. She returned to work for her next scheduled shift. This extreme case was the first time someone had told me a story like this during the interviews. In my own practice, I had never witnessed this level of violence between colleagues at work. YE said that this was her first and last experience of this type over a lengthy career.

### Theory Development

Each participant shared their previous experiences as a witness, target or perpetrator of horizontal violence. Post interview transcription and analysis of the data required reconstruction on my part as I looked for overt and tacit meaning in these shared stories. Data was coded and the codes were compared through the constant comparison method of data analysis. From these codes, the categories and core categories were generated. The theory emerged based on the conditions, context and consequences of horizontal violence as described by the nurses in this study. Because horizontal violence is a multi-dimensional

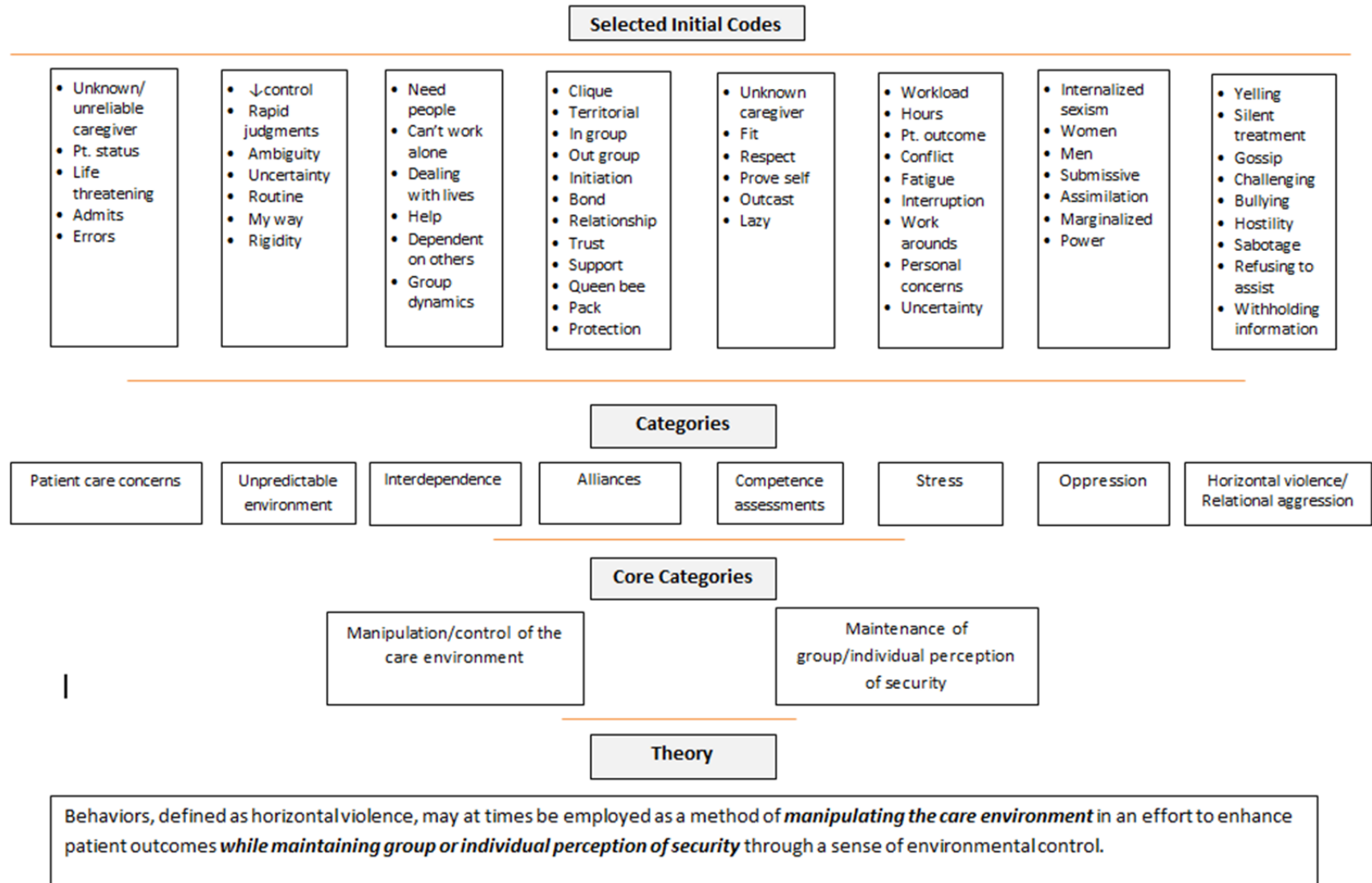
phenomenon that occurs between nurses in a complex and changing environment, the theory that emerged from the data is one of the contextual and environmental influences on the behaviors.

### *Coding*

My first level of analysis began as I listened to and interacted with each participant during the interview process. As a nurse, I understood the culture of hospital nursing. In order to ask questions, I had to interpret what I was hearing through my own experience and understanding. After the first interview was transcribed, coding the data was the next step in my analysis. Coding was influenced by my past experiences with hospital nursing and horizontal violence. The second interview was coded with the first interview in mind. As each interview was transcribed, the coding was done keeping in mind the interview data that had been coded before. Through this iterative process of comparing the subsequent data with previous data, the codes were organized into categories which are discussed in the following sections. The emergence of theory from initial codes, categories and core categories are illustrated as follows in Figure 2.



Figure 2. Diagram of theory development: Codes and categories leading to core categories and theory



### *Categories*

The codes developed during data analysis were organized into categories labeled patient care concerns, unpredictable environment, interdependence, alliances, competence assessment, stress, oppression and horizontal violence/relational aggression.

#### *Patient care concerns*

If you ask nurses what they're trying to accomplish they're going to tell you I'm trying to take care of the patient the best possible way that I know how to do and truly give them what they need. (HB:13-1)

The participants in this study talked about concerns related to providing patient care. Caring for patients in a hospital is a complicated endeavor requiring coordination between a multitude of complex departments, treatments and outcome assessments. From the pre-admission process to discharge from the hospital, the nurse is responsible for the patient's care and safety (Louisiana State Board of Nursing, 2010). The registered nurse is responsible and accountable for the quality of nursing care delivered to the patient whether the care is provided by a solely by the registered nurse or together with other licensed or unlicensed personnel (Louisiana State Board of Nursing, 2010). YE believed that the stage can be set for horizontal violence when one group of nurses judges another group as not providing the same level of patient care.

The people that care and want to do the best thing they can possibly do, do not relate to the people who I'm coming here because I'm getting paid and I can only do that. I do what I can do. They don't like these people. It goes both ways. (YE:8-2)

SD also believed that horizontal violence is influenced by patient care concerns.

I think some of the behavior is a response because someone didn't like the way a patient was treated. Or they don't think it was safe so then they'll get on that. (SD:20-1)

KM shared a story about a nurse who was an outcast from the established work group. She said that the isolating behaviors towards the target nurse had occurred over several months. KM believed that the perpetrators were responding to what they believed was a level of care that did not meet the unit standards.

If you think somebody is out of line or not doing the right thing you are supposed to tell them. you are trying to be a patient advocate. (KM:4-3)

### *Unpredictable environment*

The good nurses are the ones who are able...they're either...some days you are just lucky. Okay? Some days you are just lucky. I've been good and I've been lucky and lucky is alright. (QM:11-2)

Hospital patient care environments are, by their nature, uncertain. There is no sure method to predict which patient will follow the expected course and which will experience unexpected complications. Nurses are there to manage the expected, and perhaps more importantly, the unexpected events. Uncertainty is difficult to measure because of the challenges in operationalizing the unexpected. Garrett and McDaniel (2001) used objective data to operationalize uncertainty by counting the number of patients that nurses admitted, discharged or transferred in or out a patient care unit. Patients moving in and out of a unit can contribute to environmental uncertainty especially if nurses are managing unexpected admissions or discharges.

However patient counts alone, while they are objective measures, fail to account for the cognitive and emotional resources that may be required to manage the highly specific patient-family-illness dynamics of each individual who requires care in a hospital. Whether or not a nurse feels that he or she has the necessary resources to manage the known patient care requirements and also has reserve resources to manage any number of unexpected situations is

individual to that nurse. The nurses in this study had all practiced in the hospital and knew that anything can, and more importantly, may happen at any time with any patient.

Ah, well, first you have to go back to why is nursing a stressful situation...a stressful profession. Yes, you are dealing with lives. Yes, you're dealing with conditions that can change at a drop of a hat. (BE:10-4)

You are also dealing with life threatening things. We have our lives and issues and we have to kind of put things aside and deal with this person and try to save their life. (PW:12-2)

In a study involving critical care nurses, Hagler and Brem (2008) describe the nursing work environment as a series of ill-structured situations in an uncertain and changing environment. The complexity of nursing practice itself, which requires a great deal of cognitive and emotional resources, adds to the stress of an already uncertain work environment. The normal workload and unexpected demands of patient care can leave few resources available for effective interpersonal problem solving (Manthey, 2009). However the available resources are taxed by the demands of care, those demands must be met. The stakes are high for patients, families and nurses.

Solutions have to be found. When solutions aren't found ...you know the end result sometimes is that people die. It's not like people get their money back at the end of the day. (HB:13-1)

Nurses deal with situations that frequently have a degree of uncertainty not seen in other business environments (Begun & Kaissi, 2004). Sources of uncertainty are many and represented by the selected sources presented in Table 7.

Table 7

*Selected sources of unpredictability in the nursing work environment*

Source	Potential for unpredictability
Patients	Admits Discharges Transfers in and out of the unit Acuity changes Family concerns
Coworkers	Call outs Temporary staff Reassignment to unfamiliar units Availability of resource nurses
Equipment & supplies	Availability Functionality Operating expertise
Interdepartmental relationships	Administration Unlicensed assistive personnel Therapies Pharmacy Physicians Surgery Case Management Information Technology Laboratory Radiology Security

Uncertainty is a feeling of being unable to estimate the probability of particular outcomes with a degree of confidence. Uncertainty is a fact of life for hospital based nurses. In nursing, as in all human activities, decision outcomes are, at time, uncertain (Thompson & Dowding, 2001). Clinical decisions made by the nurse can carry significant risk for both the patient and the nurse. An inappropriate or untimely decision can lead to an unwanted outcome for the patient and perhaps legal consequences for the nurse. Although nurses rely on a variety of decision making tools such as algorithms, assessment scales and other heuristics to improve subjective decision making, they are also heavily dependent on the other nurses on

the unit. At times, quick decisions must be made. An incorrect decision can result in putting patient through unnecessary testing or, perhaps, have permanent undesirable consequences.

Both confidence and control, the feeling of being able to influence outcomes, increase with experience. Input and support from other nurses also increases confidence and a sense of control. Getting confirmation of patient assessment and decision choices from other nurses at the bedside increases the sense of believing one is able to successfully manage uncertain events (Thompson & Dowding, 2001). Corroboration of assessments from other respected nurses decreases the sense of uncertainty by increasing feelings of confidence and control.

Over time, nurses in a hospital unit can adapt to the average level of uncertainty in their specific patient population. Social support is important in environments perceived to be uncertain (Penrod, 2001). Alliances can help to mitigate effects of the environmental uncertainty that is a constant in the nursing work place. Alliances with the more experienced members can decrease the perception of environmental uncertainty through shared decision making.

### *Interdependence*

Nurses are educated to believe that they are independent practitioners within their scope of nursing practice. In fact, nurses who practice in the hospital setting have a high degree of task and outcome interdependence. Task interdependence exists when team members must share ideas, materials or expertise in order to accomplish their goals. As the level of task complexity increases, the level of outcome interdependence between team members also increases (Van de Vegt, Emans & Van de Vliert, 2005). Outcome interdependence exists when the consequences of the work is dependent upon the collective

performance of the tasks. Patient care outcomes are highly dependent upon successful and timely task completion which ranges from assessment to intervention. The reality is that nurses in the hospital setting are dependent upon each other to provide patient care. As patient care complexity increases, the level of nurse interdependence also increases. An awareness of this interdependence can be heard in the following interview excerpts:

If you're in the (unit), you're in very critical situations day after day and you need the people around you (VZ:9-6).

...the units are small and you have to depend on the people that are here. If you can't then, well, there is a big issue. Because you end up doing everything yourself. And you can't do everything yourself, or at least, not very well (PW:9-3).

It is hard to work when you are all by yourself. If something goes wrong, you need somebody (NP:3-1).

Because in that environment (acute care unit) you need people's help at some point. Or you may. You may not today but you're probably going to need it tomorrow (FF:14-1).

I don't know, it's just you have to be able to rely on them whether they're effective or not and if you can't, then how safe is your nursing license (AH:2-1)?

They are not independent although the weight of responsibility will fall on the individual nurse if something should go wrong. Nurses are individually accountable and responsible but not independent in the hospital setting. As QM noted:

We all struggle to control those factors that could have potential negative effects upon us. Every nurse in every hospital worries over their license. ...we all know that if there is anything that comes up, the chances of it being a negative outcome is very possible (QM:9:1).

Nurses need each other to provide care in times of increased demand. Collaboration between nurses increases a sense of security and well-being. The varying level of knowledge and expertise in a group of unit nurses is an advantage to the patient, families and nurses. As

nurses work together, they form alliances to enhance the level of patient care provided during routine and unexpected events.

### *Alliances*

Nurses in this study used the terms in-group, clique and pack to describe the group dynamics in the work environment. BE recalled a television program she had seen on wolf packs and how she thought she had seen pack type behavior between nurses as work.

...I think that's what you see out there with this whole thing. I can remember this program I watched on wolves and that's what it reminds me of. And how when this one approached the pack they kind of cower...Then they were sniffed out to make sure they were okay. If they were okay then they were let into the pack...I said that's what I see. (BE:6-3)

BE described what she sees as a connection between nurse alliances and wolf packs. Wolf packs organize for protection and have a defined leader. Although one wolf can usually get its own food, wolves prefer to travel with the pack. For the most part, the group is more efficient at hunting and it is safer to travel with the pack rather than to travel alone (Cares, 2005). These positive characteristics of pack membership make pack maintenance worth the effort.

Social support from the alliance (i.e., pack, in-group, clique) can modify an individual's response to an unexpected event and buffer the appraisals of the event as uncertain and stressful. Seeing an event as more controllable can inhibit responses considered unhelpful such as panic or inability to act in a timely manner.

And one time his patient was coding and all he did was stand at the end of the bed and look with his mouth open. Like he was frozen. (KM:8-1)

KM said the nurse mentioned above was isolated from the group after failure to respond to a patient emergency in what the group believed was an appropriate manner. The nurse eventually left the workgroup.



Getting second opinions from colleagues can increase confidence and enhance functioning.

...hey, I want you to come look at this. It doesn't look right to me. It takes a layer of stress off when you are not the final stopping point. (UJ:14-1).

Coordinated group efforts also enhance the ability to mount a counter attack to threats.

This type of group effect can be seen with the coordinated efforts of in-hospital emergency response teams. The support that team members provide to each other is not static but is dynamic effort dependent on the relationships between the group members. If relationships between the group members are fragile or if there is some perceived counterproductive behaviors or questions about the care provided to the patients the pack may not afford protection or security. The alliance can be broken.

Protective function to in-groups? Hmm...I think it's all in how much self-brainwashing they want to do. How much they believe that they are part of the group, they're part of the pack. It depends on how much they want to convince themselves that they are part of that group but...(trails off)

TM: But, maybe they're not? Is that what you're saying?

Yes, I think in reality they're not. You can be singled out easily. Especially if a situation arises, they will get singled out. (AH:14-2,3)

If the nurse is perceived as an unreliable care provider, the group may use horizontal violence tactics to convince the target nurse to leave, or "run them out.

Because if the other nurses didn't like me, then...

TM: They'd run you off?

Yes. (EC:7-4)

QM described these behaviors as an attempt to maintain patient care standards and group integrity.

Not everything about that process (clique) is a bad thing. Because a lot of (nursing) is a lot of intensive watching. Okay? But when intervention needs to happen, it needs to happen right away. And I need to know that you are going to do for your patient what I would do for my patient. Because you make the entire (unit) look bad if you're not doing...if you're not doing that intervention quickly and accurately then you bring disdain upon the entire (unit) and we won't tolerate that.

TM: And we can convince you to leave?

They...in overt and non-overt ways it could be...it will be done. (QM:15-1,2)

“Non-overt ways” can include isolation and the failure to share information. “Overt” methods can include any number of hostile or aggressive behaviors.

TM: How do they manipulate them out?

They treat them with such hostility they don't want to work here anymore. (VZ:8-1)

After a nurse made what was the group considered a patient care error, she was the target of horizontal violence until she decided to leave the unit.

And they rode her until she finally just resigned.

TM: The rode her...what does that mean?

They gave her bad assignments. They gave her real hard assignments. When it came time to bathing and changing sheets, nobody would go and help her. They made her do it by herself or wait or she would be the last person that got help to change the bed and change everything on the patient because they said that she didn't belong up there. (KM:6-1)

How does this look from outside the alliance? Determining the intent of another person's behavior is difficult. However, repeated aggressive or isolating behaviors would most certainly be perceived as hostile by the recipient (Einarsen, 1999).

TM: So the group may look predatory but...  
They do look predatory. Not may. They are like vultures. (YE:13-7)

TM: ...what if they decide that I'm not a very good nurse?  
Well, then you're in trouble probably.

TM: I'm in trouble?  
Maybe so. (FF:13-2)

The negative side of alliances is protection of group members who themselves may be violating the group's informal care standards. In these cases, the group overlooks violations committed by alliance members while at the same time sanctioning non-group members for the same behaviors. KM describes group members covering for each other when they were late and allowing for extended lunch breaks, a privilege not extended to those outside of the group.

...you were either in the clique or out of the clique and if were in the clique you could go to lunch...take an hour, hour and half for lunch. Nobody cared. But if you weren't in the clique they made sure that you only got the lunch that you were required to get and they weren't going to...if you came back late then they made sure to report you.  
(KM:8-4)

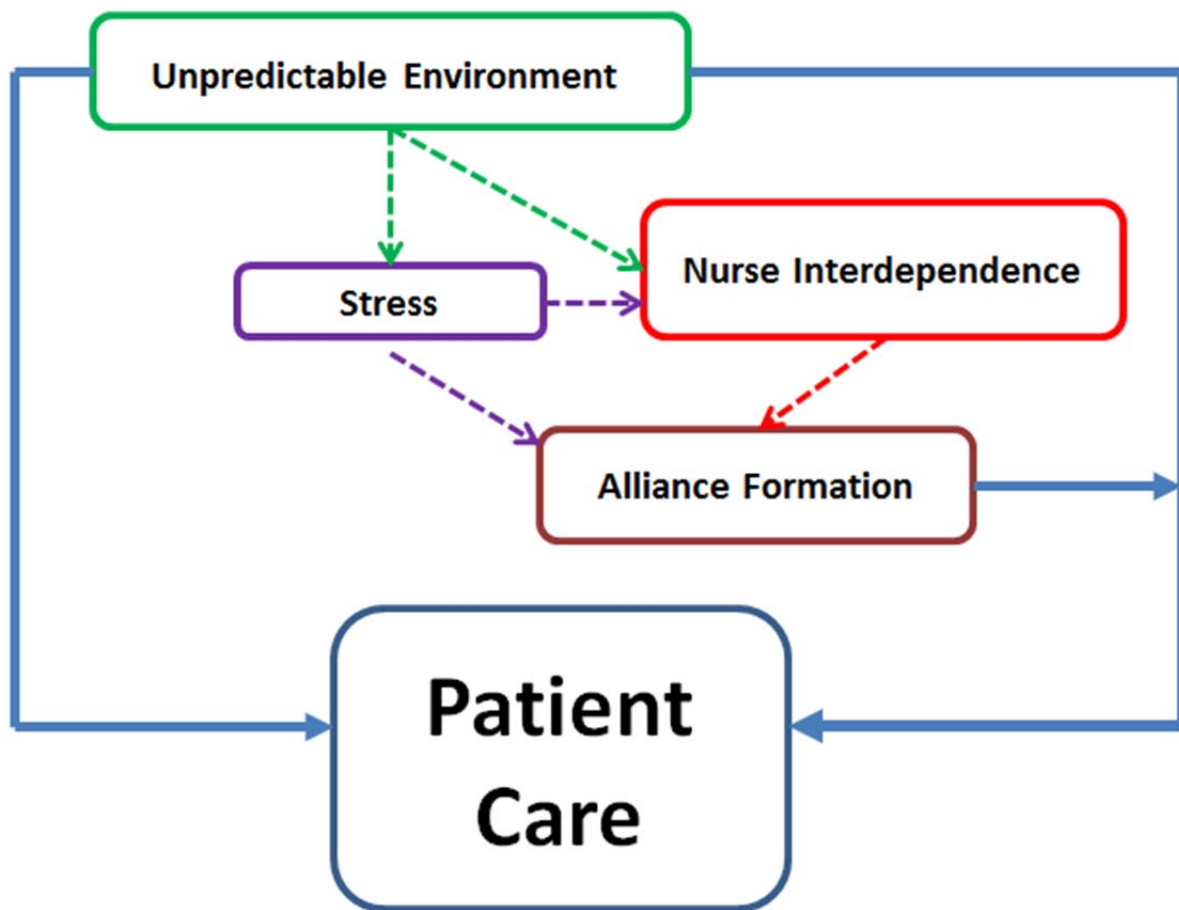
PW noted that complaints about a nurse may be valid but also said that the same behaviors were tolerated in other nurses on the unit who were part of the established alliance.

"Okay, we have complaints about the person and they are valid but you also have complaints against such and such person or should have complaints because I have noticed the same behavior." (PW:10-5)

Although the alliance members may protect each other, legally and ethically the nurse's primary allegiance is to the patient. The registered nurse is responsible and accountable for the provision of care. Violations of care standards can result in disciplinary sanctions up to and including revocation of license. Because of the complexity of hospital care, nurses who practice in hospitals are at highest risk for being involved in patient care errors (Thomas, 2010).

Maintaining a safe environment and protecting the patient from error involves managing an unpredictable and at times even chaotic environment. Although the patient's nurse is primarily responsible for coordination and direct delivery of care, nurses are dependent upon each other for timely task completion and optimum patient outcomes. Dependable alliances can help mitigate the stress related to an unpredictable environment and improve the quality of care provided to the patient. The relationship between these variables in the nursing work environment are depicted in Figure 3.

Figure 3. Relationship of Environment, Stress, Nurse Interdependence and Alliances to Patient Care.



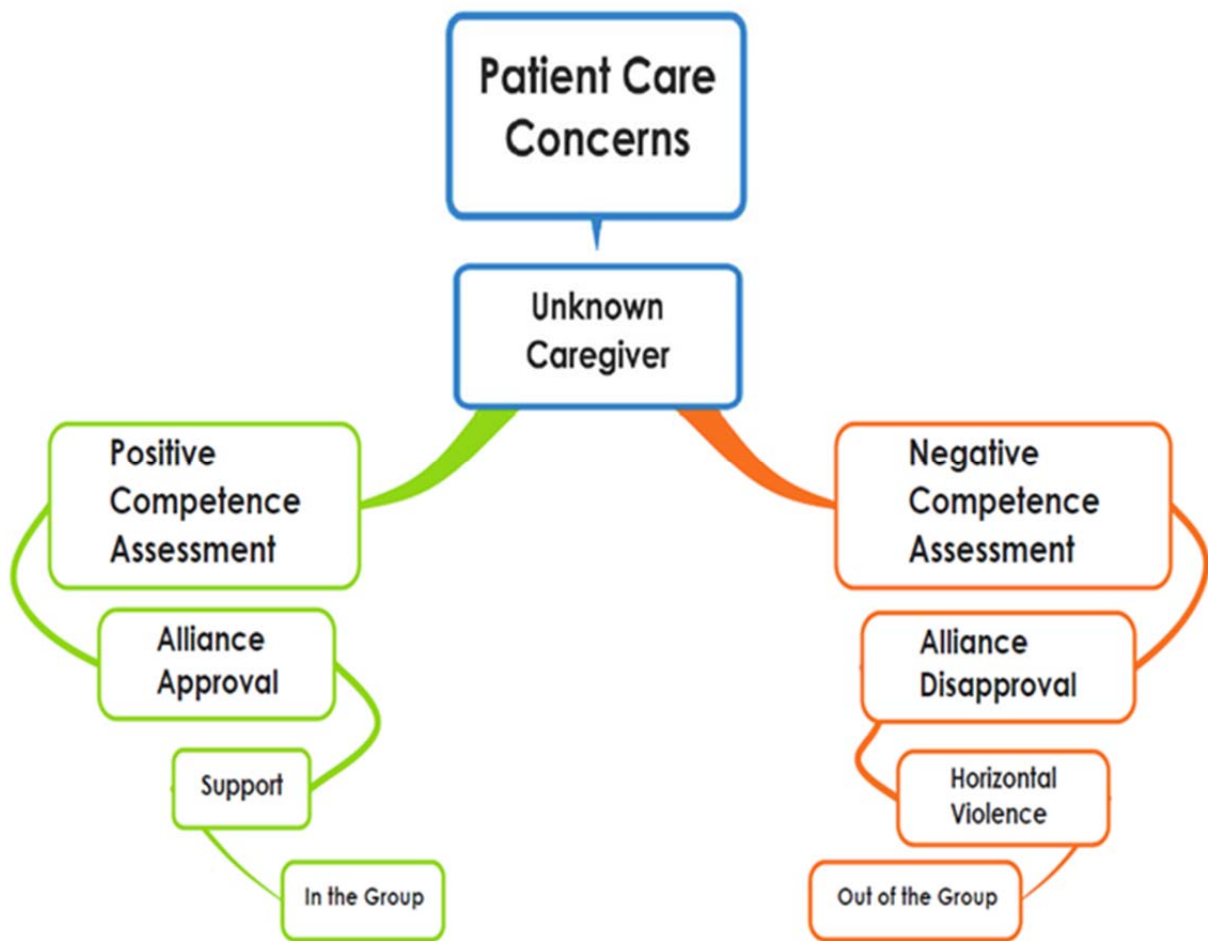
## *Competence Assessments*

...they do talk about them and they do...I guess when people are confused and not organized I think. That's the biggest ones (targets) I think (FF:3-1).

So they are very leery about letting anyone new into pack. ... They can revolve around...they're all safe with each other. They all have about the same knowledge set and they're safe with each other. (BE:6-1)

Evaluation of team member competence has to be made quickly on the patient care unit and at times these evaluations must be made without prior knowledge of the nurse's skill level. Hospital staffing offices attempt to match skill level to patient care area but the unexpected does happen and last minute substitutions sometimes must be made. If an unfamiliar nurse is assigned to a hospital unit, the unit's charge nurse is responsible for making a rapid judgment on competence before making patient care assignments. The individual state boards of nursing and the facility all have professional requirements that nurses must meet if they are to care for patients. The established work group will hold an unknown caregiver not only to the professional requirements but also to any informal group standards. The informal standards may be unspoken and known only to the group members. If the newcomer is judged as competent, he or she is brought into the supportive circle of the group. If the newcomer is judged as not meeting the group standards the nurse can be subjected to group disapproval and various forms of horizontal violence in an attempt to remove the target nurse from the group (see Figure 4)

Figure 4. Competence Assessments – Positive and Negative Assessment Outcomes.



#### *Unknown care provider*

Nurses who will be caring for a unit's patients are identified shortly before the next shift begins. Staffing offices give the names of nurses scheduled for the next shift along with information about any facility based PRN<sup>2</sup> or agency nurses. Facility-based PRN nurses are employed by the hospital and assigned to different units on a shift by shift basis. The term agency nurse refers to a nurse who is employed by an outside nursing agency and is contracted by the hospital on a temporary basis to provide patient care in the facility. The Institute of

<sup>2</sup> PRN is the abbreviation for Latin phrase *pro re nata*. The designation PRN is used to indicate on a as needed or as the circumstances require basis. Hospital based PRN nurses are called into work only when needed to meet patient care needs.

Medicine (2004) reported that use of temporary nursing staff with less knowledge of the patient population and the organization can increase the risk to patient safety. Hospital based staff nurses have reported that using temporary nurses can have a negative effect on continuity and quality of care (Anderson, Maloney, Knight & Jennings, 1996; Bowers, Esmond & Jacobson, 2000). Staff nurses are required to orient, direct and oversee temporary staff which decreases the time available to monitor and care for their own patients (Manias, Aitken, Peerson, Parker & Wong, 2003; Rowland & Rowland, 1997).

Using the information that is provided by the staffing office and little time to make assignments before the shift begins, charge nurses must make competency judgments quickly. The needs and characteristics of the patient must be matched with the nurse's competencies in order to enhance patient care delivery (Alspach, 2006). All nurses are required to have the proper licensing and other relevant credentials. However, even the most competent nurse will be working at a disadvantage when unfamiliar with the hospital, unit, specific patient population and communication structure. This disadvantage has to be compensated for by the hospital staff nurses. Temporary nurses who are unfamiliar to the established team members may be seen as unpredictable or unreliable.

AH has worked for employments agencies that place nurses in temporary assignments throughout the United States. The nurses who fill these temporary assignments are known as travelers and work for organizations called travel agencies. AH worked as a traveling nurse for many years. She described an environment she once encountered as hostile to travel nurses:

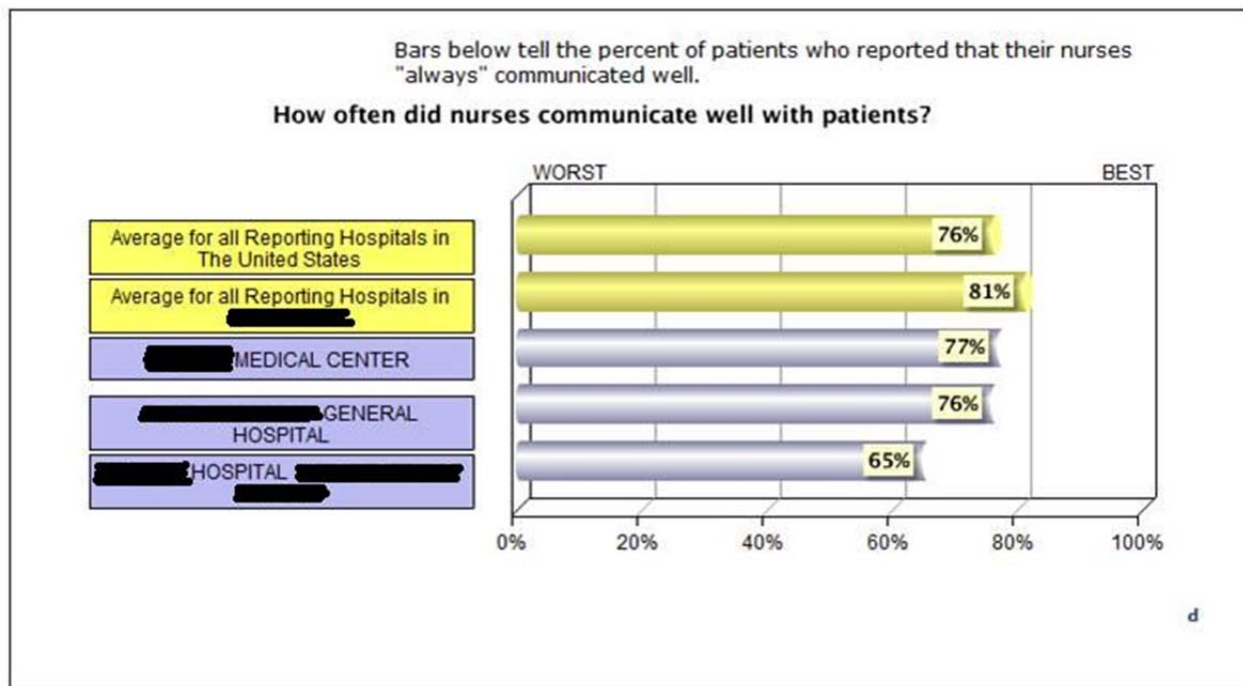
There was one place I worked in (state) they disliked all travelers. They gave us the hardest assignments. They gave us the most patients. I thought, fine, it's a good thing this assignment is only eight weeks long. So I was just busy the whole time I was there and I worked hard. (AH:5-1)

AH describes this work environment as one in which she believed the established work group had a bias against “all travelers.” Perpetuation of this bias may be the result of a bandwagon effect in which the group makes decisions solely based on information they receive from other members of the group. These members accept information offered from one another and “hop on the bandwagon” without personally considering any other available evidence. The longer the bandwagon continues, the stronger the effect on the group members (Bikhchandani, Hirshleifer & Welch, 1992). Although counterproductive at times, there is an economy in this decision process. Whoever the unknown nurse may be, the group has already decided that they “dislike all travelers” and no further time or effort is needed to assess the individual. The unknown nurse is automatically an outsider and normal considerations related to workloads or group inclusions do not apply.

Staff mistrust of unknown caregivers and bandwagon bias against temporary nurses may not be completely unfounded. Research has found that hospitals with higher percentages of temporary nurses have higher 30 day patient mortality rates (Estabrooks, Midodzi, Cummings, Ricker & Giovannetti, 2005), higher numbers of hospital acquired line infections (Alonso-Echanove, et al, 2003), increased risk of patient falls (Bae, Mark & Fried, 2010), low patient satisfaction and increased patient complaints (Hurst & Smith, 2011). These quality indicators are published within the hospital and many of these scores are also available to the public from the Centers for Medicare and Medicaid (CMS), the Agency for Research in Healthcare Quality (ARHQ) and other government agencies. An example of a publicly available quality report from CMS is presented in Figure 5.



Figure 5. Quality of Nurse Communication with Patients (July 2009 through June 2010)



Source: US Department of Health and Human Services (2011). ([www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov))

Published quality indicators are posted and discussed within, and if publically available, outside of the hospital. Reputations are earned or damaged based on these scores. Most nurses pride themselves on the quality of care they give to their patients. With outcome, readmission and mortality rates accessible to any interested party within the organization and to the public, there is little tolerance for those who are judged as unreliable caregivers and may damage the reputation of the unit and the nurses who work there.

#### *Unreliable care provider*

Perceived counterproductive behaviors or questions about the level of care provided to the patients may negatively affect the opinion of the group members towards a target nurse. Research indicates that fears of questionable care practices are not uncommon. In the 2010 "Silent Treatment" study, 82% of nurse respondents ( $n = 6,628$ ) reported that they believed

incompetence was common and that this incompetence had resulted in near misses or actual harm to patients (Maxfield, Grenny, Lavandero, & Groah, 2010). It is important to note that the assessment of incompetence may be based only on perception rather than defined criteria or outcomes. A nurse identified as incompetent may only be uncomfortable in an unfamiliar setting. It is difficult to tell the difference (LaDuke, 2000). However the group arrives at their assessment of competence, if they believe that the nurse will or may make it difficult to successfully accomplish their tasks they may classify that nurse as a threat to the patient care and to the group. Perceived threats to patient care and group integrity may be met with hostile behaviors (horizontal violence) intended to remove the unreliable caregiver.

The group can be harsh in their judgments when they believe they are acting as patient advocates. They believe that their judgments and actions are legitimate and warranted when the issue is patient care.

Well, I have this mentality that you are going to take care of the patient. ... Or you are not going to work here. (NP:5-2)

(When asked if a nurse could get "run off" by the group) Definitely. Oh, that's a definite. ... If you are a good nurse and you do your job you can kind of get in on them. But, if you're lazy and don't want to work they sometimes, you don't fit in with the group. (BE:8-4)

Part of it is that every nurse in every hospital worries about a bad nurse. A nurse who is going to make that mistake that is going to hurt a patient. So they are always prodding. Especially new people who they don't know if they can trust or whatever. To know if they are going to be safe or not. (QM:10-4)

I think when a new nurse comes in, she's automatically on trial. ... I think that can be interpreted by a new nurse as threatening and, not so much a learning experience as a personal attack. I would think. (AB:4-1)

You have to prove yourself. I think if you prove that you're a good nurse. I think by doing your work. I don't think you have to go around telling people, I have these credentials and I've done this and I've done that. I think your work is going to show. (EC:3-5)

The American Nurses Association's (ANA) Code of Ethics states that when the nurse is, "aware of inappropriate or questionable practice in the provision or denial of healthcare, concern should be expressed to the person carrying out the questionable practice" (ANA, 2001, p. 7). The code does not provide guidance on how these concerns about questionable practices should be expressed. While this may seem an oversight, the vigor with which a questionable practice would be addressed would depend, in large part, on the immediacy of real or potential harm inherent in the questionable action. The ANA also suggests that reporting incompetent practice should go through official channels. Having the obligation and responsibility of monitoring colleagues for "questionable practices" adds to the complexity of hospital nursing practice. KM echoed the Code of Ethics for Nurses published by the American Nurses Association (2001) when she said when nurses think another nurse is "out of line" they are obligated to "tell them" (KM:4-3). Unknown or unreliable coworkers increase the demand for constant vigilance which can increase the perception of stress in the other nurses.

### *Stress*

The hospital can be a stressful and at times chaotic environment. Stress levels are associated with the individual's perception of the demands being made on them as well as their ability to meet those demands. Nursing care of hospitalized patients provides a wide range of stressors including working with unfamiliar nurses in a variety of situations. There is a degree of uncertainty in most situations and this is particularly so when caring for hospitalized patients. Stress in the nursing work environment has been discussed in the literature for years.

Nursing is hard work. The hours are long and physically demanding. Nurses are required to manage the complex technology required to treat a wide range of illnesses and injury. Nurses are also vulnerable to human suffering and loss. Organizational changes associated with cost containment strategies can result in staffing cuts, heavier workloads and turbulence in the work environment (Jennings, 2008). Non-supportive relationships with nursing colleagues add to the stress associated with nursing work (Azoulay, et al., 2009; Breakwell, 1990).

Theoretically, when using grounded theory methodology, the researcher begins a study without preconceived ideas which can influence the study. However, because of my professional and academic experiences I had long considered stress as a trigger for horizontal violence in the nursing workplace. I knew that nurses are educated to help their patients manage the stress of illness and hospitalization and I wondered if they were as well prepared to manage stress on an interpersonal level between themselves. The nurses in this study acknowledged the role that stress may play in the negative interactions between colleagues at work. They believed that stress could increase the risk of negative interactions between nurses. They also believed that stress could increase the intensity of horizontal violence. As the nurses talked about stress in their workplace, the underlying themes revolved around patient care, uncertain environments and fatigue. In the table that follows, their voices can be heard in transcript excerpts as the nurses discuss some of their concerns associated with stress (see Table 8).

Table 8

*Participant Reflections on the Effects of Stress in the Work Environment*

Participant (page-paragraph)	Statement	Codes
AB (7-1)	Plus all the other things that tap dance on you. Family members, administration, ah...lack of sleep, whatever. Stressors. Personal stressors outside of the workplace. That's (horizontal violence) just like one more interference with patient care, I think.	<ul style="list-style-type: none"> <li>• Fatigue</li> <li>• Patient outcomes</li> <li>• Personal concerns</li> </ul>
AH (9-1)	(on the role stress plays in negative nurse-to-nurse interaction) It plays a big role. You know that when you have a challenging patient in the (unit) setting, and your co-worker helps you, it helps to relieve your stress. But when you are both getting assaulted by all of these demands and you feel that you're an inch tall with this mountain of demands and everybody making demands on you. If you are not able to prioritize, you might as well just go home.	<ul style="list-style-type: none"> <li>• Uncertainty</li> <li>• Patient outcomes</li> </ul>
LA (8-3)	Sometimes people can be rude to you because of the stress...the stress is not directed at you but they are already on alert, I call it already on alert. Anything, they will snap at anything.	<ul style="list-style-type: none"> <li>• Stress as trigger for behavior</li> </ul>
NP (1-2)	I think what makes you do these things is the fact that you work under stress. In the (unit), it is stress...all the time stress. I worked at a big, the (type of) hospital so that when you got these patients in, they were sick, they were emergencies.	<ul style="list-style-type: none"> <li>• Patient outcomes</li> <li>• Uncertainty</li> </ul>
PW (12-3)	You are also dealing with life threatening things. It is a stressful environment which makes everything worse. ... But we are dealing with people lives.	<ul style="list-style-type: none"> <li>• Uncertainty</li> <li>• Patient outcomes</li> </ul>
SD (12-4)	Every day is different. You never know what the day will hold. Who called in or you get extra patients or admissions.	<ul style="list-style-type: none"> <li>• Uncertainty</li> <li>• Patient outcomes</li> </ul>

Table 8. *Continued*

Participant (page-paragraph)	Statement	Codes
TT (16-2)	What happens when you are sleep deprived? Sleep deprivation and add stress on top of that and all you have to add is a little bit of a fuse to it and you're going to blow up.	<ul style="list-style-type: none"> <li>• Fatigue</li> </ul>
WM (4-10)	I think stress plays a big part in it. A big part. My job is very stressful and I can do it two or three days a week. But I think for those girls sitting there every day ... with that stress...I don't know, maybe I'd be lashing out too. Maybe I'd be lashing out at somebody, too.	<ul style="list-style-type: none"> <li>• Stress as trigger for behavior</li> </ul>
YE (11-2)	(on what part stress plays in negative nurse-to-nurse interaction) Oh, I'm sure a lot. But you want to do the right things. ... Sometimes they have to leave off stuff because they can't do it in their 12 hours. So they leave off stuff that's important and then they probably have some guilt about that. But I think the stress of it all plays, oh...I don't know...I think it depends upon the people. It is very stressful.	<ul style="list-style-type: none"> <li>• Patient outcomes</li> </ul>

Although the participants recognized that stress can be a negative influence on interpersonal interactions, no one said that they believed stress was the primary driving factor behind horizontal violence. “Lashing out” (WM:4-10) or a “blow up” (TT:16-2) is not the same concept as purposefully excluding and isolating a target nurse over time with the intent of removing them from the work group.

### *Oppression*

I think it's their sense of power, you know, towards other nursing staff. Because in a hospital setting, as a staff nurse you really don't have a lot of power. (AH:7-3)

It's oppression because we're women, not necessarily the nurse but being a woman and the human response to stress and acting out. (TT:16-1)

I could not ignore the long standing theory in the literature used to explain horizontal violence in the nursing workplace. As noted earlier, the theory that horizontal violence is a manifestation of oppressed groups has been recognized as an important explanation for negative nurse-to-nurse interactions. Researchers have analyzed nurses' discussion of horizontal violence and attributed their statements to oppression (Hedin, 1986; Roberts, 1983). I held a bias against this theory because I, personally, did not feel like an oppressed nurse. I had to remind myself that oppressed people are often unaware of their own oppression and perhaps this unawareness was why I did not feel oppressed. I offered the theory to my participants and asked them what they thought of oppression as an explanation for horizontal violence in the workplace. My bias led me to expect them to dismiss the theory.

Instead of dismissal, each participant appeared to carefully consider the theory before commenting. It is common knowledge that what people hear is at times different from what is actually said, but this was the first time I was so personally aware of this phenomenon. While I recognized the nurses did not dismiss the idea completely, what I thought I heard during the interviews was disagreement with the oppressed group behavior theory. As I began coding the interview transcripts, I realized that what I thought I had heard during the interviews had been influenced by my bias against this long held theory behind horizontal violence in the nursing workplace. What I read as I began coding and analysis of the interview transcripts was different.

Oppression and its effect on the nursing profession were introduced in the literature by Roberts in 1983. Horizontal violence in the nursing workplace has been described as the result of oppression and the effects of subjugation (Group & Roberts, 2001; Melosh, 1982; Street,

1992). The theoretical concept of nursing as an oppressed group is related to the teachings of Freire (2007) who described the consequences of exploitation of one group by another more powerful group. Freire's profile of an oppressed group includes assimilation, marginalization, low self-esteem and horizontal violence as a manifestation of group oppression (2007). Although, as previously stated, I held a negative view of oppressed group theory as applied to nursing, I could not dismiss what I read as an undercurrent of oppressed group sentiment in some of the participants' stories.

### *Assimilation*

With assimilation the values or rules of the powerful group are internalized by the oppressed while the oppressed group's own values are rejected. The oppressed members attempt to assimilate into the powerful group by adopting the values and rules of the powerful. Assimilation is an attempt to look and behave like a member of the dominant group. The powerful group's culture and values are respected and internalized as oppressed group members come to devalue their own identity. In the excerpt that follows, skill level and autonomy appear to hold higher status than the caring aspect of nursing practice.

Med-surg nurses...I don't want to use the term more compassionate because that's not really that it is...it's just a different breed than your ICU nurse (BE:1-1).

TM: A different breed.

A different breed. Your ICU nurse is, I have critical patients, I'm matter of fact, I know what I'm doing, move out of my way and it's going to get done. Your floor nurses are more like, let me stroke your hand, let me make sure your bath water is good. They are the more touchy-feely (BE:1-2).

The ICU nurse description that "I have critical patients, I'm matter of fact, I know what I'm doing" is compared to the "touchy-feely" floor nurse who is concerned with bath water



temperatures and hand stroking. Even within nursing itself there are hierarchical divisions between different nursing specialties (e.g., medical-surgical, critical care, emergency, obstetrics).

But when you are over in the (other unit), those nurses want nothing to do with you. They really don't know much about (critical patients) anyway because that's a different critter. So you are kind of over there all by yourself. No back-up. (UJ:2-1).

Other nurses, who are in a different area of nursing, do not provide “back up” and “they really don’t know much about (critical patients).” When UJ was talking about having to work in an area outside of the home unit, the discussion was focused on patient care and how difficult it was to practice in an unfamiliar environment. During the interview, my interpretation of UJ’s concerns was for the ability to provide safe care to a patient without the support and familiarity of the home unit. When the statement was analyzed during initial and subsequent coding of the interview, I recognized the sentiment from my own patient care experience. Although specializing in different patient care areas increases proficiency and expertise in that particular area, in a hospital environment there are very few, if any, nurses who “don’t know much” about critical or any other type of patient. Intergroup rivalry and lack of unity are characteristic of oppressed groups (Roberts, Demarco & Griffin, 2009).

But, seeing how the great majority of my experience is in (critical care units), ah, I find that those....usually those very forceful personalities gravitate towards those positions. Most of those forceful personalities want to know...they see themselves as tough. Able to take it. Able to, no matter what, they can do it. (QM:3-2).

“Tough” and “able to take it” are interesting descriptors for nurses who are part of a profession that holds caring as a core value. QM continued to explain that these “tough” nurses had little respect for any nurse who did not feel as “tough” as they felt. Both of these ideas could be interpreted as devaluation of the caring aspect of nursing practice.

There are those who do demean the floor people even though the floor people have no control and they have six patients (FF:1-2).

“Floor people” refers to nurses caring for patients on a medical or surgical floor rather than a specialty unit. Their patients are considered stable enough to not need intensive monitoring but are not stable enough to be discharged. What image does a lack of control portray? Who has control if the “floor people” do not? This statement seems to imply that control of floor nurses lies with other than nursing professionals and that they are subordinate to those who hold more power in the hospital hierarchy.

### *Marginalization*

Oppressed group members who are able to successfully assimilate into the powerful group find themselves marginalized. Marginalization results from the oppressed no longer feeling part of their own group while knowing that they will never truly belong to the powerful group. However privileged in the hospital hierarchy, they retain some characteristics of the oppressed group and therefore cannot fully belong to the group in power (Freire, 2007; Matheson & Bobay, 2007; Street, 1992). They remain on the fringes of both groups.

I’ve done the job for (number of) years but yet still there’s sometimes it’s like I’m invisible (LA:13-1).

But I am saying that we are trying to hold ourselves to a level that we are not at. And so everybody sees us as the handmaiden. Getting the doctor's coffee. Getting up and letting the doctor have the chair. Time has moved on but we are stuck right here. (PW:6-1)

### *Low self esteem*

Low self-esteem is the result of rejecting one’s own values and attempting to replace them with the values of the powerful. It can be difficult to maintain a sense of professional pride in an identity that is not valued by those seen as leaders of the hospital. Nurses, being a

majority female profession, can be devalued socially as women and professionally as nurses as they live and practice in a patriarchal system (Group & Roberts, 2001; Melosh, 1982; Street, 1992; Witz, 1992). WM did not think that these negative interactions were related to oppression of nurses, but that women had these difficulties when working together. WM believed that men working together were more independent than women and “didn’t need to have a friend” to function at work. This was suggestive of group esteem issues and internalized sexism.

I don’t know that it’s nurses. I just think it’s women trying to work together.

TM: You think so? Do you think men act like this when they work together?

I don’t know. No. No. Men are more independent...on their own. They don’t need the camaraderie that the girls need. They don’t need to have a friend like females do.  
(WM: 12-4)

The suggestion of internalized sexism is heard again in the following excerpts:

I think it may be because we are a profession of mostly women and we are used to talking about issues and problems and I don't want to go and say the, well, the stereotypical, we are women so we are going to treat each other... we are all emotional creatures and we are going to treat each other this way. That's what women do. We are mean to each other. (PW:11-2)

Ah...I don’t think nurses are an oppressed group.

TM: You don’t think nurses are an oppressed group?

No.

I think nurses are, a lot of times, their own worst enemies. Nurses are such whiners. They whine about everything. (BE:13-2)

### *Submissive behaviors*

So I think that maybe sometimes they get into that position where they don't think for themselves. They expect to just give data to the physician and wait for them to feed back what they want (SD:3-1).

YE described an incident in which she was threatened with physical violence after requesting assistance from co-worker on a different floor. Although one nurse threatening to physically harm another nurse at work is clearly inappropriate behavior, BE was still fearful that hospital leadership would blame her for the incident. Oppressed group members are often fearful of confrontation with the dominant group (Dunn, 2003).

TM: That is a very traumatic experience.

It was. It scared me out of my mind. I was okay when I knew that the (hospital leadership) backed me up. I was afraid before then thinking they might think I did something or whatever (YE:5-2).

One nurse spoke of how “everybody’s afraid” (VZ: 16-2) of powerful medical organizations and their ability to use punitive tactics against negative publicity although no specific examples of punitive behaviors were offered during the interview. The voice of oppression coming through these narratives does not contradict the theory that these disruptive behaviors, categorized as horizontal violence, may be employed as a method of manipulating the care environment in an effort to enhance patient outcomes while maintaining group or individual perception of security through a sense of environmental control. However, long standing and unrecognized oppression may be a contextual influence on an almost cultural acceptance of horizontal violence between nurse colleagues.

### *Horizontal Violence*

(The silent treatment) Oh yes. I've done it. I'm doing it at work. I just don't talk to (them) or I talk to them as little as I possibly can because they need to get a grip (AH:6-1).

The interview excerpts from each participant presented in the introductory sections represent evidence of horizontal violence in the workplace. Although horizontal violence includes a wide variety of complicated behaviors, all participants had witnessed or personally experienced horizontal violence during their years of nursing practice. This was part of my inclusion criteria so it was expected that they would each have experience with the phenomenon. What I did not expect was the range of behaviors that the nurses would report. Behaviors ranged from inflexibility, isolation of target nurses, hostile and aggressive behaviors up to and including threats of physical violence.

### *Perpetrators and targets*

The nurses in this sample described witnessing acts of horizontal violence. Most believed that these events were either not reported to management or not adequately addressed by management when the events were reported. Some participants described being the target of hostile behaviors. Others described participating in negative interactions between nurse colleagues. Describing the experience of being a target nurse was more emotional than describing witnessing or participating in horizontal violence towards another nurse. Stories related to being a target nurse were described almost in the present tense even when the event had occurred many years earlier. More than one participant was close to tears while talking about feeling alone and isolated by an established staff nurse or group of nurses at work. In contrast, stories related to being the perpetrators were told in a calm and

unemotional manner. Listening to their stories, it was clear that some of these nurses were very aware of what they were doing when they targeted another nurse to be “run out” of the patient care unit.

Workplace bullies are described in the literature as socially incompetent with unstable self-esteem (Zapf & Einarsen, 2003), confrontational, aggressive, impulsive and moody (Seigne, Coyne, Randall & Parker, 2007) or, at the extreme end, sadistic, psychopathic and sociopathic (McCarthy, 2000). Although describing behaviors that would be probably be perceived by the target nurse as horizontal violence or bullying, none of the participants described themselves or other perpetrators as other than aggressive. No one said they believed that perpetrators were psychopathic or sociopathic.

#### *Relational aggression*

Relational aggression is a term used to describe bullying behaviors that result in relationship damage through psychological and emotional harm. Behaviors associated with horizontal violence and relational aggression are similar (e.g., gossip intended to damage reputations, social exclusion, isolation). However, relational aggression is not limited to people on the same professional level such as with nurse-to-nurse aggression. Relational aggression occurs in social environments and can be described as “adolescent-like bullying” (Dellasega, 2009, p. 54) that occurs between adults.

It’s like mean girls. It’s the mean girl syndrome. I’m sort of the ringleader and the rest of the girls in the group are going to do as I say because I’m very influential (HB:4-2).

This little clique. Are they going to participate in even a conversation with you or just a couple words? (AH:3-2)

Although the participants described using horizontal violence to enhance the delivery of patient care, evidence of relational aggression also emerged. Patient care concerns may be used to justify horizontal violence although that may not always be explanation for every case. Alliances developed to strengthen workgroup cohesiveness and ease the sense of environmental uncertainty may also serve as shelter for relational aggression that does not serve to enhance patient care outcomes. VZ described her experience with an established group of nurses who she believed were working together to sabotage her efforts at work.

I mean, they could do the sabotage 24/7 and I couldn't do it and the (nursing leadership) didn't seem interested in helping. So, I got pretty disgusted at that point. ... It was about a year later that ... I just left. (VZ:4-1)

AB talked about nurses she had encountered in her career that were “mean” to other nurses unrelated to patient care concerns.

I’ve also seen some people that just pick out certain people that for some reason they don’t like and they’re mean to them. (AB:1-5)

There are people who are uncivil and disrespectful to others in all work environments. Nursing is no exception although the difficulty in recruiting new nurses to the hospital may increase tolerance for such behaviors.

I think that, I just don’t know why the mean people are in nursing and they are tolerated. I think it’s because there are shortages and they just put up with it. It’s either put up or shut up. (LA:13-1)

#### *Organizational factors*

Hospital administration or unit leadership that tolerates horizontal violence in the workplace by doing nothing to stop the behaviors is seen as passive participants (Bell, 2011; Johnson, 2010). A culture that tolerates horizontal violence, in effect, supports the behavior. Passively supporting an environment with communication and teamwork problems can be a

threat to patient safety. In an effort to control this acknowledged threat to patient care, The Joint Commission (TJC), a hospital accreditation agency, published a leadership standard (TJC,2009) aimed at controlling what was labeled called disruptive behaviors in the workplace. These standards require the organization to define and manage “disruptive and inappropriate behaviors” (TJC, 2009). The organization is responsible for defining which behaviors are disruptive and what steps are to be taken to control the defined behaviors. TJC’s suggested actions focus on education, policy development and accountability and “zero tolerance” for disruptive or intimidating behaviors (TJC, 2008). Although The Joint Commission does not define “zero tolerance,” (TJC, 2008, p. 2) they do offer a recommendation for managing disruptive medical staff with non-adversarial informal “cup of coffee” conversations” (TJC, 2008, p. 2).

The standards for controlling disruptive behavior were initially directed at medical staff. Nurse disruptive behavior has as much influence on the patient care environment and is now included in the requirement to control these negative behaviors at work. The Joint Commission’s initial focus on medical staff may contribute to the participants’ feelings of inadequate organizational follow up on reports of nurse-to-nurse disruptive behaviors. These participants did not believe that policy change alone was effective.

No, I don’t think a policy makes a difference. ... Unless they crack down, unless you have consequences, you're not going to get any change in behavior. You have to have consequences. ... They don’t (have) consequences. They just...the bullies and that sort of thing sometimes get moved on to the...they stay in the system.

TM: Just moved out of the environment?

Yes, to a different one. To bully other people. (FF:9-4)



You can have any policy that you want to whether it's disruptive behavior or progressive discipline policy, if there's no follow through, no one is going to change. If there's no accountability for the way I behave when I act towards another person then I have nothing that's going to prevent me from doing that. (HB:9-2)

KM said that she was not aware of a disruptive behavior (horizontal violence) policy that addressed nursing. Nurses were not considered disruptive but unprofessional.

I think that the hospital doesn't have a policy about disruptive behavior aimed at nursing. Their disruptive behavior policy is aimed at the physicians. They think that the physicians are the only ones that are disruptive. That is what our policy is, for disruptive physician behavior. They don't really have anything...what they call the nurses being disruptive is not being professional. Unprofessional. (KM:17-3)

SD believed the hospital was interested in managing horizontal violence but that the events were underreported by staff members.

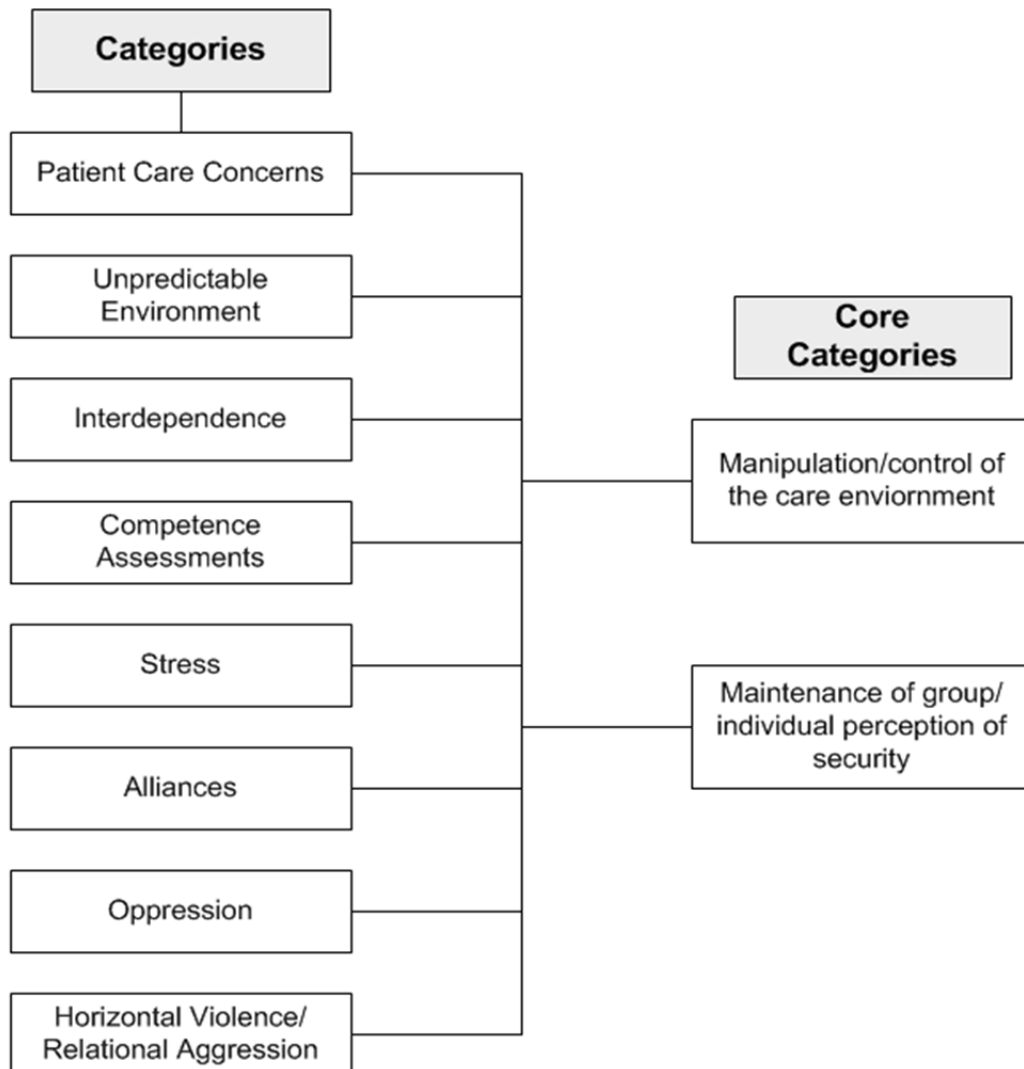
They're trying. They're trying to address it. I think that one of the biggest problems is that it goes on and nobody who should know about it knows about it. (SD:18-1)

Although the hospital may be interested in controlling these behaviors, the roadblocks to efficient reporting and incident management are many. Informal "cup of coffee" discussions can give the impression that nothing is being done. Reporting can be perceived as ineffective in managing negative behaviors if no obvious action is taken. Reports of horizontal violence also need to be in writing in order for action to be taken by administration. This takes time and after a long shift working on a patient care unit, many nurses just want to go home. Retaliation against those who report negative behaviors may also be possible. When there are no clearly defined rules on which behaviors are unacceptable and no standardized follow up to reports from hospital staff, the behaviors are able to continue..

### *Emergence of Core Categories and Theory*

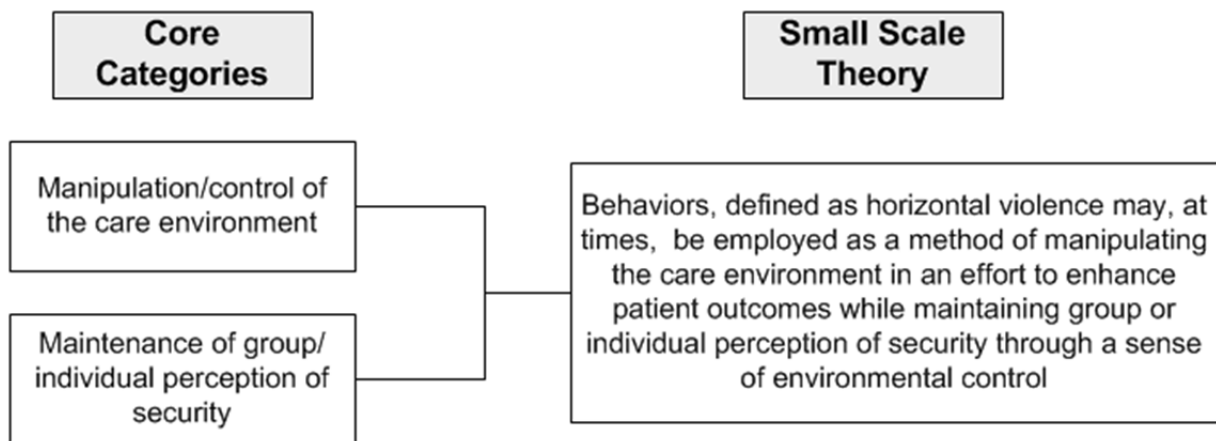
The participants in this study had all witnessed or experienced horizontal violence in the nursing workplace. Some participants openly discussed their participation as passive or active perpetrators of negative behaviors between nurses at work. Sometimes these behaviors were dismissed as just “being mean.” Their transcripts were coded and from these codes, the categories emerged. Through the process of constant comparison of the data as interviews were conducted and transcribed, the core categories that emerged are depicted in Figure 6.

Figure 6. Emergence of Core Categories from Categories



From the core categories, a small scale theory emerged focused specifically on the central phenomenon of horizontal violence in the nursing work environment. The process of theory emergence from the core categories is depicted in Figure 7.

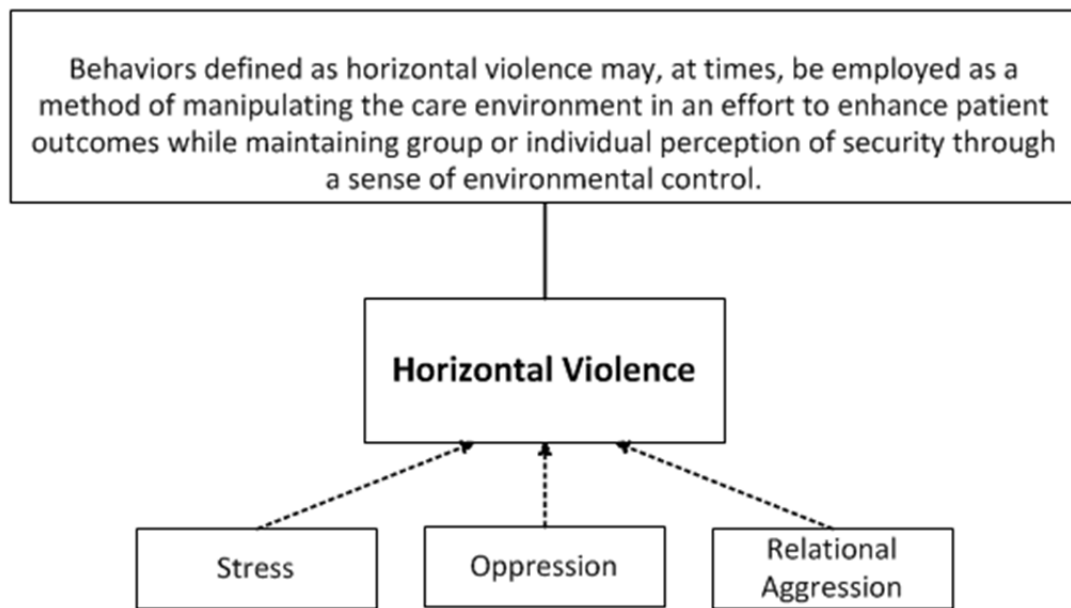
Figure 7. Emergence of Theory from Core Categories



#### *Theoretical, Environmental and Contextual Influences*

Three environmental and contextual influences emerged from this data that may also have an effect on negative nurse-to-nurse interactions in the workplace. Because horizontal violence is a multi-dimensional phenomenon that occurs between nurses in a complex and changing environment, it is appropriate to consider these contextual and environmental influences (see Figure 8).

Figure 8. Theoretical, Contextual and Environmental Influences on Horizontal Violence in the Nursing Work Environment



### *Stress*

The majority of participants in this study believed that stress can have a negative influence on interpersonal interactions between nurses at work. One participant described her stressed coworkers as being “already on alert” and that in that stressed state “they will snap at anything” (LA;8-3). None of the participants said that stress was the primary motivation for horizontal violence. The purposeful and deliberate actions to exclude and isolate a target nurse with the intent of removing him or her from the work group is not the same concept as “lashing out” (WM:4-10) or a “blow up” (TT:16-2). However, the participants recognized that stress can be a negative influence making “everything worse” (PW:12-3).

### *Relational aggression*

Relational aggression can influence a nurse's choice of behaviors used to react to uncertain and unexpected occurrences in the work place if these negative behaviors are part of the workplace culture. Although the participants described using horizontal violence to enhance the delivery of patient care, evidence of relational aggression also emerged. Alliances may be used as shelter for relational aggression that does not serve to stabilize the environment. Sheltered behaviors may become first line reactions to normal frustrations in the workplace rather than these behaviors being reserved for environmental control.

### *Oppression*

The participants made statements that reflected contextual influence from oppression such as valuing technical skill over caring and believing that nurses were their own worst enemies. It is possible that the level of horizontal violence between nurses may be influenced by the historical context of social oppression. None of the nurses said that they thought that horizontal violence was related to oppression by the medical profession. QM stated that rather than causing dissension between nurses, friction with physicians, if it exists, may strengthen nursing alliances.

I don't think that doctors have that big of an impact on nursing whatsoever. So, no, I don't think doctors have anything to do with the attitudes of nurses. If anything, doctors give nurses a common enemy and unite us. (QM:19-4,6)

Tension between organized medicine and nurses was not evident in this data. Some participants described tension between administration and the hospital's nurses. However, this tension would be focused on hospital administrators rather than directed towards other nurses.

## Summary

The nurses in this study all recognized horizontal violence in their work experiences. Some had witnessed these negative behaviors between other nurses while some participants had been the target nurse. Some of the nurses also discussed being the perpetrator. The nurses who described being perpetrators felt that they were acting as patient advocates when using negative behaviors to “run out” a nurse they judged as unreliable or not meeting formal or informal care standards. None of the perpetrators described their behaviors as bullying.

The main concern of the nurses in this study was caring for their patients. They recognized that they provided this care in an unpredictable environment. Alliances are formed to decrease perceptions of uncertainty and increase feelings of control over outcomes. A perceived barrier or threat to providing patient care may be met with efforts aimed at removal of the threat through established hospital channels or informal group sanctions. Informal group sanctions can range from isolation of the target nurse to overt hostility. These actions are intended to remove the target nurse from the work group. Target nurse removal is intended to stabilize the patient care environment and maintain group integrity. As one participant explained, these hostile actions are sometimes necessary to “get my job done” (NP:8-3). Study participants agreed that the target nurse would see the hostile behaviors as horizontal violence rather than a form patient advocacy.

## **CHAPTER FIVE**

### **DISCUSSION**

The problem with denial (of horizontal violence) is it's like closing a dirty wound. You are just hiding the problem. It's going to fester and eventually it's going to burst through and there's going to be problems. (UJ:17-2)

#### **Introduction**

This grounded theory study sought to understand horizontal violence through the stories of nurses who have experienced the phenomenon in their work environments. All of the participants had experienced horizontal violence either as witnesses, targets or perpetrators. The work environments of the participants were familiar to me because of my own experience as a hospital based nurse. The negative behaviors, such as yelling, the silent treatment and failure to provide assistance, described by the participants were also familiar to me. Although the work environments and the behaviors were familiar, these nurses provided a new and unexpected explanation for horizontal violence in the nursing workplace.

The main concern reported by the nurses in this study was caring for their patients. They recognized that they provided this care in an unpredictable environment. Alliances are formed to decrease perceptions of uncertainty and increase feelings of control over patient outcomes. A perceived barrier or threat to providing patient care, including other nurses judged as unreliable, may be met with efforts aimed at removal of the perceived threat from the group. These removal efforts may be through established hospital channels or, if those channels are believed to be ineffective, through informal group sanctions. Informal group sanctions can range from isolation of the target nurse to overt hostility and are intended to remove the target nurse from the work group. The intent of target nurse removal is to stabilize

the patient care environment and maintain group integrity. Although study participants acknowledged that the target nurse would see the hostile behaviors as horizontal violence and not as patient advocacy, one participant explained, these hostile actions are necessary, at times, to “get the job done.”

### Chapter Overview

This chapter will continue with a brief summary of the purpose and main points of the study as have been discussed in the previous chapters. Also included in this chapter will be a discussion of the delimitations and limitations of the study design and implementation. I will present implications of the study findings for nurse educators, hospital leadership and staff nurses. The chapter will conclude with recommendations for further research in the area of horizontal violence in the nursing work environment and a chapter summary.

### Purpose of the Study

Previous studies have identified and documented behaviors defined as horizontal violence in the nursing workplace. Researchers have examined data and ascribe these negative behaviors between nurses at work to oppressed group behavior. These aggressive behaviors include but are not limited to belittling, shouting, accusing, making disparaging remarks to the target nurse directly or to others about the target nurse. Also included in these aggressive behaviors are, facial gestures such as eye rolling and raised eyebrows, withholding information, snide comments, the silent treatment, public criticism, the unnecessarily difficult patient assignment, undermining, in-fighting, scapegoating and bickering. Horizontal violence includes any behaviors that leaves the target nurse feeling isolated, devalued and under attack. These behaviors impair team communication and are a threat to patient care.



When I began this study I was unable to find studies that specifically asked nurses what they believed influenced horizontal violence and provided the participants' own words and explanations. Therefore, this research was undertaken with the intent of allowing the nurse participants to describe and explain this negative phenomenon in their work environment. Oppressed group behavior has been the prevailing framework used to explain these negative nurse-to-nurse interactions for over 30 years without a definitive resolution to the problem. Horizontal violence continues in the workplace in spite of years of discussion and recent attention from regulating agencies.

The prevailing theoretical framework used to understand horizontal violence between nurses in the workplace is the oppressed group behavior model developed by Freire in the 1970s. Freire based his model on behaviors he observed in members of the Brazilian working class whom he believed were dominated and oppressed by the more powerful European privileged class. In Freire's model, oppression is characterized by assimilation, marginalization, self-hatred, low self-esteem, submissive behaviors and horizontal violence. The values of the powerful group (the oppressors) are internalized by the oppressed while the oppressed group's own values are rejected. The oppressed group members attempt to assimilate into the powerful group by adopting the values of the powerful. With successful assimilation of the powerful group's values, the oppressed become marginalized.

Marginalization results from the oppressed being alienated from their own group and kept from becoming a member of the powerful group. They are alienated from both groups. Feelings of marginalization are thought to lead to self-hatred and low self-esteem. Fear of retaliation from the powerful group leads to submissive behaviors. Self-hatred, low self-esteem

and submission lead to anger. Submission and fear prevent the anger from being directed at the powerful group members. The anger is therefore directed towards members of the oppressed's own group in the form of horizontal violence.

In 1983, Roberts proposed that aggression between nurses at work, called horizontal violence, was a product of nursing, as a profession, being oppressed by more powerful groups in the hospital hierarchy. Since Roberts' proposal, researchers have continued to document the incidence of these negative and damaging behaviors between nurses at work. In 2008, the Joint Commission, a hospital accreditation agency, acknowledged the presence of what they term disruptive behaviors and recognized these behaviors as a threat to patient safety. The Joint Commission has required hospital administrations to institute measures in order to control these negative behaviors between patient care providers.

Although oppressed group behavior has provided some understanding of horizontal violence, other environmental factors may also contribute to the phenomenon. Research has documented the incidence of horizontal violence but there is less known about the circumstances that surround these negative behaviors between nurse colleagues in the work place. This study was undertaken in an attempt to understand the circumstances surrounding the behaviors from the nurses' point of view. The evidence indicates that the majority of working nurses will experience horizontal violence in the workplace (e.g., Sofield & Salmond, 2003; Thomas & Burke, 2009; Walrath, et al., 2010). From the stories of the nurses' experiences with horizontal violence, more was learned about the situations in which these negative behaviors occur. A grounded theory approach was chosen as the best means to examine what nurses say contributes to horizontal violence in the workplace.

## Summary of the Methods

Quantitative research has provided a foundation describing the frequencies, trends and relationships associated with horizontal violence in the nursing workplace. There is ample evidence that these negative behaviors occur, are long standing in the workplace and that the behaviors are a threat to patient safety. Researchers have suggested that nursing is an oppressed group and that horizontal violence is a manifestation of their oppressed state. Qualitative methods are well suited to examine phenomenon by hearing from the individuals involved and allowing them to share their stories and reflections. Qualitative research is an appropriate approach to the examination of interactions between people when the interactions are setting and context dependent. A grounded theory approach was chosen for this study in order to examine the circumstances, from the nurse participants' perspective, that are associated with horizontal violence in the workplace. Grounded theory allows for the constructs to arise from the data and is specifically designed to generate, enhance or expand theory from the data rather than using data to verify existing theory.

My goal was to expand understanding of horizontal violence from the nurses' perspective. I chose grounded theory methods to examine this phenomenon in the nursing work environment and found a similarity between the method and how nurses interact with each other. Although each nurse is an individual agent, in the work place, nurses interact with each other as a complex unit to produce certain outcomes. These outcomes are dependent upon interaction between the nurses. Similarly, although each interview represented the experiences of an individual nurse, each interview interacted with the initial and subsequent

interviews through the constant comparison method of analysis until the core categories and theory emerged.

Nurse participants were chosen for this study based on their experience with horizontal violence and their ability to discuss and reflect on those experiences. The initial participants subsequently brought other nurses who had experience with horizontal violence to the second round of interviews. As data was collected and compared to other data using grounded theory's constant comparison method of analysis, other participants were recruited to help answer questions generated from the data. A total of 17 participants were interviewed for this study. Each interview was digitally recorded and transcribed verbatim by me. The transcripts were coded and compared to previous and subsequent transcripts. From the codes, categories emerged which led to the development of two core categories. This process resulted in a small scale theory focused specifically on horizontal violence in the nursing work environment.

### Summary of the Results

The nurses in this study all recognized horizontal violence in their work experiences. Some had witnessed these negative behaviors between other nurses while other participants had been targets. Some of the nurses also discussed being perpetrators and targeting other nurses with aggressive and hostile behaviors. The nurses who described being perpetrators believed that they were acting as patient advocates when using negative behaviors to "run out" a nurse they judged as unreliable. One nurse described the "run out" process as making the environment so hostile that the target nurse would no longer want to work in that particular patient care area. These participants did not believe that behaviors defined as horizontal violence (e.g., isolating behaviors, public criticism) were related to individual personality

characteristics of either the target nurses or perpetrators. One of the nurses, when discussing new nurses as targets of horizontal violence, said that inexperience was an influence on the established group's negative behaviors towards them. This nurse believed that the balance of power is on the side of the experienced and established group members. None of the perpetrators described their behaviors as horizontal violence, bullying or as workplace aggression.

Although the participants did not describe their behaviors as bullying or horizontal violence, evidence of relational aggression emerged from the data. Patient care concerns may, at times, be used to justify horizontal violence even if that may not be the explanation for every case. Alliances developed to strengthen workgroup cohesiveness may also serve as shelter for relational aggression that does not serve to enhance patient care outcomes.

Although the participants made statements that reflected the influence of group oppression, none of the nurses said that they thought that horizontal violence was related to oppression by the medical profession. Tension between organized medicine and nursing was not evident in this data. Tension between physicians and nurses, if it exists, may act to strengthen nursing alliances. Administrative actions and directives were described as sometimes causing resentment but this resentment would be focused on the source rather than displaced onto other nurses.

The behaviors associated with horizontal violence are complex and I believed that a one dimensional concept such as oppression could not explain behaviors occurring between different people in the ever changing environment of hospital nursing. My personal bias was that I believed stress was a trigger for horizontal violence between nurses at work. I did not

recognize at the beginning of this study that my alternative explanation for horizontal violence, stress in the workplace, was as one dimensional as the prevailing theory of oppression. The participants recognized the stress inherent in nursing work but believed that stress was only a part of this complex phenomenon. I had believed that horizontal violence was a product of the environment but did not consider that these behaviors could be a method of maintaining control of factors which, at times, may appear uncontrollable.

Caring for hospitalized patients is a complicated endeavor which requires the nurse to coordinate multiple levels of care across all the patient's required healthcare disciplines. Patient care and hospital systems are increasingly complex. Nurses are also required to manage the necessary documentation and accounting of each patient care intervention and associated patient response. Nurses manage whatever occurs on the patient care unit within very prescribed and regulated time frames. Nurses are dependent upon each other to successfully coordinate and manage the organizational intricacies inherent in hospital care. When demands increase, they can overwhelm the ability of any single nurse to meet those demands. In the interest of their patients nurses rely on one another to provide the care needed for optimum patient outcomes. As the nurses discussed horizontal violence a common theme was their dependence on the other nurses at work to help deliver patient care.

If one or more members of the nursing team are judged as unreliable, patient outcomes and the group's identity as competent patient care providers may be threatened. The established group members may respond with isolating and other hostile behaviors towards the target nurse. Attempting to go through formal organizational channels to report practice related concerns with another nurse was not seen as a satisfactory way to resolve competency

concerns. Nurses who feel a lack of support from hospital leadership may choose instead to manage their perceived issues themselves. Even when formal channels were in place these nurses managed what they perceived as unreliable team members through horizontal violence with the intent of removing the target nurses from the work unit.

The nurses in this study recognized that they practice in an unpredictable environment in which they are frequently dependent upon group efforts for optimal patient care outcomes. These patient care outcomes are measured as well as published within the hospital organization documenting successful as well as less successful patient care units. Patient care outcomes are also available to the public through a variety of websites and publications. These reports are intended to help patients find quality care providers. The quality of patient care can be difficult to measure related to the many factors that influence ultimate outcomes. Some of these factors are not within the caregiver's control such as preexisting conditions or patient compliance with treatment (Hussey, Mattke, Morse & Ridgely, 2007). Even with the problems associated with measuring quality outcomes, the effects of the reports are clear. Better scores can improve professional reputations and lower scores can damage professional reputations. Public access to quality reports can drive hospitals and practitioners to improve their scores by improving outcomes. Maintaining a competent team of care providers is central to optimum patient outcomes.

Nurses provide care in an environment that includes factors that are out of their control including, but not limited to, patient non-compliance, unexpected condition changes in one or more patients, unanticipated admissions, staffing shortages and intermittent malfunction of equipment in the care environment. The participants in this study described workgroup

alliances developed to manage expected and unexpected problems in the patient care unit. The nurses described the positive aspects of working with the support and protection of the alliance when managing environmental threats to the quality of patient care that included nurses judged as unreliable care providers. The group may employ negative behaviors, described as horizontal violence, to manipulate the nurse judged to be unreliable out of the care environment. These behaviors are believed to impose a degree of quality control in a highly dependent and, at times, unpredictable environment. Enhanced patient outcomes maintain group or individual perceptions of security through a sense of environmental control. Better outcomes lead to better quality reporting which keeps the group's identity as competent care providers intact.

#### Delimitations

##### *Location*

My study was based on experienced nurses' perception of horizontal violence in the work environment and what they believed were environmental influences on these negative behaviors. All of my data was from the participants' recollection of past events collected during tape recorded interviews at locations of their choice. I did not observe real time interactions on a hospital nursing unit. Recruiting participants for on-site observations at a hospital was not a practical option for this study. In the hospital environment, there are numerous confidentiality and privacy issues involving patients, staff and the facility. In addition to confidentiality and privacy concerns was the potential for interruption of patient care activities. Researcher



presence and interaction can disrupt the work flow of a patient care unit. The presence of an outsider in the close confines of a patient care unit could have changed how the staff interacted with each other.

### *Sample Size*

Another delimitation of the study was the number of participants. This sample of 17 experienced nurses was not chosen for purposes of representativeness but for their experience with horizontal violence and their ability to reflect on those experiences. This sample of nurses, although small, was able to provide richly detailed data and therefore met the requirements of my study. Since the intent was not to generalize but to obtain details from a specific group of experienced nurses, I believe that this sample of nurses was adequate to provide information not previously obtained about horizontal violence in the nursing work environment.

### *Researcher Influence*

My participants knew that I was a nurse and that I have an insider's knowledge of the practice of nursing. I have also practiced in acute care hospitals and in various specialty units much like my participants. I believe that because of my experiences I was able communicate with the participants as someone who had similar experiences and a common background. I believe that my participants could tell that my interest in their perspectives was genuine and that they could be open with me as I would maintain their confidentiality. I believed that my experiences as a nurse gave me the advantage of common ground with the participants and an insider's perspective of nursing work.

Although I believed that being a nurse was an advantage, I was concerned that the participants, wanting to present themselves in the best light to a colleague, could minimize

their own roles as perpetrators of horizontal violence. However, these nurses spoke in what I perceived as an open manner about being a witness, target or perpetrator involved in horizontal violence between nurses at work. Their responses may have been positively influenced by my role as a nurse colleague with experience and an understanding of hospital nursing culture. I was also aware that their responses may have been influenced in a negative way by my role as a colleague. A participant's internal motivations are not observable and I accepted what they said as their personal truths.

#### Limitations

##### *Data Collection*

Data collected was limited to single interviews due to the time limitations of the participants. Nurses have work and family obligations just like everyone else. Participants agreed to 45 minute interviews and I was careful to stay within this time limit. I promised to keep track of the time so that they could get to their next appointments. One participant met with me at a restaurant during her lunch break. Time was important, however, several participants did agree to continue past the 45 minute time limit and I took advantage of their generosity.

##### *Definitions*

One of the limitations of qualitative work is deciding how the phenomenon of interest is defined. Researchers have defined the behaviors labeled as horizontal violence to include perpetrator intent as well as results of the behaviors from the target nurse's perspective. In this study, I used a definition for horizontal violence that includes any non-physical behaviors that leave the target nurse feeling isolated and attacked. Feelings of isolation and attack are

uniquely defined by each individual and I accepted the feelings of target nurses exactly as what each participant said they were. I also accepted the perpetrators' motivations or intent to be exactly as they explained them.

### *Recall Bias*

Remembering an event from the past involves recalling and reconstructing information from a different point in time. This process involves an interpretation of past events based in current experience and perception and is subject to distortion known as recall bias (Ebner-Priemer, et al., 2006). Because the environment provides more information than can be processed at any one time, people prioritize what information will receive their attention and cognitive resources. In general, negative events are believed to receive more thorough processing, increased attention and deeper reinterpretations (Baumeister, Bratslavsky, Finkenauer & Vohs, 2001). More thorough processing may result in stronger memories of negative events. Stronger memories are easier to recall. Whether the stories were about themselves or others recall bias may have resulted in the participants telling more stories about a target experience than the experiences of perpetrators.

In this study, participants were asked to recall, relate and reflect on their experiences with horizontal violence which, for a target nurse, is usually a negative event. I noted in the results section that participants who talked about their experiences as a target of horizontal violence displayed more emotion than those participants who talked about their experiences as witnesses or perpetrators. Participants displayed strong emotions when talking about being targeted and isolated by the established work group. Although some of the incidents had

occurred years before, participants were able to recall very specific details of what had happened, who had been involved and how they reacted to the incident.

### Implications

#### *Nurse Educators*

The nurses in this study believed that nursing students are frequently the targets of abuse from staff nurses during their clinical experiences in the hospital. Study participants described incidents when nursing students were left in the clinical area on their own without support or guidance from the staff nurses. Students and their instructors are considered visitors in the hospital and, as welcome as they may be, they have little influence on the behavior of hospital staff nurses. One participant described how a nursing instructor worked around conflict by avoiding staff nurses who did not want to work with students or switching assignments if tension between student and staff nurses developed. Students may see that these problems in the clinical setting have to be worked around rather than worked through in order to avoid conflict with staff nurses.

Nurses in this study recognized horizontal violence as a threat to patient safety. However, open conflict between staff nurses and student nurses could also create a threat to the quality of care and should be avoided. The results from this study also indicate that students are exposed to horizontal violence during their clinical experiences in the hospital. Before and after their time in the hospital, the academic environment is an ideal place to teach the skills necessary to respond appropriately to horizontal violence between nurses at work. The safe environment of the classroom can give students an opportunity to discuss the

different behaviors they have witnessed and develop constructive strategies for recognizing and managing these interactions.

The data in this study indicate that in the unpredictable patient care unit, horizontal violence may, at times, be employed as a method of manipulating the care environment and enhancing patient care delivery. Classroom discussion of group behavior under unpredictable conditions could provide students with a deeper understanding of the circumstances that surround horizontal violence. Nursing instructors who have an appreciation of the protective aspects of established nurse groups and sensitivity to the staff nurse's sense of patient advocacy can talk to their students about the phenomenon in the safe classroom environment. Nurse educators and nursing students can practice positive communication methods to manage behavior that may be perceived as a personal attack but, at times, may be intended to protect patient care and the established work group. Teaching student nurses evidence based solutions to the problem of horizontal violence will promote awareness and can provide a knowledge base that will help them to recognize, resolve and perhaps prevent future horizontal violence in their practice setting.

### *Hospital Leadership*

Participants in this study did not see hospital policy as an effective tool without employee accountability and leadership follow-up on reports of disruptive behavior. Although hospitals accredited by The Joint Commission are required to have a policy for managing disruptive behaviors (TJC, 2008), some of the participants were not aware of such a policy at their hospitals. Other nurses who knew of their hospital's policy to control disruptive behaviors

did not believe the policy was not enforced or effective. Whether factual or merely perceptual, a lack of effective policy to control horizontal violence was what the participants believed.

In order to further understand the participants' view of policy, I reviewed five hospital policies<sup>1</sup> targeting disruptive behavior which includes the behaviors associated with horizontal violence. The policies I reviewed attempt to define unacceptable behaviors and outline disciplinary steps that could be taken if reports of disruptive behaviors are determined to be valid. However, the focus of each policy is short term management of the perpetrator without an examination of personal, cultural and environmental influences that may have contributed to the incident. The results of this study indicate that horizontal violence is a pervasive and long standing negative influence in the nursing workplace. Therefore, short term interventions should be considered as the beginning steps in a long term plan to understand and manage this negative phenomenon.

Although some participants in this study did not see self-regulation as mandated by The Joint Commission as particularly effective in controlling horizontal violence, concern on the part of this accrediting agency has given the phenomenon visibility and attention in the hospital. Now that the phenomenon has been recognized and acknowledged, the next step is for hospital leadership to gain an understanding of the personal, cultural and environmental influences that surround these negative behaviors in the nursing workplace. In this study, the evidence indicates that nurses, at times, use horizontal violence to manipulate the care environment in an effort to enhance patient care outcomes. However, the nurses also recognized the historical influence of oppression, the presence of stress and the phenomenon

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<sup>1</sup> The five hospitals are not identified in order to maintain confidentiality.

of relational aggression as contextual and environmental influences on horizontal violence between nurses at work.

The results of the study indicate that nurses may attempt to manage some personnel issues outside of formal hospital administration channels through aggressive behaviors associated with horizontal violence. Although these efforts may be effective over time, this behavior, regardless of intent, distracts the nurses' attention from patient care. This method of managing perceived personal issues is not efficient and is inappropriate for nurses practicing in the clinical environment. In order to develop plans for a secure, safe and healthy environment for all hospital patients and the nurses who care for them, I suggest the following interventions:

- Secure input and participation from staff nurses and other professional disciplines in the hospital to develop a disruptive behavior policy that is relevant and applicable to the work environment.
- Provide disruptive behavior prevention and management training for all staff that includes specific information on unacceptable behaviors, cultural and environmental influences as well as formal hospital channels available to manage disruptive events.
- Develop an immediate response plan providing a timely and appropriate intervention when staff witness or are targeted by unacceptable behavior.
- Encourage nurses and other staff to report incidents of disruptive behavior in a safe environment.
- Institute a debriefing process to provide support after incidents.
- Track and review disruptive behaviors in the workplace to identify circumstances that may be contributing to these behaviors.

Hospital administration's efforts to understand and positively manage horizontal violence in the workplace may translate into a more satisfied nursing workforce and a higher quality of patient care.

One venue for targeting horizontal violence is continuing education programs on developing positive interpersonal interactions skills and relationships in the workplace. Given the time constraints in nurses' work day and off time, a possible solution is to develop short five

to ten minute continuing education presentations given on the unit rather than longer classes that require one or more hours. Horizontal violence between nurses, disruptive behaviors on the part of other clinicians and suggested constructive interventions are all topics that can be presented in this format. The continuing education sample outline that follows can be used in a classroom format or divided into short presentations covering each relevant section and given on the work units, in person or on the hospital network.

### **Creating a cycle of civility and respect in the nursing work environment**

- Welcome
- Creating a safe place for discussion
  - Civility
  - Respect
- What is horizontal violence?
  - Defining the behaviors
  - Discussion of example incidents
- Consequences of horizontal violence
  - Possible threat to the delivery of patient care services
  - May hinder the recruitment and retention of nurses
  - Organizational effects
- Controlling the behaviors
  - State Board of Nursing (if applicable)
  - The Joint Commission
  - Hospital policy and procedures
  - Organizational resources
- Reporting strategies
  - Supervisors and managers
  - Human Resources Department
  - Quality and compliance departments
- Preparation for constructive confrontation
  - Group suggestions for constructive management of incidents
  - Interactive training and practice sessions
- Follow up resources

### *Staff Nurses*

Nurses in this study recognized the presence of stress in their work environment. These nurses also recognized the influence that stress can have on interpersonal relationships



between nurses at work. The participants in this study believed that nurse-to-nurse aggression was sometimes used to eliminate an unreliable care provider from the established work group. They believed that these hostile behaviors could be viewed as a form of patient advocacy. When these behaviors are seen as successful management of environmental threats, the group will use the same tactics again and again which can result in a normalization of horizontal violence in the work group.

Normalization horizontal violence can create a revolving door for new nurses who cannot work their way through the informal group rules and choose to leave for another environment. When the work group does not have enough nurses on the team, the remaining nurses have to work harder with fewer resources. Hostility based enforcement of informal and unspoken group standards may appear to resolve one issue, but these behaviors lead to more problems for the patients and nurses left behind.

Results of this study indicate that, at times, the group may be correct in their assessment of competence and fit. It is possible that a nurse may be better suited to a different patient care area. With so many different areas of nursing practice, it is not reasonable to believe that any nurse is a good fit for every environment. However, in order to obtain the best resolution for the target nurse and for the group, hospital leaders are the best choice to manage this type of situation. Management has the time and resources to work out the best solution for all involved parties. Nurses and patients are both better served when the nurses can focus on patient care instead of personnel issues.

Nurses also need to recognize that the intent of the behaviors associated with horizontal violence may initially be protective, but the end result is dysfunctional and poses a threat to

patient care. Mentoring of new nurses and opening the group to new members will increase the amount of support available to all of the group's nurses. A positive outcome for all interested parties is more likely when hospital leadership and the nurses who provide patient care develop a strong relationship based open communication and trust. Nurses need to believe that their concerns will be appropriately managed in the best interest of the patients.

Horizontal violence has been documented in the nursing work environment for over 30 years. Changing behaviors that have been used and seen as effective short term solutions will take time, patience and perhaps ongoing mediation. Immediate interventions include education of new nurses on horizontal violence in the workplace and interactive instruction on constructive responses to different forms of nurse-to-nurse hostility. Griffin (2004) reported that nurses who received this type of training believed the information and opportunity to practice responding in a safe environment was helpful in dealing with the phenomenon. Although Griffin's sample was small, the study highlights the effectiveness of an education program aimed at raising awareness of the problem and providing staff nurses with tools for positive outcomes. Nurses can be provided education on recognizing the following aspects of horizontal violence:

- Definition of horizontal violence with "real life" examples
- Effects of horizontal violence on patient safety
- Predisposing factors that may contribute to horizontal violence
- Constructive communication techniques
- Staff mentoring and development
- Developing respectful relationships

The results of this study indicate that patient care is the nurse's priority. Mentoring and nurturing new nurses can be seen as an integral component of that patient care. New nurses

have not yet developed the confidence and self-esteem of the more experienced and skilled nurse. Study participants noted that lack of experience and skill leaves the new nurse vulnerable to horizontal violence if they are seen as less capable caregivers. Mentoring new nurses and providing them with a safe environment to learn, develop their skills and confidence ultimately enhances the quality of patient care. Mentoring experienced staff in constructive communication techniques and intervention skills can improve nurse-to-nurse relationships, foster trust and respect between nurses and create a productive and safe patient care environment. Mentoring also contributes to the advancement of the nursing profession through the dissemination of nursing knowledge by fostering high standards of nursing practice and contributing to the welfare of nurses in the workplace.

#### Recommendations for Future Research

Much has been written on the incidence of horizontal violence between nurses. Less is known about what nurses believe influences these behaviors. This study asked experienced nurses what they believed were the circumstances surrounding horizontal violence in the nursing work environment. The participants in this study believed that in the interest of providing patient care, these negative behaviors were an accepted method for managing the care environment and thus maintaining the perception of group integrity. However, these participants were experienced nurses and had been practicing as professional nurses for years. They are nurses who have successfully navigated their way through their respective groups' formal and informal standards and earned the respect and protection afforded to group members. Nurses who practice within the safety of the group could be expected to have a positive view of the effects of horizontal violence towards a nurse labeled as unreliable. Future

research soliciting the views of student nurses, nurse educators and new graduate nurses would add another dimension to our understanding of this phenomenon.

An exploration of organizational characteristics that fosters behavior aimed at protecting the group's interest in maintaining its informal standards would contribute to our understanding of horizontal violence in nursing. Future research can focus on what organizational factors result in an employee or group of employees believing that horizontal violence is an acceptable method of staff control rather than depending on legitimate action from hospital leadership.

### Conclusion

Throughout the more than thirty years that the nursing profession has been discussing horizontal violence no definitive resolution to this recognized problem has emerged. Although the terms used to identify the phenomenon have changed over the years, the underlying problem of nurse-to-nurse hostility and aggression have been a constant in the nursing work environment. Horizontal violence is a complicated phenomenon influenced by complex interpersonal and environmental interactions occurring in a frequently unpredictable environment. Oppression has been proposed as the sole influence driving horizontal violence between nurses in the workplace. The participants in this study did not actively acknowledge oppression as the cause of negative behaviors between nurses. They did, however, make statements during the interviews that can be interpreted within the oppressed group behavior framework as developed by Freire (2007).

Horizontal violence has been described as a product of individual personality characteristics that are amenable to policy mandates as required by The Joint Commission.

However, these behaviors can also be viewed as a product of formal and informal organizational processes which act to trigger and reinforce these ultimately dysfunctional behaviors between nurses. In this study, the main concern of the nurses was caring for their patients. They recognized that they provided this care in an unpredictable environment. Alliances are formed to decrease perceptions of uncertainty and increase feelings of control over patient care outcomes. A perceived barrier or threat to providing patient care may be met with efforts aimed at removal of the threat through established hospital channels or informal group sanctions. When these informal sanctions are successful in removing a perceived threat from the patient care environment, the behaviors are reinforced and a sense of control is maintained.

Professional nurses are required by state board regulations to act as patient advocates. Nurses are subject to human error, and confrontation may, at times, be necessary to avoid care mistakes. However, controlling the patient care environment is not dependent upon hostile behaviors. Care can be part of these necessary nurse-to-nurse interactions in the same way that care is part of nurse-patient interactions. Mentoring and empowering less experienced nurses develops a professional nursing staff able to provide high quality care for their patients today and into the future.

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## APPENDICES



**APPENDIX A**  
**Human Subjects Approval**

**University Committee for the Protection  
of Human Subjects in Research  
University of New Orleans**

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*Campus Correspondence*

Principal Investigator: Ann O'Hanlon  
Co-Investigator: Therese M. Mendez  
Date: September 15, 2010  
Protocol Title: "Horizontal Violence in the Nursing Work Environment:  
Oppressed or Stressed Behaviors"  
IRB#: 03Sept10

The IRB has deemed that the research and procedures are compliant with the University of New Orleans and federal guidelines. The above referenced human subjects protocol has been reviewed and approved using expedited procedures (under 45 CFR 46.116(a) category (7)).

Approval is only valid for one year from the approval date. Any changes to the procedures or protocols must be reviewed and approved by the IRB prior to implementation. Use the IRB number listed on this letter in all future correspondence regarding this proposal.

If an adverse, unforeseen event occurs (e.g., physical, social, or emotional harm), you are required to inform the IRB as soon as possible after the event.

Best wishes on your project!

Sincerely,

Robert D. Laird, Ph.D., Chair  
UNO Committee for the Protection of Human Subjects in Research

## **APPENDIX B**

### **Letter of Consent**



## LETTER OF CONSENT

Dear \_\_\_\_\_:

My name is Therese Mendez. I am a nurse and a graduate student at the University of New Orleans under the direction of Professor Ann O'Hanlon in the Curriculum and Instruction Department in the College of Education and Human Development. I am conducting a research study investigating horizontal violence in the nursing work environment. Horizontal violence has been described as a form of mistreatment, spoken or unspoken, that is threatening, humiliating, disrespectful or accusatory. The behavior is directed towards a nurse peer.

I am requesting your participation, which will involve one to two audio taped interviews of 30 to 45 minutes each. I will also ask you to review the transcripts of your interview to give you an opportunity for additional input. Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, there will be no penalty whatsoever. The results of the research study may be published, but your name or any other identifying information will not be used.

It is possible that the interview may bring up unpleasant memories. You may feel uncomfortable thinking about these experiences. There are no other risks anticipated with participation in this study. Although there may be no direct benefit to you, one possible benefit of your participation is development of interventions to help improve the nursing work environment.

The interviews will be audio recorded using a digital file format. The principal investigator and co-investigator are the only ones who will have reason to hear the recordings. The digital audio files will be kept on a password protected external drive for no longer than three years at which time the files will be erased. No individual will be identified by name or their own initials in the research report. Participants will be identified in the report by a randomly drawn two letter designation.

If you have questions about this research, please contact Dr. Ann O'Hanlon (504-280-3990) at the University of New Orleans, 2000 Lakeshore Drive, New Orleans, LA, 70148. Please contact Dr. Robert Laid, Professor of Psychology and IRB chair at 504-280-5454 or [rlaird@uno.edu](mailto:rlaird@uno.edu) if you have any questions about your rights as a human subject and your concerns regarding a research-related injury.

Sincerely,

Therese Mendez

By signing below you are giving consent to participate in the above study.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

**APPENDIX C**  
**Interview Guide**

## **Interview Guide**

- Tell me about a typical day in your unit.
- Tell me about your experience with nurse to nurse interaction in your work environment.
- When did you first notice or experience negative interactions, also called disruptive behavior, in the workplace?
- Was it you or someone else involved in the event?
- Can you describe the circumstances that led up to or preceded the event?
- What happened?
- What was going on in the unit when the event occurred?
- What was going on in the unit that you think may have contributed to the event?
- What was going on with the nurses involved that may have contributed to the event?
- Were there other events of this type that you saw/experienced?
- When you think about it, are there any of these events that stand out in your mind?
- Could you describe that/those events?
- Tell me about your thoughts and feelings when you observed/experienced the event.
- How did you manage the event while it was occurring?
- Did anyone intervene?
- If so, how did that happen?
- What was the outcome?
- How did the event end?
- What happened afterward?
- What, if any, effect do you think the event had on relationships in the workplace?

- If any, can you tell me in what way you think the relationships were affected?
- What do you think are the most effective ways to manage these experiences?
- How did you discover these techniques?
- What advice would you give someone who may not have experienced disruptive behavior between nurses at work?
- The Joint Commission has added zero tolerance for disruptive behavior in the workplace to the hospital standards for accreditation. (Nurse participants will be familiar with The Joint Commission standards.)
  - What do you think of this zero tolerance standard?
  - What effect do you think the standard has on disruptive behavior?
- Is there anything you think I should know in order to understand disruptive behavior between nurses in the work environment better?
- Is there anything you would like to add that we haven't talked about?
- What would you like readers of this study to know about the phenomenon we have been talking about?
- Is there anything that you would like to ask me?

## **VITA**

Therese Mendez was born in Miami, Florida. She obtained her nursing degree from Louisiana State University Health Sciences Center in New Orleans, Louisiana. She obtained her baccalaureate degree (BA) and master's degree (MEd) from the University of New Orleans. Ms. Mendez has been a practicing nurse for 28 years. She has practiced in the Surgical Intensive Care and Post Anesthesia Care Units. She has been a clinical educator in New Orleans, Louisiana and Director of Education overseeing clinical education programs for a multi-state hospital corporation. Ms. Mendez is a member of the American Association of Critical Care Nurses.