

RECOGNIZING AND REDUCING HORIZONTAL VIOLENCE AMONG NURSES AT A
VETERANS AFFAIRS MEDICAL CENTER: A COGNITIVE REHEARSAL QUALITY
IMPROVEMENT PROJECT

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ABSTRACT

Ivuoma Igwe: Recognizing and Reducing Horizontal Violence at a Veterans Affairs Medical Center: A Cognitive Rehearsal Quality Improvement Project
(Under the direction of Cheryl Giscombe)

Aim: The aim of this project was to help nurses at the Veterans Affairs Medical Center (VAMC) in Durham, North Carolina recognize and reduce horizontal violence in the workplace using an evidence-based educational session with a cognitive rehearsal technique.

Background: Mounting evidence compiled over the last two decades has established the existence of horizontal violence in the nursing profession. Further, horizontal violence continues to be an ongoing challenge despite substantial evidence that it can negatively affect a nurse's quality of life and compromise patient safety.

Methods: VAMC staff nurses attended two educational sessions (one hour in total) of training about ways to combat horizontal violence and to learn cognitive rehearsal techniques. The first session presented the theoretical concept of horizontal violence, discussed how horizontal violence affects nurses, and included discussion of nurses' responses to three open-ended questions. In the second educational session, participants learned about and practiced appropriate responses to the most common forms of horizontal violence through cognitive rehearsal, an interactive role-playing experience. At the end of the session, each participant was given cue cards that each stated a common form of horizontal violence and its appropriate response. A follow-up survey was conducted at the end of the session to determine participants' satisfaction with and perspectives about the educational intervention.

Results: Participants reported that participation in the educational session (1) increased their awareness of horizontal violence and (2) enabled them to identify at least three strategies to combat horizontal violence. Further, participants recommended that nursing colleagues would greatly benefit from the training.

Conclusion: This educational session targeted the negative effects of horizontal violence and used an evidenced-based cognitive rehearsal technique to increase awareness of interventions to offset negative behaviors associated with horizontal violence. Raising awareness and labeling this problem are the first steps in reducing the occurrence of horizontal violence among nurses. These initial steps establish horizontal violence as a legitimate problem and hopefully will set in motion an action plan for change at the VAMC.

Keywords: horizontal violence, cognitive rehearsal technique, hostile workplace, bully, nurses.

This project and the completion of my DNP are dedicated to my father, Late Elder Jonathan Oji.

Daddy, you were my greatest support through this journey. Your love, support, and encouragement through all the ups and down were invaluable. A special thank-you for instilling the value of education to all your children. It is hard to believe that you left this planet earth a few months before my graduation. It is really very hard that you will not be there when I finally get this degree. I miss you very much but know you are resting comfortably in the arms of your Lord and savior Jesus Christ.

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LIST OF ABBREVIATIONS

ANCC	American Nursing Credentialing Center
CBT	cognitive behavioral therapy
CDC	Centers for Disease Control and Prevention
DNP	Doctor of Nursing Practice
ERIC	Educational Resource Information Center
HCAHPS	Hospital Consumer Assessment of Healthcare Provider and Systems
ICARE	integrity, commitment, advocacy, respect, and excellence
NIOSH	National Institute for Occupational Safety and Health
VA	Veterans Affairs
VAMC	Veterans Affairs Medical Center

CHAPTER 1: INTRODUCTION

Over the last two decades, a growing body of evidence has emerged that documents the existence of horizontal violence in healthcare environments and associates horizontal violence with negative effects on members of the nursing profession and, in turn, on their patients. Horizontal violence, which includes hostility or intimidation, occurs between members of the same profession or work unit (Vessey, Demarco, and DiFazio, 2010). Other terms in the literature that are used to describe this behavior include ‘lateral violence’, ‘incivility’, and ‘disruptive behavior’ (Burgess and Curry, 2014; Embree, Bruner, and White, 2013). Today, the nursing profession is challenged with solving the ongoing problem of horizontal violence in daily practice. Susan Roberts first identified nurses as an ‘oppressed group’, referencing earlier work by Freire (Roberts, 1983; Freire, 2000). As an oppressed group, nurses may resolve their anger and frustration by intimidating (bullying) other members of the group. Of course, the irony here is that horizontal violence persists in a system where caring for others is the main objective, and nurses are an integral part of that system.

The not-for-profit healthcare accreditation organization, The Joint Commission (Joint Commission, 2008), identified the negative effects of horizontal violence and issued a Sentinel Event Policy that urges healthcare organizations to establish and implement strategies to address horizontal violence. In addition, the American Nurses Association 2015 position statement condemned horizontal violence and required employers to create and nurture a safe and healthy workplace environment for nurses (American Nurses Association, 2015). The Centers for Disease Control and Prevention/National Institute for Occupational Safety and Health

(CDC/NIOSH) also identified horizontal violence as a threat to workplace safety and proposed that such violence leads to psychological and physical injury and may lead to medical error and increased mortality (CDC/NIOSH, 2016). Therefore, horizontal violence not only holds the potential to negatively impact healthcare providers, it may also negatively impact the quality of patient care delivery and ultimately patients' health outcomes.

The Department of Veterans Affairs (VA) established and prioritized a set of organization-wide values referred to as ICARE (integrity, commitment, advocacy, respect, and excellence). VA workers are expected to strive for effective interpersonal behavior as reflected by the ICARE values and such statements as "I care about my fellow VA employee" and "I care about choosing the harder right instead of the easier wrong". The CDC/NIOSH considers horizontal violence a safety hazard, and thus, horizontal violence is a violation of the VA's ICARE values (CDC/NIOSH, 2016). Furthermore, the Veterans Health Administration implemented the Workplace Violence Prevention Program, which involves guidelines for workplace behavior risk assessment and employee training to prevent and manage disruptive behaviors. Horizontal violence, which not only violates the VA's values and mission but also threatens overall personnel and patient safety, is a significant workplace problem among the VA nursing profession and demands urgent attention.

1.1 Horizontal Violence Defined

Although the term 'horizontal violence' has been defined and used in non-healthcare contexts, this project's implementation and educational session is concerned with horizontal violence in the nursing profession specifically. The Joint Commission defines 'horizontal violence' as intimidating and disruptive behavior that can foster medical error, contribute to poor patient outcomes and adverse effects, increase the cost of care, and cause healthcare workers to seek new jobs (Joint Commission, 2008). 'Horizontal violence' also has been defined as a "rude,

disruptive, and disrespectful demeanor that is demonstrated toward others, usually with low intensity but with the intent to harm someone” (D’Ambra and Andrews, 2014).

Horizontal violence can be physical or verbal, overt or covert. Overt examples of horizontal violence include name-calling, bickering, fault-finding, backstabbing, criticism, intimidation, gossip, shouting, blaming, and using put-downs. Covert expressions are often subtle and difficult to discern and include unfair assignments, sarcasm, eye-rolling, raising eyebrows, ignoring, making faces behind someone’s back, refusal to help, sighs, whining, refusal to work with someone, sabotage, obstruction, isolation, exclusion, undermining, and fabrication (Bartholomew, 2006; Griffin, 2004; Vessey, Demarco, and DiFazio, 2010). Most human communication is non-verbal, so covert expressions can have a particularly significant impact (Bartholomew, 2006). Such rude or disruptive behaviors often result in psychological or physical distress for all parties involved (targets, offenders, bystanders, stakeholders, and organization). Horizontal violence is a repeated behavior that is offensive, abusive, intimidating, and/or threatening, and creates stress and undermines the self-confidence of others (Vessey, Demarco, and DiFazio, 2011). In short, horizontal violence is defined here as an act of unwanted abuse or hostility among nursing professionals (Becher and Visovsky, 2012).

1.2 Problem Statement

Horizontal violence is a serious problem that affects the nursing profession nationally and globally (Edward, Ousey, Warelow, and Lui, 2014). Vast evidence in the literature demonstrates that horizontal violence poses a threat to patient care; thus, the fact that horizontal violence persists in light of such evidence is especially concerning (Burgess and Curry, 2014; Embree et al., 2013). Horizontal violence has both physical and psychological effects (Becher and Visovsky, 2012; Christine Moffa and Longo, 2016). It leads to poor job satisfaction, decreased

productivity, and poor communication, which in turn results in a lack of teamwork as well as increases in costs, absences, and employee turnover (Griffin and Clark, 2014; Johnson, 2011).

Horizontal violence creates a hostile workplace environment, which impacts a nurse's ability to accomplish his/her professional responsibilities, thus leading to the likelihood of increased medical errors and poor patient outcomes (Ceravolo, Schwartz, Foltz-Ramos, and Castner, 2012; Christine Moffa and Longo, 2016), notwithstanding the nurse's own personal stress and strain that are related to the threat of physical and/or psychological harm. Furthermore, horizontal violence is a difficult problem to address and solve, because, although approximately 84 percent of working healthcare professionals have experienced horizontal violence in the workplace, only about 10 percent have reported the action of perpetrators (Burgess and Curry, 2014). This phenomenon is a particular problem for the nursing profession (American Nurses Association, 2011). In sum, the problem of horizontal violence affects a nurse's capacity to provide quality and safe care and, therefore, demands attention.

1.3 Purpose of the Project

The purpose of this Doctor of Nursing Practice (DNP) project was to develop and pilot an educational session that could eventually improve the quality of nursing by raising awareness about horizontal violence and the adverse effects that horizontal violence has on Veterans Affairs Medical Center (VAMC) nurses' wellbeing and on patient safety. This work is grounded on the premise that horizontal violence is a safety hazard and a violation of the VA's ICARE values. The first goal of this project was to develop and pilot an educational session to increase awareness of the existence of horizontal violence and to label associated negative, bullying behaviors as horizontal violence. Naming the problem as horizontal violence legitimizes the feelings that nursing staff members may be experiencing and thus enables the nursing staff to be better equipped to set in motion an action plan that is designed to prevent, or at least mitigate,

horizontal violence. The second goal of this project was to empower and motivate VAMC nurses to act, that is, to make the changes that are needed to begin to address, mitigate, and possibly even solve this problem (Weinand, 2010). Together, the two goals of increasing awareness and enacting change may increase job satisfaction, decrease silencing, improve communication, and create a less hostile workplace environment (Stagg, Sheridan, Jones, and Speroni, 2013; Embree, Bruner, and White, 2013), thereby improving both patient care and the nursing profession.

1.4 Significance and Prevalence of the Problem

The Institute for Safe Medication Practices surveyed over 2,000 healthcare workers regarding horizontal violence in the workplace; 7 percent of nurses said they had made a medical error within the past year as a result of intimidation, and 49 percent reported adverse patient outcomes due to nurses not asking questions or for assistance due to bullying (Practices, 2004). In addition, the VA's recently completed national All Employee Survey asked nurses how they feel about working with their co-workers and about the workplace environment at their VAMC. Although results of this survey are not publicly available, anecdotal communication with VAMC employees and nurse leaders suggest that more work needs to be done to ensure an environment that promotes respect for others, job satisfaction, teamwork, and a better workplace. In short, the problem of horizontal violence among nurses is both significant and prevalent in healthcare settings, including the VAMC.

Horizontal violence has physical and psychological effects on individuals as well as organizational impacts on healthcare. The physical effects of horizontal violence can include weight loss, fatigue, high blood pressure, tachycardia, chest pain, sleep disturbance, headaches, anorexia, gastrointestinal upset, loss of libido, sleep disorders, and increased tobacco and alcohol use (Castronovo, Pullizzi, and Evans, 2016; Edward, Ousey, Warelow, and Lui, 2014). The psychological effects of horizontal violence can include depression, anxiety, irritability, panic

attacks, tearfulness, depression, loss of confidence, low self-esteem, mood swings, post-traumatic stress disorder, suicidal ideation, and suicide (Becher and Visovsky, 2012; Castronovo et al., 2016). The organizational impacts of horizontal violence include distress and avoidance of the workplace, poor job satisfaction, lack of commitment, increased employee turnover, decline in morale, decreased productivity, decreased nursing care delivery, patient injuries, falls, delayed medication administration, direct and indirect costs, intent to leave, burnout, and increased cognitive distractions (D'Ambra and Andrews, 2014; Vessey et al., 2010). Withholding necessary information is another facet of horizontal violence behavior that has organizational impacts because it can affect the quality of patient care and may lead to medical errors.

The Joint Commission Sentinel Event Alert outlines the need for hospitals to prevent horizontal violence (Joint Commission, 2008). A recent survey on horizontal violence suggests that between 65 percent and 80 percent of nurses have experienced or witnessed horizontal violence in the workplace (Stagg, Sheridan, Jones, and Speroni, 2011). However, horizontal violence tends to be under-reported among nurses (Becher and Visovsky, 2012). The fact that horizontal violence persists despite the overwhelming evidence of its disruptive nature and negative effects on patient safety is disheartening at best (Burgess and Curry, 2014). An imbalance of power that is maintained by a cycle of oppression keeps nurses dominated by other nurses (Rodwell and Demir, 2012). Theorists posit that the negative, reactive behaviors displayed by nurses are not willful acts but rather an expression of their workplace environment and a response to the unequal treatment of nurses by other medical professionals (Griffin and Clark, 2014).

Horizontal violence is a workplace problem. According to the Workplace Bullying Institute (Institute, 2014), "27% of Americans have experience with bullying at work, 72% of

Americans are aware of it, on the other hand, 72% of Americans do not think it is a problem.” Burgess and Curry (2014) reported that 84 percent of working healthcare professionals have experienced horizontal violence, but only 10 percent spoke up against the action of the perpetrators (Burgess and Curry, 2014). Furthermore, in 2011, the American Nurses Association acknowledged that horizontal violence is a critical global issue and reported that 48 percent of nurses experienced verbal abuse, 43 percent witnessed threatening body language, and 53 percent of student nurses experienced horizontal violence (American Nurses Association, 2011). In a descriptive study by Vessey et al. (2010) 76 percent of nurses reported witnessing horizontal violence either towards themselves or colleagues on a weekly basis. Stagg et al. (2013) reported that 50 percent of all nurses surveyed had witnessed horizontal violence. Thus, horizontal violence is common to both healthcare and non-healthcare organizations.

The prevalence of horizontal violence is clearly evident in the literature. However, evidence of the prevalence of horizontal violence at VAMCs specifically is not publicly available. Nonetheless, the VA understands that horizontal violence is a serious issue in nursing, as evidenced by its inclusion in ICARE value statements and initiatives related to workplace violence (e.g., the Workplace Violence Prevention Program). In response to the problem, the VA has developed and adopted workplace policies that promote healthy workplace environments for its employees.

CHAPTER 2: REVIEW OF LITERATURE ON HORIZONTAL VIOLENCE IN NURSING

To identify the current literature on horizontal violence among nurses and potential strategies for intervention, the project director conducted a literature search using three databases: CINAHL, PsyINFO, and PubMed. The search was restricted to English language articles and articles published from 2011 through 2016. The search terms used were *horizontal violence, bully, bullie, incivil, uncivil, workplace violence, workplace mistreatment, hostile, work, workplace, job, nurse, nurses, cognitive behavior therapy, and oppress*. The three databases provided an excellent range of articles that are relevant to this topic. A manual search of reference lists, or the ‘snowball’ method, identified additional research studies. The search was limited to articles about workplace violence that was directed specifically towards nurses. This search process yielded 20 articles, although no randomized control trials or meta-analyses were used in this research study. These articles are described briefly in the following paragraphs.

2.1 Incidences of Horizontal Violence in Nursing

Susan Roberts was the first researcher to describe nurses as an oppressed group and to discuss the implications of the concept of ‘oppressed group’ on nurses’ leadership styles (Roberts, 1983). In her 1983 article, Roberts argues that nurses lack real leadership because they lack self-initiative and assertiveness in the nursing profession (Roberts, 1983). According to Roberts, the nursing profession has been exploited and dominated by hospitals administrators and physicians who have benefited from their hierarchical power over nursing. Such domination over nursing has been enabled by the fact that early nursing education, although originally autonomous, later became controlled by physicians. The nursing profession then became

conditioned to this culture and accepted the characteristics of warmth, nurturance, and sensitivity that are viewed as negative or inferior when compared to characteristics attributed to physicians such as power and control. Therefore, Roberts concludes that nursing leadership behavior can be understood only when nurses are viewed as an oppressed group, as evidenced by the nursing profession's lack of autonomy, accountability, and control over itself.

Nearly thirty years after Roberts' 1983 article was published, Roberts and colleagues described nurses as "doubly oppressed" because they are both nurses and women (Roberts, Demarco, and Griffin, 2009). Unfortunately, due to such 'double oppression', nursing leadership has not been able to make the changes needed to move nursing from a low position in the hierarchy of healthcare providers because nurse managers are chosen by the powerful hospital administrators and doctors. Once nurse managers are in such positions of power, they then owe their allegiance to organizational values and not necessarily to values that support nursing staff, especially when these values are in conflict (Roberts et al., 2009). As a result, staff nurses may feel that they are marginalized by their managers, feel oppressed, become frustrated, and repress their anger. Roberts and colleagues (2009) stated that nurses may demonstrate passive-aggressive behavior, which further erodes their contributions to patient care, results in self-devaluation, and undermines their ability to provide care. As a result, the management style of nurse leaders is usually one of "avoiding and compromising" (Roberts et al., 2009). Nurses may also internalize the perceived message that they are in a low position and do not have a voice in expressing their needs or uniting to support each other. Thus, nurses keep silent in order to be seen as 'good' employees and because they do not feel that their voices have value or that they are worthy to speak against the organization. Such 'silencing' is a strategy that nurses sometimes employ to avoid conflict and maintain the *status quo* in the workplace (Roberts et al., 2009).

2.2 Negative Consequences of Horizontal Violence among Nurses

Martin et al. (2008) proposed a model to identify the ‘breaking point’ for nurse retention and satisfaction (Martin, Stanley, Dulaney, and Pehrson, 2008). Similar to Roberts’ work, this model also identifies nurses as an oppressed group, with nurses being both the victims and the perpetrators of horizontal violence (See Appendix A). According to Martin et al., (2008), nurses have low self-esteem and feel powerless. This powerlessness and loss of voice then leads to frustration. The nurse is unable to voice his or her opinion or make meaningful contributions regarding the healthcare system. This unhealthy situation leads to incivility, tension, and workplace hostility. The nurse develops distrust of his/her peers due to the inability to create changes in the system. This lack of trust creates low self-esteem and low morale, thus leading to a cycle of horizontal violence. Furthermore, Martin and colleagues (2008) suggest that the predominance of females in the nursing profession is a contributing factor to oppression. Generational variability in the nursing workforce (veterans, baby-boomers, Gen X, and Gen Y) may also cause significant variation in the work ethics and core values of the different generations.

Moffa and Longo (2016) described the negative influence of workplace violence on nurses’ wellbeing through the lens of social injustice as theorized by Powers and Faden (Moffa and Longo, 2016). Moffa and Longo (2016) identified workplace mistreatment as a barrier to maximizing the full potential of both nurses and patients. Nurses are required to possess cognitive and interpersonal skills; so, according to Moffa and Longo, any interference with their ability to perform their job is an injustice. Horizontal violence can affect the physical and psychological health of the nurse and lead to fear and insecurity, decreased productivity, low self-esteem, social withdrawal (such as being ignored when questions are asked), and can

interfere with promotions, such as being denied opportunities for professional advancement (Moffa and Longo, 2016).

Johnson used an ecological model to explain the origin and outcomes of horizontal violence where the workplace is considered a society comprised of a series of nested and interconnected layers that constitute horizontal violence (Johnson, 2011). The layers are society (macrosystem), corporation (exosystem), coworkers and managers of the perpetrators and targets (mesosystem), and the perpetrator and target (microsystem) (Johnson, 2011). Like an ecosystem, the workplace is a community in which people live by interacting with each other, which may lead to unresolved conflicts, support for horizontal violence by co-workers, and so-called 'rites of passage' that nurses face as they transition from being a novice nurse to a seasoned nurse. New nurses may suddenly become disillusioned after only a few months of work, sensing that they may not get help from the seasoned nurses when they ask for help.

Furthermore, new nurses may feel isolated because they have not been properly initiated to the nursing profession. In the microsystem described by Johnson (2011), horizontal violence results in lack of self-esteem, poor social competence, ineffective leadership skills, and a lack of desire to advance in one's career. Horizontal violence takes place in an environment in which the perpetrator may not believe he/she is harming others, displays narcissistic pride, and tends to blame and express anger at or with others. In Johnson's mesosystem, horizontal violence may be demonstrated by high levels of gossip, mockery, backbiting, incivility, role conflict, role ambiguity, poor work conditions, low levels of social support, low levels of job control, low levels of job demand, favoritism, and autocratic or laissez-faire leadership. Exosystem horizontal violence is the result of a rigid, highly vertical organizational structure, sloppy operating procedures, restructuring, downsizing, job insecurity, a competitive work culture, and the misuse

and misappropriation of power to silence and discipline any challenges to the *status quo*. In the macrosystem, Johnson purports that horizontal violence in nursing is due to the profession being predominantly female within a predominantly male-dominated medical environment, which leads to displays of anger by nurses who are an oppressed group (Roberts, 1983).

Vessey and colleagues (2010) conducted a review of articles written by nurses and/or that described nurses as targets of horizontal violence. Vessey et al. (2010) found no standardized definition for 'horizontal violence'. They noted that the terms 'horizontal violence', 'lateral violence', 'incivility', 'bullying', and 'aggression' were used interchangeably. Their study reported that: violence towards peers is a learned behavior that is reinforced over time; females are more susceptible to horizontal violence than males because they avoid conflict to maintain relationships; exposure to horizontal violence leads to physical and psychological problems; and feelings of low self-esteem, injustice, frustration, and resentment lead to emotional abuse and the intent to 'get even'. According to Vessey and colleagues (2010), the prevalence of horizontal violence is difficult to quantify due to a lack of comprehensive data about prevalence, differences in measurement techniques, and the lack of systematic data collection. Their article further states that horizontal violence continues because it has been accepted as a norm; a hierarchical organizational structure enables it, and incidents are under-reported by witnesses. Also, Vessey et al. (2010) found that horizontal violence leads to poor job performance, lack of motivation, increased turnover, and poor patient outcomes. The article proposes three strategies for addressing horizontal violence: primary intervention, which includes identifying the causes of horizontal violence and eliminating it, secondary intervention, which includes screening for these behaviors even when they are not noticeable, and tertiary intervention, which includes disciplinary action and termination that are implemented after a problem erupts.

Edward et al. (2014) conducted a systematic review of studies that were undertaken to determine the relationship between occupational anxiety and aggression. Edward et al. (2014) reviewed papers from outside the United States and found that evidence of aggression was similar in every country. Younger nurses were more prone to workplace violence than older nurses, verbal abuse was the most common form of violence, the incidents of violence toward nurses were more numerous compared to in other professions, male nurses were more likely to experience physical violence than female nurses, night shift and weekend shift nurses experienced more horizontal violence than daytime and weekday shift nurses, and among student nurses females were more susceptible to experiencing aggression in mental health settings than males (Edward et al., 2014). Further, these authors identified the key causes of aggression as time constraints, burnout, inexperience, and communication breakdowns.

In a cross-sectional study conducted by Rodwell and Demir (2012) to determine the causes of workplace violence, the researchers sent questionnaires to all nurses in a hospital in Australia. A total of 217 (31%) nurses returned a completed questionnaire. The results of the surveys showed a positive correlation between negative affectivity and workplace violence ($\beta = 0.08, P < 0.001$). The study also found a positive correlation between morning shifts and workplace violence ($\beta = 0.66, P < 0.05$), indicating that morning staff experienced horizontal violence more than workers in other shifts. Nurses with less experience were given the less desirable morning work. Typically, morning shifts require more interactions with patients, patients' families, and doctors, which requires the knowledge base to answer often demanding questions, which a new nurse may be less qualified to address than an experienced nurse. Rodwell and Demir found that nurses with less than nine years of experience were subjected to more horizontal violence than those with over 20 years of experience. Further, the Rodwell and

Demir (2012) study found that more incidents of emotional abuse were related to lack of job control, low supervisor support, and low co-worker support. The low level of job control is related to Roberts' argument that nurses are an oppressed group with a low level of power (Roberts, 1983). For example, less experienced nurses may be assigned especially demanding patients because experienced nurses often realize that new nurses will not question the assignment, despite the greater likelihood of poor patient outcomes. Workplace violence cannot be understood without reference to the imbalance of power that exists in institutions, and oppressed group theory is the explanatory framework for horizontal violence. The Rodwell and Demir (2012) article highlights that persistent and repeated exposure to horizontal violence can lead to psychological distress and depression and a decrease in morale, work performance, and job satisfaction. The key limitations of the Rodwell and Demir study are its cross-sectional design and self-reporting because bias can occur with self-reporting, although self-reporting from a victim's perspective should not be ignored. Further limitations of this study include that only 37 percent of the nurses that were sent a survey returned a completed questionnaire. One implication for nursing from the Rodwell and Demir (2012) study is the need to establish a management structure that gives nurses more control over their work environment and resources. A second implication is that the occurrence of workplace violence can drive experienced nurses away from the profession and potentially lead to a shortage of nurses.

Becher and Visovsky (2012) examined the relationship between horizontal violence and job retention. Knowledge of this relationship may enable organization leaders to identify the impact of horizontal violence as a cause of poor nurse retention, poor communication, and decreased productivity. A safe and supportive environment is required in order for nurses to provide high-quality care to patients; however, victims of horizontal violence find it difficult to

seek assistance within their workplaces (Becher and Visovsky, 2012). A negative workplace environment, created by unhealthy relationships, can lead to burnout, stress, job dissatisfaction, increased staff turnover, and poor patient outcomes. Horizontal violence can be subtle and not easily recognized (Becher and Visovsky, (2012). As a result, incidents and the prevalence of horizontal violence are under-reported. Because covert horizontal violence is difficult to discern, nurses who have experienced horizontal violence in the workplace find it hard to seek help in their workplaces. An implication of the Becher and Visovsky (2012) study is that implementing educational programs and strategies that identify the causes and negative effects of horizontal violence can increase job retention and decrease resignations. Therefore, implementing such programs and strategies is a major focus of the project.

Garon (2012) conducted a descriptive qualitative study to identify nurses' perceptions of their ability to speak and be heard in the workplace. Garon emphasized the unique advocacy role of nurses and the need for nurses to be able to freely communicate about patients' needs as well as workplace conditions. The Garon (2012) study found that communication affects nurses' satisfaction and job retention, which are vital keys to maintaining a healthy workplace environment. When nurses are silent, critical issues that could impact the whole organization are not raised. The Garon study also noted the role of power relationships, citing the conceptualization of nurses as an oppressed group (Garon, 2012; Roberts, 1983). Nurses as an oppressed group "silence themselves" (Roberts, 1983) because they want to avoid conflict and maintain relationships. This behavior simply reaffirms the class system of the healthcare profession and continues to keep nurses in a position of low value in their organization. Other factors mentioned in the Garon (2012) article that encourage nurses to remain silent include that nurses lack confidence in the knowledge they have, and nurses from different cultural and

sociocultural backgrounds often do not challenge authority due to their inability to voice their ideas because of language differences, accents, or other sociocultural barriers that may lead, in turn, to a potential position of victimization through horizontal violence. Nurses as an oppressed group are often reluctant to voice their opinions or concerns regarding patient care because of the power held by the medical team. The Garon (2012) study reported that nurses are silenced by the system, physicians, patients, and their families, and that organizational silencing is dangerous to patient care because organizations do not receive necessary information from nurses in order to provide the best care to the patient.

2.3 Potential Remedies for Horizontal Violence among Nurses

Castronovo et al. (2016) proposed a solution for horizontal violence in the context of nursing that involves incentives that hospitals may develop and implement to effectively reduce horizontal violence. For example, hospitals might develop and implement a national standardized measurement tool that quantifies levels of horizontal violence among nurses in hospitals throughout the United States. These data would be collected and reported publicly and factored into incentive payments to a hospital value-based purchasing program. Castronovo et al. (2016) also proposed a tool that would measure nurses' perspectives of workplace violence. This tool would be similar to the Hospital Consumer Assessment of Healthcare Provider and Systems (HCAHPS) survey. Patient satisfaction scores on the HCAHPS survey have increased because hospitals have focused on meeting metrics in order to obtain incentive payments. Barriers to the implementation of a similar program include obtaining the funding that would be needed to develop and run it and the willingness of hospitals to support such a program because of the administrative and financial commitment that it would entail. Also, hospitals would not like to see poor scores publicly reported, as these results would negatively affect their reputation and

profits. Other limitations of this incentive program include that nurses may not report horizontal violence for fear of retaliation and that nurses may make false claims.

An integrated review of the literature on incivility and new graduate nurses by D'Ambra and Andrews (2014) found that horizontal violence arises due to efforts by one party to control the behavior of and oppress another party based on the imbalance of power between the two parties. Individuals who are unable to challenge authority then vent their frustrations on their peers. Referencing the Roberts' oppressed group behavior model (Roberts, 1983), the D'Ambra and Andrews (2014) study reports that new graduate nurses suffer the effects of a power struggle among nurses, doctors, and administrators. Oppression leads to silencing and silencing leads to horizontal violence. According to D'Ambra and Andrews (2014), horizontal violence also leads to poor job satisfaction for new nurses and high turnover. High turnover rates affect the delivery of quality care, the cost of patient care, intent to leave, decreased job satisfaction, burnout, cognitive distractions, psychological distress, commitment, and errors. These "low intention" behaviors cause emotional damage to the recipients (D'Ambra and Andrews, 2014). Victims of horizontal violence experience repeated negative behaviors, threats, attacks from peers, belittling remarks, cynicism, verbal abuse, humiliation, and negative self-image.

As part of a quality improvement project to strengthen communications in order to overcome horizontal violence, Ceravolo et al. (2012) delivered 203 60- to 90-minute educational sessions over a three-year period to 4,000 nurses on the topic of assertive communication to raise awareness of horizontal violence. At the end of their project, Ceravolo et al. (2012) reported that 90 percent of nurses had experienced verbal abuse in their workplaces, verbal abuse decreased by 76 percent as a result of assertive communication, most of the nurses were unaware of their negative behaviors to peers, and nurses' perceptions regarding the need to create a positive

workplace environment were changed. Ceravolo et al. (2012) also reported that horizontal violence persists because these negative behaviors have not been acknowledged as a problem outside of the nursing profession. Other healthcare professions deny horizontal violence or accept it as the norm, thus creating a silence that prohibits finding a solution to the problem. Such normalization of horizontal violence leads to stress, absenteeism, health problems for nurses, sleeplessness, anxiety, and depression. Ceravolo et al. (2012) also reported that raising awareness of horizontal violence through education and assertive communication can reduce incidences of horizontal violence. They found that most perpetrators are ignorant of their negative behavior, nurse managers tolerate negative behavior from clinically sound nurses, and nurse managers lack the skills to confront negative behavior. Ceravolo et al. (2012) further stated that horizontal violence leads to higher costs due to increases in absenteeism, sick time, job turnover, low productivity, and recruiting and retraining new staff. For example, the estimated cost of replacing one medical-surgical nurse is \$92,000 and the cost to replace a specialty nurse is as high as \$145,000.

Griffin (2004) conducted a qualitative exploratory design study to provide a theoretical understanding of horizontal violence, its negative influence on the nursing profession, and cognitive rehearsal. The Griffin (2004) study focused on teaching new nurses a cognitive rehearsal technique as a strategy to combat horizontal violence. A sample of 28 new nurses participated in the Griffin (2004) study. The cognitive rehearsal training was part of a new nurse orientation program and was intended to enable new nurses to acquire the knowledge and skills required for their job without being hindered by horizontal violence. During the first week of the orientation, two hours were set aside for nurses to focus on horizontal violence. The first hour was devoted to a lecture on horizontal violence as well as its impacts on nursing practice. The

second hour was an interactive role-play session using the cognitive rehearsal technique and learning appropriate responses to the ten most common forms of horizontal violence. Participants were given a laminated cue card with appropriate responses to various types of horizontal violence. At the end of one year, 97 percent of participants reported experiencing horizontal violence since they started their employment, 100 percent of participants reported confronting the perpetrator and using the information they had learned, and 96 percent of the participants overwhelmingly recommended cognitive rehearsal training for all nurses. The Griffin (2004) study concluded that such an education program could certainly effect change in the behavior of nurses. The implication of the Griffin (2004) study is that horizontal violence does exist in the nursing profession and that incorporating educational strategies will increase nurses' ability to recognize and address instances of horizontal violence.

Griffin and Clark (2014) revisited the concept of cognitive rehearsal and reported that other researchers used this technique in their studies as an evidence-based strategy to ward off horizontal violence. Their study results support that cognitive rehearsal equips nurses to confront horizontal violence effectively and that applying the skills learned through cognitive rehearsal allows nurses to speak up when faced with incidents of horizontal violence. By applying these skills, nurses are more confident and comfortable about asking for additional information that may be needed for patient care, which ultimately leads to better patient outcomes. According to the Griffin and Clark (2014) study, horizontal violence has devastating effects. It negatively affects nurses' physical and mental health, self-worth, self-confidence, clinical judgment, patient care, job satisfaction, productivity, and commitment to work. Furthermore, horizontal violence leads to financial burdens on healthcare organizations in terms of job retention and recruitment.

In a systematic review of the literature to determine the effectiveness of workplace violence prevention programs, Stagg and Sheridan (2010) obtained 1,176 relevant articles from MEDLINE, CINAHL, the Educational Resource Information Center (ERIC), and Cochrane Library databases. These researchers found a lack of standardized measurement methods in these violence prevention programs and found that most of the studies lacked instrument reliability and validity, as these features were not mentioned in the study results. However, Stagg and Sheridan (2010) suggested the cognitive rehearsal technique as the method that led to the best efficacy.

Stagg et al. (2013) conducted a pilot study to determine the effectiveness of workplace anti-bullying programs that used cognitive behavior techniques to reduce bullying. Fifteen medical and surgical staff participants completed a two-hour cognitive rehearsal training program that was based on the Griffin (2004) study. The Stagg et al. (2013) study included theoretical concepts of horizontal violence, consequences of horizontal violence for nurses, and cognitive rehearsal techniques. Ten of the 15 medical and surgical staff nurses who participated in the program completed a six-month post survey, and five of those ten who completed the survey reported witnessing horizontal violence since completing the training. Also, 100 percent of those five participants who completed the survey reported backstabbing as the most frequent horizontal violence action that they experienced. Of the ten participants who completed the survey, 83 percent reported that they did not respond to horizontal violence when it occurred for fear of losing their job. Of all the participants who completed the survey, 90 percent said their ability to recognize and confront horizontal violence improved, and 70 percent said they changed their behavior as a result of attending the educational training (which suggests that these nurses were unaware of their negative behavior), and 30 percent recommended the training.

Embree et al. (2013) conducted pre/post studies to determine if an educational project that targeted lateral violence and cognitive rehearsal education would lead to a decrease in perceived levels of nurse-to-nurse horizontal violence in a hospital. Thirty-five percent (48) of 135 hospital nurses participated in the pre-survey, and 24 percent (35) of those 135 nurses took part in the post survey. The educational training forum was designed to empower new nurses and current nurses (some of whom were perpetrators of horizontal violence), with the goal of liberating the oppressed group. Analysis of the results that were obtained via the Nurse-Workplace Scale and Silencing the Self-Work Scale showed an increased awareness of horizontal violence and that nurses requested more training about dealing with disruptive behavior. The Embree et al. (2013) study results also indicated an increased sense of empowerment and self-esteem among nurses.

Burgess and Curry (2014) conducted a collaborative educational initiative in North Carolina to raise awareness that horizontal violence leads to poor quality of care, to furnish nurses with resources, and to enable nurses to develop, collectively and professionally, strategies to improve their communication and leadership concerns in the workplace. Three consecutive educational sessions provided a collective approach towards the improvement of team communication, conflict resolution, and leadership skills. Nursing educators disseminated information regarding the negative effects of horizontal violence on nurse and patient safety. Also, 58 nurses signed commitments to change their personal behavior and volunteer in further collaborative nursing sessions. These sessions were positively supported by nurses and nursing groups across North Carolina. This collaborative initiative took the position that informed nurses with common professional values will improve the healthcare system overall.

2.4 Conceptual Model and Framework

Freire describes negative behaviors displayed by oppressed groups in his seminal book, *Pedagogy of the Oppressed* (Freire, 2000). According to Freire, the oppressed are marginalized and controlled by a powerful dominant group. The powerful oppressors promote their values and their norms but devalue the culture of the oppressed group. The oppressed group subsequently develops self-hatred and believes that they are inferior, which, in turn, leads to loss of pride and a feeling of low self-esteem. Members of the oppressed group become submissive, silent, and unable to voice their needs due to fear and low self-esteem. The oppressed group members ‘resolve’ their frustrations and anger through intimidation (bullying) of other members of their group; these acts are referred to as ‘horizontal violence’. This negative behavior prevents the oppressed group from unifying and gaining power in their environment. However, the oppressed group must gain an understanding of the cycle of oppression to change their behavior and empower themselves. In order to achieve this understanding, the oppressed group must reject the negative image they have been forced to accept about themselves and develop a sense of pride in their group and their ability to succeed.

In the oppressed group model, nurses often are silenced by those higher in the hierarchy of healthcare organizations that include physicians, patients, and patients’ families. Organizational ‘silencing’ is dangerous to patient care because it can prevent nurses from providing necessary patient care information to others in the organization (Garon, 2012). Nurses may be reluctant to voice their opinions or concerns within the healthcare organization due to their lower position in the hierarchy and limited self-confidence (D’Ambra and Andrews, 2014; Griffin and Clark, 2014). Silence is often a key characteristic of an oppressed group and is a strategy that the oppressed group uses to avoid conflict and maintain the *status quo* in the workplace; however, such silence prevents the oppressed from challenging their oppressors

(Ceravolo et al., 2012). Nurses' oppressed state can lead to anger and frustration, which may manifest as horizontal violence as well as silence. These are ineffective ways to solve their problems or bring about long-term change (Moffa and Longo, 2016).

Proponents of the oppressed group theory highlight that nurses should not be blamed for wrongdoing. They argue that nurses' negative behaviors are a result of an imbalance of power at the workplace that is maintained by the cycle of oppression. The negative behaviors displayed by nurses are not willful acts but rather expressions of their feelings about their workplace and the unequal treatment of nurses (Griffin and Clark, 2014). By contrast, a secure and affirming workplace attracts and retains the best nurses and ensures the provision of quality patient care (Garon, 2012).

Communication is essential to the delivery of safe patient care, and improving staff communication is listed as one of the goals in the 2017 Hospital National Patient Safety Goals (Joint Commission, 2017). Nurses play a vital role in healthcare, and thus, they must be able to communicate their concerns about their patients' care and their concerns about workplace conditions, because without that crucial information the care provided to patients could be compromised (Garon, 2012).

Nurses are not the only workers who encounter horizontal violence in the workplace, but the nursing profession appears to experience more horizontal violence than other professions. According to Becher and Visovsky (2012), between 65 percent and 80 percent of nurses have either experienced or witnessed acts of horizontal violence. Becher and Visovsky further state that most of the events of horizontal violence are not reported. Likewise, Burgess and Curry (2014), referencing The American Association of College of Nursing survey of 1,700 nurses,

reported that 84 percent of nurses admitted to having witnessed peers taking shortcuts in the delivery of patient care due to a hostile workplace, but only 10 percent of nurses spoke up against such practice.

CHAPTER 3: DOCTOR OF NURSING PRACTICE PROJECT PLAN

A growing body of literature suggests that education about horizontal violence and cognitive rehearsal education (an evidence-based practice) will raise awareness about horizontal violence and its adverse effects on and in the nursing workplace (Embree et al., 2013; Garon, 2012; Griffin, 2004; Griffin and Clark, 2014; Stagg et al., 2013). By raising awareness of horizontal violence and its potentially detrimental outcomes among nurses, nurses can gain skills and knowledge to address this problem and enact change. In short, education about this issue may decrease its negative effects. Therefore, this Doctor of Nursing Practice (DNP) project focuses on education via cognitive rehearsal with the ultimate aim of increasing knowledge and enacting change.

3.1 Design

This DNP project designs and evaluates the implementation of a horizontal violence educational session. This session provides cognitive rehearsal training for the reduction of horizontal violence and was implemented for quality improvement purposes. Session attendees evaluated the educational session to determine its potential to increase awareness about cognitive rehearsal behavior techniques that can be implemented to reduce horizontal violence at the VAMC. The project director submitted the DNP project proposal for review by the internal review boards of both the University of North Carolina at Chapel Hill and the VAMC.

3.2 Setting

The VAMC is a tertiary hospital located in the southeastern United States. This hospital provides services to over 200,000 veterans; these services include general and specialty

medicine, surgical services, psychiatric services, and ambulatory services. In addition, this VAMC has a 120-bed Community Living Center that focuses on wellness and rehabilitation, a comprehensive Women's Health Center, and offers programs such as Home-Based Primary Care and Telemedicine Home Care. The VAMC also supports geriatric, mental health, and epidemiology research.

3.3 Key Stakeholders/Program Participants

The key stakeholders for the project were nurses, charge nurses, nurse managers, nurse educators, and nurse executives. The project director also had the support of a Ph.D.-prepared nurse site sponsor with several years of experience working at the VAMC. The project director first sought the support of nurse managers for this project by presenting information about her proposed DNP project at one of their meetings. Three managers expressed interest in having their unit participate in the project. The project director invited nurses to attend the one-hour educational session via email and face-to-face contact. To improve recruitment, participants had the opportunity to receive one hour of American Nursing Credentialing Center (ANCC) continuing education credits organized through the VA Education Department. To obtain credits, participants signed in and provided their name, unit, and contact information. The project director provided pizza and drinks to all participants after the didactic session as an expression of gratitude for their time. The project director conducted two one-hour sessions that were attended by N = 16 and N = 9 staff nurses, respectively.

The participants in the cognitive rehearsal educational session were staff nurses. The nurses attended a one-hour session, which included reviewing the session and evaluating its educational content. The project director delivered this content. Nurses who participated in the session completed a post-seminar evaluation of the educational session. The educational session evaluation survey did not require disclosure of personal data from the participants. The

educational session evaluation tool did not include items about the nurses who attended, nor was monetary incentive offered or given for participation.

3.4 Procedure for Project Implementation

The project implementation and educational session content were based on the work of Griffin (2004). The project director asked the staff nurses (registered, licensed practical nurses, and nursing assistants) to attend one one-hour session that had two components: (1) an educational session about horizontal violence and cognitive rehearsal and (2) an evaluation of the educational session's content. The intent of the sessions was to provide information about cognitive rehearsal and horizontal violence to raise nurses' awareness of negative behavior and strategies that they could use to counter horizontal violence (Griffin and Clark, 2014; Griffin, 2004; Stagg, Sheridan, Jones, and Speroni, 2013).

In Part I of the educational session, the project director gave participants a piece of paper and asked them to jot down answers to the three open-ended questions listed below.

- (1) When you hear the words 'workplace bullying' or 'horizontal violence', what comes to mind?
- (2) What do you think contributes to workplace bullying or horizontal violence among nurses?
- (3) Please describe potential strategies to address workplace bullying/horizontal violence

In this didactic session, the project director introduced the following items via a PowerPoint presentation: (1) definition of horizontal violence, (2) VA ICARE values, (3) a theoretical framework to enhance understanding of horizontal violence in the nursing profession, (4) review of ten common horizontal violence behaviors and the impact of horizontal violence on nursing, (5) discussion of appropriate responses to the ten most common types of horizontal violence, (6) incidences/statistics regarding horizontal violence, (7) review of determinants of

horizontal violence, (8) review of the physical, psychological, and organizational effects of horizontal violence, (9) behaviors expected from professionals, (10) strategies to combat horizontal violence, and (11) potential challenges (barriers) related to implementing horizontal violence educational programs (See Appendices B-F)

Part II of the training session was comprised of an interactive role-playing session in which the project director provided five cognitive rehearsal cue-cards to guide participants to identify the most frequent forms of horizontal violence and prepare and practice appropriate responses (see Appendix D; Stagg, 2013). The cognitive rehearsal cards were color-coded based on the specific horizontal violence behavior. On one side of the card was an example of horizontal violence (e.g., backbiting). On the opposite side of the card was a scenario to describe a nurse-nurse encounter that exemplified the horizontal violence behavior. Participants were given approximately seven minutes to share their reaction to the scenario and discuss potential appropriate responses to the horizontal violence behavior. Then, a matching card was distributed that gave an optimal behavioral response for that scenario.

The one-hour training sessions on horizontal violence and cognitive rehearsal took place in the third-floor educational conference room of the VAMC and at the VAMC outpatient clinic. At the end of the completed session, the project director gave the nurses laminated cue-cards (Appendix G) to use at work. These cue-cards included additional information about the most frequent forms of violence, the appropriate response to common horizontal violence behaviors, and acceptable behaviors of professional nurses (see Griffin, 2004).

3.5 Evaluation of the Educational Seminar

At the end of the educational session, participants were asked to complete an evaluation questionnaire with thirteen survey items about the educational session (Appendix H). Feedback provided by the participants was intended to revise the educational session and implementation

strategies for further session offerings at the VAMC. This future implementation will not be conducted as part of this DNP project.

3.6 Evaluation/Data Analysis

The project director collected the participants' written answers for analysis. The project director used descriptive statistics to summarize the responses of the participants and content analysis to analyze the responses to the open-ended survey questions (Walrafen, Brewers and Mulvenon, 2012) in order to describe participant reactions to the session as well as to identify key components of the educational session that could benefit from revision.

3.7 Strategies to Minimize Potential Barriers to the Implementation of the Project

Merely acknowledging that nurses are an oppressed group will not eliminate horizontal violence unless a concerted effort is made to resolve the problem. According to Freire (2000), nurses, like other groups, can achieve liberation through education, thereby gaining a critical understanding of the problem of horizontal violence and taking action. Nursing leadership may not necessarily see horizontal violence as a problem, especially because horizontal violence is a complex issue and difficult to prove due to its subtle nature (Johnson, 2011; D'Ambra and Andrews, 2014). The complexities surrounding horizontal violence present challenges in determining the relationship between horizontal violence and its adverse effects.

The VAMC has a hierarchical management structure and formal culture that may have constrained implementation of the proposed project. Therefore, VAMC leadership support was critical to the success of the implementation of the project. The project director secured the support and endorsement of a member of the nursing management team at the Durham VAMC for the proposed project. The project director's mentor, who was also the project director's third doctoral committee member, had worked at the VAMC and other nursing agencies for over 30

years. This mentor agreed to help the project director navigate the leadership system in order to obtain support for this project.

A barrier to the implementation of the proposed project as well as to the eradication of horizontal violence itself was the perception by nurses that horizontal violence is a regular norm and ‘part of the job’ and that nothing can be done to stop it (Castronovo et al., 2016; Roberts, 1983; Ceravolo, Schwartz, Foltz-Ramos, and Castner, 2012). Nurses may not have chosen to participate in the proposed project’s educational session due to apathy that stemmed from either lack of interest or the feeling that nothing will ever change. The project director thus obtained buy-in from nurses to ensure the implementation of the project. The project director was concerned that apathy about change would prevent nurses from participating in the project.

Further, perpetrators of horizontal violence likely did not see the need to change their behavior because they may not have realized they were causing harm to and thereby undermining their peers (Johnson, 2011). To gain nurses’ interest in participating in the project, the project director placed fliers that advertised the project in the cafeteria, unit floors, elevators, and common areas of the VAMC. As an employee of the VAMC, the project director also was able to hand-deliver fliers to nurses on the floors where the project was to be implemented. The project director also asked nursing leadership to attend the training session and to address the participants on the day of the training with the goal to encourage the attendance of nurses who desired change to improve patient outcomes and eliminate workplace violence.

Under-reporting horizontal violence is a well-known barrier to the effective implementation of programs designed to combat horizontal violence (Martinez, 2016; Edward et al., 2014; Vessey et al., 2010; Griffin and Clark, 2014). Nurses silence themselves due to fear of misunderstanding, fear of retaliation, or the belief that reporting incidents of horizontal violence

is a waste of time (Stagg et al., 2013). If nurses do not see the benefit of the proposed project, they may not report horizontal violence in their units. If they do not see the need for change, they may resent the implementation of the project. Furthermore, lack of support from their peers would greatly hinder the project (Stagg and Sheridan, 2010).

Another potential barrier to the implementation of the proposed project was the commitment of time required by potential educational session participants. The project director garnered support of the nurse manager at the outset of the project and kept him/her informed about the progress of the project. Typically, the support of the nurse manager is the key to cultural change and to the development of a respectful workplace environment (Ceravolo et al., 2012). Thus, the support of the nursing leadership was critical to the implementation of the project. If the manager was supportive of the project, then he/she would allow nurses the time to attend the session and to complete the survey (D'Ambra and Andrews, 2014).

Lastly, participants may dislike role-playing. The project director overcame this barrier by creating an open 'no blame' atmosphere during the training sessions to facilitate openness and trust and encourage feedback (Burgess and Curry, 2014).

3.8 Strengths and Potential Weaknesses of the Proposed Project

The strength of this proposed project was that the educational session used an evidence-based strategy, i.e., cognitive rehearsal, which is designed to reduce horizontal violence. Because the VAMC uses cognitive rehearsal as a treatment modality for veterans, many VAMC staff members were familiar with the concept. Thus, the ability to draw from the wealth of experience and knowledge of these trained staff members was a strength of the project. The project director talked with one of the social workers who is cognitive behavioral therapy (CBT) -trained at the VAMC. In recognition of VAMC support for the project, the project director will provide a 30-minute summary of the project evaluation report to VAMC nurse leadership.

Potential weaknesses of the project include the fact that the session was delivered within a 60-minute time-frame. Although prior studies conducted such educational sessions and rehearsals in two hours, efficient delivery of educational content must be considered for the benefit of nursing staff members who have limited time away from their patient care responsibilities. Therefore, the 60-minute time-frame was advantageous and could be considered a strength of the project as well.

CHAPTER 4: RESULTS AND EDUCATION PROGRAM EVALUATION

The aim and focus of this project were to pilot and evaluate an educational session that can be implemented for quality improvement purposes by providing cognitive rehearsal training to reduce horizontal violence. Based on a one-hour session with two components, (1) an educational session on horizontal violence and cognitive rehearsal and (2) an evaluation of the educational session's content, 25 nurses working in a high-intensity area of a VAMC in the southeastern United States were assessed for their increased awareness about horizontal violence at the VAMC and reducing horizontal violence via cognitive rehearsal behavior techniques. The results of this quality improvement educational session were assessed based on content analysis of participants' (n = 25) responses to open-ended questions (Appendix I) that were asked prior to the training session and descriptive qualitative analysis of a post-training survey (n = 25). Three pre-training, open-ended questions were asked:

- When you hear the words 'workplace bullying' or 'horizontal violence', what comes to mind?
- (2) What do you think contributes to workplace bullying or horizontal violence among nurses?
- (3) Please describe potential strategies to address workplace bullying/horizontal violence.

Sixteen nurses from an outpatient clinic and nine in-patient new graduate nurses participated in the educational session, and all these participants completed both pre-session open-ended questions and the post-session survey (see Appendix J). The common themes

associated with the question “When you hear the words ‘workplace bullying’ or ‘horizontal violence’, what comes to mind?” included suppressed anger, intimidation, isolation, insubordination, abuse, humiliation, lack of managerial support, lack of respect, lack of teamwork, lack of communication, behaviors are not recognized, and unfair assignments. The nurses gave very candid and open responses to the questions. The nurses said they see horizontal violence displayed often in the workplace. The seriousness of horizontal violence at this workplace was expressed through some of responses they gave, such as “be or assign someone harder assignment because they know they won’t say no”; “I think of people gossiping and spreading rumors that are not true”; “People having their own clique. They only associate with certain people.”

The common themes associated with the question “What do you think contributes to workplace bullying or horizontal violence among nurses?” included lack of communication, fear of retaliation, unfair promotions, lack of teamwork, stress, burnout, lack of managerial support, negative behaviors, lack of empathy, abuse of power, unfair assignments, personal unhappiness, lack of training on horizontal violence, and unfair culture (see Appendix J). Oppression seems to be an underlying factor in the responses that the nurses gave to this question. According to Freire, when a person is oppressed he/she feels marginalized and controlled by higher powers. The oppressed person develops a loss of pride and a feeling of inferiority. Members of an oppressed group become submissive and silent. They are unable to voice their opinions due to the fear of retaliation. The oppressed group members ‘resolve’ their frustrations and anger through intimidation of other members of their group. The common themes identified in this question are a by-product of the oppressed state of the nurses at this organization. Some of the responses from this question include: “Some people are just mean”, “A weak person who is not

sure of who they are will often times become a bully or bullying has been a part of their environment”, “The old saying, ‘nurses eat their young’”, “Sometimes when they are close to other employees and those employees in particular don’t like another employee, the bully tends to take on the behavior of their ‘friend’”, “some treat others the way they were treated”, “personal unhappiness”, “inconsideration for others”, “emotionally charged situation”, “lack of management following up on complaints”, and “leadership not supporting fair workplace culture at the VA”.

The common themes associated with the question “Please describe potential strategies to address work place bullying/horizontal violence” included termination, enforce zero tolerance of such behaviors, be a role model, better staffing, mediation, mindfulness, open communication, team-building activities, fair assignments, and provide education on horizontal violence and strategies to confront the behaviors (Appendix J). Respondents overwhelmingly agreed that implementing team-building exercises during their staff meetings would help enhance staff relationships. They wanted a neutral place where they could get to know one another in a non-threatening way. They suggested having retreats, outings other than work, and getting-to-know-each-other activities. Training staff members and management to be aware of the signs and strategies to confront negative behaviors also was noted in the responses. Other responses to this question included: “I think employees should be able to comfortably go to their supervisor and comfortably speak on how they feel”, “fair assignment”, “use same proficiency standards”, and “support staff equally”. The conceptualization of nurses as an oppressed group and the unequal balance of power in the nursing profession were important points. Because nurses are an oppressed group, they usually do not speak up to avoid confrontation or retaliation. It is

interesting here that nurses are asking for fairness and the freedom to be able to go to their supervisors to voice their opinions.

Eighty percent (n = 20) of the participants agreed that the content of the training was interesting. Seventy-six percent (n = 19) of the participants said that the educational session increased their knowledge about the definition of horizontal violence and behaviors associated with horizontal violence. The educational session also increased their knowledge about the potential causes of horizontal violence. Seventy-two percent (n = 18) of the participants said the educational session increased their knowledge about strategies for addressing horizontal violence. Eighty percent (n = 20) commented that they loved the scenario and the cue-cards given to them at the end of the training. Eighty percent (20) of the participants indicated that they loved the discussions that came out of the scenario presented during the training. They felt the discussion made their feelings heard. They felt that the ideal responses to the selected horizontal violence behaviors discussed during the training were good examples that they could use to handle each situation. Several of the participants indicated that the training was very informative regarding ways they could handle negative behavior. However, participants also shared that the time was not enough for them to get the full benefit of the training. They also said they would love this training to be available hospital-wide and requested a better setting, such as having the training during their monthly staff meeting.

4.1 Discussion

The primary objective of this quality improvement project is to raise awareness of horizontal violence and its detrimental outcomes among nurses. The objective is to enable nurses to gain skills and knowledge to address horizontal violence and enact change in a high intensity area of the VAMC. This project focused on education via cognitive rehearsal with the ultimate aim of increasing knowledge and enacting change. The one-hour educational session on

horizontal violence and cognitive rehearsal and the evaluation of the educational session can be used to counter horizontal violence by raising awareness of negative behaviors and potential strategies to address horizontal violence.

The findings from this project indicate that cognitive rehearsal techniques were acceptable to the educational session participants and may help to decrease instances of identified themes among nurses as well as raise awareness of the negative impacts of horizontal violence. The participants reported patterns of increased knowledge of horizontal violence, increased awareness of its negative effects, and strategies to confront these negative behaviors. Furthermore, the findings from this project aligned with those of previous studies that focused on the cognitive rehearsal technique as a strategy to reduce horizontal violence (Embree et al., 2013; Garon, 2012; Griffin, 2004; Griffin and Clark, 2014; Stagg et al., 2013). The results from the educational session suggest that nurses who work in a high intensity environment such as the VAMC can benefit from educational training that raises awareness of horizontal violence and its potential detrimental outcomes as well as provide strategies and skills nurses can use to confront such negative behaviors. Through the use of cognitive rehearsal training, nurses can gain skills and knowledge to address this problem and enact change.

The participants overwhelmingly liked the role-playing section and using the scenario cue-cards. They said they liked the discussion that came out of the scenarios. Hearing coworkers' responses to the questions made them feel they had been heard. The participants reported that the sessions caused them to think about themselves and the behaviors they express to their coworkers. The participants reported that the way the negative behaviors were explained and the appropriate responses to such negative behaviors taught them skills about ways to handle negative behaviors.

The participants recommended that more time should be allotted to this training because it is a very interesting subject that affects them all. The participants recommended repeating the training in monthly staff meetings and they also wanted this training to be implemented hospital-wide. Some of the new graduate nurses suggested that it be included in the new graduate orientation program at the VAMC.

In addition, the participants liked the fact that the training was linked to the ICARE values of the VAMC and the All Employees Survey results. Lack of respect for one another was one of the themes identified in the training; interestingly, according to the ICARE values, nurses are to treat everyone they work with with respect and dignity. Unfortunately, nurses cannot adhere to a high professional standard until they are able to confront these negative behaviors.

4.2 Limitations

Numerous challenges were encountered during the implementation of the project. Initially, three nurse managers had indicated that they would be interested in their staff members participating in the educational session. However, when the project director contacted them about implementing the project, they all said that they could not afford to take nurses off the floor for two hours to attend the session. When the managers indicated to the project director that the length of the training time was problematic, the project director modified the educational session and reduced the time to just one hour. When the project director reached out to these managers again, she was told again that they could not afford to take nurses off the floor for an hour.

In addition, on the day of the educational session at the clinic, the project director's nurse manager informed her a few hours before the training about a conflict regarding the reservation of the conference room that the project director had reserved for the training session. Because the educational session was not work-related, the project director was not able to implement the project in the room that she initially reserved. The project director asked the participants to come

to a smaller room to avoid missing the opportunity to implement the project that day. The new room was crowded but the project director had to continue the project so as not to abandon it that day.

Also, two days before implementation of the project at the main hospital with the new graduate nurses, the project director asked one of the nurse executives to reach out to her managers to see if they could send nurses to the training. The nurse executive sent an email to seven of the managers who reported to her directly and to two other managers who did not report to her. Only one of those managers sent a nurse to the training.

The initial lack of interest in the project could have been due to apathy or the feeling that nothing will change. Another possible reason for the initial lack of interest in the project could be that the leadership did not see horizontal violence as a problem at the VAMC. Interestingly, when the project director presented the outcomes of the project implementation to management staff members, they shared that their insights into the problem of horizontal violence had been expanded. They are now more open to supporting future sessions.

The constraint of time was another limitation that was encountered in the implementation of this project. The nurses wanted more time to talk about the scenarios that focused on different horizontal violence behaviors and their appropriate responses. Feedback received from the participants after the training included that they would have loved to have spent more time talking about the scenarios. They truly liked the presentation and are still talking about the training at the clinic. After the project director conducted the training, her colleagues often came to her to discuss an example of negative behavior or horizontal violence that they had experienced at work.

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS FOR PRACTICE

Because horizontal violence is a violation of the ICARE values, implementing training to help counteract negative behaviors among nurses is a very good strategy to promote a culture of change at all VAMCs. The goal of this project was to increase awareness of the existence of horizontal violence and to label the problem as horizontal violence. Naming the problem as horizontal violence legitimized the feelings that the participants at the education training expressed and enabled the nursing staff to be better prepared to set in motion an action plan for change.

The results obtained from this project are valuable, and the leadership of the VAMC may benefit from the findings. Cognitive rehearsal training, an evidence-based technique, is already used at the VAMC with veterans who suffer from post-traumatic stress disorders, anxiety, and depression. It is a feasible strategy to raise awareness about and address horizontal violence among nurses at the VAMC. A less hostile workplace environment is critically important for improving the quality of life of employees. With the ever-increasing psychological stress of working in a high intensity organization, nurses will continue to experience horizontal violence. Successfully increasing the workplace quality of life for staff and abiding by the ICARE values of the VAMC may be more likely to be achieved if the leadership of the VAMC implements interventions such as cognitive rehearsal training to reduce horizontal violence.

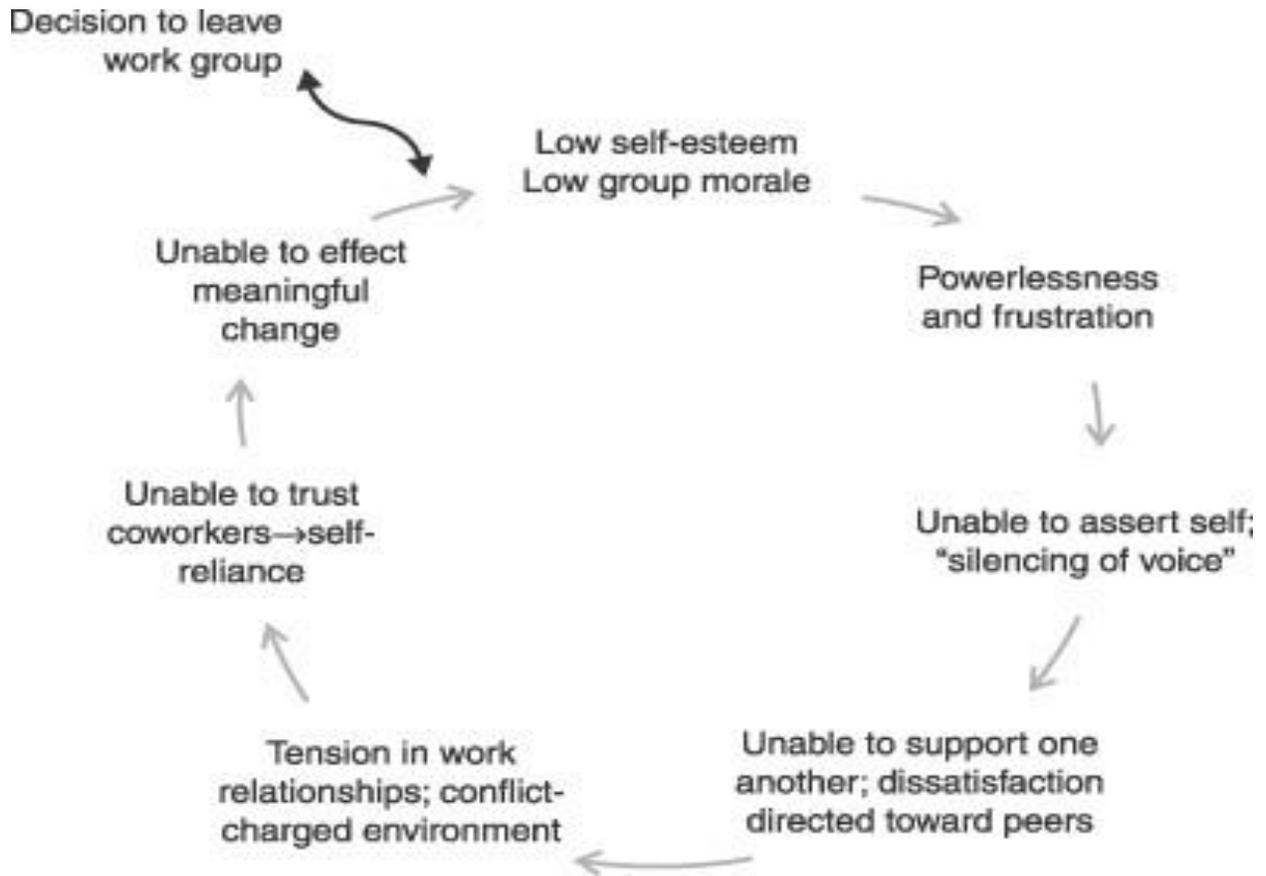
The outcomes of this project suggest that cognitive rehearsal training may be useful for reducing horizontal violence among nurses at the VAMC. It also suggests that implementing cognitive rehearsal training at the VAMC can provide nurses with strategies to confront negative

behaviors. The project introduced an evidenced-based technique for raising awareness of the negative effects of horizontal violence, decreasing nurses' experiences of oppression, and empowering nurses with strategies to resist and reduce horizontal violence at the VAMC.

The next steps involve considering the benefits of implementing cognitive rehearsal in other departments of this VAMC and at VAMC facilities nationwide.

APPENDIX A: DIAGRAM/MODEL OPPRESSED BEHAVIORS

(Martin *et al.* (2008))



APPENDIX B: TOPICS TO BE COVERED IN DIDACTIC SESSION (PART 1)

- Definition of ‘horizontal violence’
- Review of VAMC ICARE values and relevance to project
- Theoretical framework: Oppressed group behavior
 - Description of Roberts’ framework and its relation to Freire’s work
 - Illustration of applied model of oppressed group behavior to guide discussion
- Review of ten most common types of horizontal violence behaviors
- Discussion of appropriate responses to the ten most common types of horizontal violence
- Description of incident /statistics of horizontal violence
- Review of determinants of horizontal violence
- Review of physical effects of horizontal violence
- Review of psychological effects of horizontal violence
- Review of organizational effects of horizontal violence
- Behaviors expected from professionals [to prevent and reduce horizontal violence]
- Strategies to combat horizontal violence
- Potential challenges related to implementing horizontal violence educational programs

APPENDIX C: VETERAN AFFAIRS ICARE VALUES

<https://www.va.gov/icare/>

Integrity: Act with high moral principle. Adhere to the highest professional standards. Maintain the trust and confidence of all with whom I engage.

Commitment: Work diligently to serve Veterans and other beneficiaries. Be driven by an earnest belief in VA's mission. Fulfill my individual responsibilities and organizational responsibilities.

Advocacy: Be truly Veteran-centric by identifying, fully considering, and appropriately advancing the interests of Veterans and other beneficiaries.

Respect: Treat all those I serve and with whom I work with dignity and respect. Show respect to earn it.

Excellence: Strive for the highest quality and continuous improvement. Be thoughtful and decisive in leadership, accountable for my actions, willing to admit mistakes, and rigorous in correcting them.

APPENDIX D: THE 10 MOST COMMON FORMS OF HORIZONTAL VIOLENCE IN NURSING PRACTICE

(Griffin, 2004)

- Nonverbal innuendo (raising of eyebrows, face-making)
- Verbal affront (covert or overt, snide remarks, lack of openness, abrupt responses).
- Undermining activities (turning away, not available).
- Withholding information (practice or patient)
- Sabotage (deliberately setting up a negative situation).
- Infighting (bickering with peers)
- Scapegoating (attributing all that goes wrong to one individual).
- Backstabbing (complaining to others about an individual and not speaking directly to that individual)
- Failure to respect privacy
- Broken confidences

APPENDIX E: EXPECTED BEHAVIORS OF PROFESSIONALS
(Griffin, 2004)

- Accept one's fair share of the workload.
- Respect the privacy of others.
- Be cooperative with regard to the shared physical working conditions (noise, temperature).
- Be willing to help when requested.
- Keep confidences.
- Work cooperatively despite feelings of dislike.
- Don't denigrate superiors (e.g. speak negatively about, have a pet name for).
- Do address co-workers by their first name; ask for help and advice when necessary.
- Make eye contact with co-workers when speaking.
- Don't be overly inquisitive about each other's lives.
- Repay debts, favors, and compliments, no matter how small.
- Don't converse about a co-worker with another co-worker.
- Stand up for the "absent member" in a conversation when he/she is not present.
- Don't criticize publicly.

**APPENDIX F: SCENARIOS OF COMMON HORIZONTAL VIOLENCE BEHAVIORS
AND SUGGESTED RESPONSES**
(Stagg *et al.*, 2013)

Horizontal violence behavior	Scenario	Targeted suggested responses
Backbiting	Situation: You mention to a coworker that you need to complete the computerized mandatory education. The coworker states, "I still have to do that too. I was going to do it yesterday, but Stephanie took forever to finish her education. She always monopolizes the computer!"	"Not having been there, I don't feel comfortable talking about Stephanie. Have you talked to her?"
Nonverbal innuendos	Target: "I am having problems with a new compression stocking. Can you help me?" HV: Rolls her eyes to another nurse standing near you	"I can see you have something to say. You can just say it."
Verbal affront	Target: "Sally, I have not used this lift equipment. Can you help me get the patient to room 256 into the chair?" HV: "I HAVE MY OWN PATIENTS TO TAKE CARE OF!" Walks off.	"I learn best when I understand the direction and feedback given. Can we create this type of situation?"
Undermining activities	Situation: A family member of one of your patients asks if she can bring her 6-year old daughter to visit the patient. You tell the family member no and explain that the visitation restrictions are the result of the current influenza outbreak. The family member then asks another nurse if she can bring in her daughter. The other nurse says it is okay, knowing you have told her no.	"When something happens that is different from what I understood. It leaves me with questions. Help me understand how this happened."
Sabotage	Situation: You are assigned to work with a co-worker on a project to foster implementation of the unit electronic medical record. She is hogging all the work, what little she does give you, she goes over with a fine-toothed comb, highlighting all supposed errors and showing them to your boss. You heard a rumor she is trying to get you fired, but she is always nice to your face. Today, she sent an e-mail to the unit staff, stating	"There is more to this situation than I am aware. Could we meet privately to discuss what happened?"

Horizontal violence behavior	Scenario	Targeted suggested responses
	<p>someone relatively new to the templates (obviously you, but never named outright) had made so many mistakes that she was going to have to re-create them. This will delay the program implementation until the next week. Now everyone is mad at you. You looked over your work log and not ONCE did you work on the templates. But it is her word against yours.</p>	

APPENDIX G: CUE CARDS
(Griffin, 2004)

Side 1	Side 2	Single Card Attached to ID
<p>Nonverbal innuendo (raising of eyebrow, face-making)</p> <ul style="list-style-type: none"> I sense (I see from your facial expression) that there may be something you wanted to say to me. It's okay to speak directly to me. <p>Verbal affront (covert or overt, snide remarks, lack of openness, abrupt responses)</p> <ul style="list-style-type: none"> The individuals I learn the most from are clearer in their directions and feedback. Is there some way we can structure this type of situation? <p>Undermining activities (turning away, not available).</p> <ul style="list-style-type: none"> When something happens that is 'different' or 'contrary' to what I thought or understood, it leaves me with questions. Help me understand how this situation may have happened. <p>Withholding information (practice or patient)</p>	<p>Sabotage (deliberately setting up a negative situation).</p> <ul style="list-style-type: none"> There is more to this situation that meets the eye. Could "you and I" (whatever, whoever) meet in private and explore what happened? <p>Infighting (bickering with peers). Nothing is more unprofessional than a contentious discussion in non-private places. Always avoid.</p> <ul style="list-style-type: none"> This is not the time or the place. Please stop (physically walk away or move to a neutral spot). <p>Scapegoating (attributing all that goes wrong to one individual). Rarely is one individual, one incident, or one situation the cause for all that goes wrong. Scapegoating is an easy route to travel, but rarely solves problems.</p> <ul style="list-style-type: none"> I don't think that's the right connection. <p>Backstabbing (complaining to others about an individual and not speaking directly to that individual).</p> <ul style="list-style-type: none"> I didn't feel right talking about him/her/situation when I wasn't there, or 	<ul style="list-style-type: none"> Accept one's fair share of the workload. Respect the privacy of others. Be cooperative with regard to the shared physical working conditions (e.g., light, temperature, noise). Be willing to help when requested. Keep confidences. Work cooperatively despite feelings of dislike. Don't denigrate superiors (e.g., speak negatively about, have a pet name for). Do address coworker by their first name; ask for help and advice when necessary. Look coworkers in the eye when having conversation. Don't be too overly inquisitive about each other's lives.

Side 1	Side 2	Single Card Attached to ID
<ul style="list-style-type: none"> • It is my understanding that there was (is) more information available regarding this situation and I believe if I had known that (more), it would (will) affect how I learn or need to know. 	<p>don't know the facts. Have you spoken to him/her?</p> <p>Failure to respect privacy</p> <ul style="list-style-type: none"> • It bothers me to talk about that without his/her/their permission. • I only overheard that. It shouldn't be repeated. <p>Broken confidences</p> <ul style="list-style-type: none"> • Wasn't that said in confidence? • That sounds like information that should remain confidential. • He/she asked me to keep that confidential. 	<ul style="list-style-type: none"> • Do repay debts, favors, and compliments, no matter how small. • Don't engage in conversation about a coworker with another coworker. • Stand up for the 'absent member' in conversation when he/she is not present. • Don't criticize publicly.

**APPENDIX H: HORIZONTAL VIOLENCE EDUCATIONAL SEMINAR
EVALUATION TOOL**

Please answer the following questions.

1. The content on horizontal violence was interesting

Disagree Agree

1 2 3 4 5

Additional Comments:

2. The educational session increased my knowledge about the definition of horizontal violence.

Disagree Agree

1 2 3 4 5

Additional Comments:

3. The educational session increased my knowledge about behaviors associated with horizontal violence.

Disagree Agree

1 2 3 4 5

Additional Comments:

4. The educational session increased my knowledge about the potential causes of horizontal violence.

Disagree Agree

1 2 3 4 5

9. The educational content was well-organized.

Disagree

Agree

1 2 3 4 5

Additional Comments:

10. The cognitive rehearsal activities were implemented in a useful manner.

Disagree

Agree

1 2 3 4 5

Additional Comments:

11. The educational materials (Power Point presentation and cue cards) are potentially useful.

Disagree

Agree

1 2 3 4 5

Additional Comments:

12. Please indicate the components of the educational session what were most useful.

13. Please indicate strategies for improving the educational session.

14. Please include any additional comments below.

Thank you for taking the time to complete this survey!!!

APPENDIX I: OPEN-ENDED QUESTIONS ASKED PRIOR TO THE EDUCATIONAL SESSION

1. When you hear the word 'bullying' or 'horizontal violence', what comes to your mind?
2. What do you think contributes to workplace bullying or horizontal violence among nurses?
3. Please describe strategies to address workplace bullying/horizontal violence.

APPENDIX J: RESPONSES TO THE OPEN-ENDED QUESTIONS ASKED PRIOR TO THE EDUCATIONAL SESSION

1. When you hear the words ‘workplace bullying’ or ‘horizontal violence’, what comes to mind?

- Coworker not being respectful
- Someone being intimidated to another person
- Horizontal violence is nurse to nurse or nursing assistant to nursing assistant or a mixture.
- Picking on someone
- Be or assign someone harder assignment because you know they won't say ‘no’
- Someone trying to intimidate you
- Disrespect
- Rudeness
- Lack of teamwork
- Being mean to coworker
- Talking down to them
- NA staff
- Workload
- Assignment
- Coworker being mean or abusing each other
- Not help
- Throwing under the bus
- Lack of communication
- Manager
- Rudeness

- Pain
- Misuse of authority
- Insubordination
- Among coworkers
- Coworkers bullying other staff
- Pushing the work to other staff
- Nurse manager who follow too close
- Victimizing
- Anger
- Shame
- Unfair treatment
- Intimidation
- Continuous attacking of another co-worker
- When I hear this question. I think of people gossiping and spreading rumors that are sometimes not true
- People having their own cliché. They only associate with certain people
- Abuse
- Intimidation
- threatening

2. When you hear the words ‘workplace bullying’ or ‘horizontal violence’, what comes to mind?

- Lack of management following up on complaints
- No disciplinary actions
- Unhappy work environment

- Stress
- Burnt out
- Some people are just mean
- A weak person who is not sure of who they are will; often times become a bully or bullying has been a part of their environment
- Personnel unhappiness
- Inconsideration for others
- People not doing their jobs
- Pay scale
- Assignment
- Skills
- Lack of education
- Positions
- Entitlement
- Across divide
- Overwhelmed on the floor
- Not working together as a team
- Culture
- Training
- Degrees
- Lack of leadership
- No communication
- Attitude

- Poor communication
- Disrespect\power
- Overworked
- Power
- Emotionally charged situation
- Jealousy
- What people think
- What's unfair
- Unfair promotion
- Lack or resources
- People don't really like themselves. They are angry with themselves
- Sometimes when they are close to other employees and those employees in particular don't like another employee, the bully tends to take on the behavior of their "friend"
- The old saying" nurses eat their young"
- Burn out
- Some treat others the way they were treated
- Leadership not supporting fairly workplace culture at the VA
- Unfair, unsafe assignment

3. Please describe potential strategies to address work place bullying/horizontal violence.

- Termination
- It should not be tolerated
- Head on confronting the bullies
- Making workplace meeting

- Making class for incivility
- Talking
- Being a positive role model
- Loving yourself
- Getting to know each other
- Don't take everything said personal
- Talking to each other to get understanding of what they think is bullying
- Avoidance-"I don't feel it is my responsibility to address sometime that should be common place .We are all grown adult. We should all do our job
- In-service
- Outings other than at work. Getting to know each other activities
- Mediation
- Mindfulness
- Team building
- Rules/consequences/open communication
- Have respect for each other and approach
- Be open.
- Talk to each other,
- 1:1 interaction among
- Mediation with supervisor
- Positive enforcement
- Better staffing
- Make employees happy

- Reduce work load
- Retreats
- Team building exercises
- Communication
- Use same proficiency standard
- Squelch escalation of “tattling”
- Team building exercises
- Treat other the way you want to be treated
- Communication
- Check in meeting
- I think employees should be able to comfortable go to their supervisor and comfortably speak on how they feel
- Training should be provided
- Control busy body people acting like children
- Fair assignment
- Support staff equally

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