The Dark Side of Nursing Practice: Lateral Violence and Bullying Behaviors Among Nurses

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Health care and nursing literature contain thousands of references to a destructive phenomenon that has only been recently acknowledged to occur among adults, and within the profession of nursing. Although incidences of childhood bullying are receiving daily attention in the media, limited attention focuses on the interactions and destructive interpersonal behaviors that occur among nurses in a variety of practice settings across the globe, including long-term care and senior living. As articulated by Johnson, Boutain, Hsin-Chun Tsai, Beaton, and DeCastro (2015) research on workplace bullying began in the 1980’s, and a proliferation of academic articles and research endeavors addressing bullying in the nursing profession have only occurred in the last ten years.

Many of the academic articles reviewed in preparing this article indicated that nurses experience varying exposure rates to bullying and that rates of bullying among nurses are the highest of all health care occupations. Ekici (2011) completed a cross sectional and descriptive study of workplace bullying and the effect on performance and depression status of physicians and nurses and found that seventy four percent of doctors and eighty two percent of nurses experienced some form of bullying in the workplace. Workplace violence is defined by NIOSH (2016) as the act or threat of violence, ranging from verbal abuse to physical assaults directed toward persons at work or on duty. The risk for nonfatal violence resulting in days away from work is greatest for health care workers and social assistance workers. According to NIOSH (2016) sixty-seven percent of victims are female, and sixty-nine percent of the individuals experiencing workplace violence are health care or social assistance workers. Verbal abuse, bullying, or physical assault by a coworker represent the most common forms of workplace violence, occurring between worker and worker when current employees or past employees of an organization become perpetrators (Gale, 2016).
Additional terms used to describe bullying include lateral or horizontal violence, mobbing, disruptive behavior, workplace incivility, lateral aggression, or workplace psychological violence. Workplace bullying may be perceived by nurses as a justifiable “rite of passage,” that “nurses eat their young,” and that “tough love” must be utilized when introducing new nurses to clinical practice settings (Leong and Crossman, 2016). The intent of this article is to highlight bullying behaviors among nursing professionals and identify evidence-based interventions to combat workplace incivility. The article will also provide recommended strategies for educating leaders to protect against this abusive behavior that may exist in any health care or academic setting.

**Concept and Importance of Leadership and Organizational Management**

This phenomenon creates severe and negative impacts on the individual, work team and health care organization. Wilson (2016) suggests that nurses are more likely to be bullied than any other health care professionals. She further indicates that most bullying occurs between nurses of the same gender and that bullying is more prevalent in occupations where one gender is dominant. Research institutes, hospitals, and health care organizations remain largely patriarchal systems with a disproportionate percentage of male physicians and health care executives serving in key leadership roles. In many long-term care and senior living communities, the majority of nurses and nursing assistants remain positioned in the lower hierarchy, and become involved in a cycle of hierarchical abuse, acting out their professional frustrations on younger or less experienced team members lateral to their positions (Chu and Evans, 2016). Heavy workloads represented the most significant organizational factor in the manifestation of workplace bullying.
Although alarming, these researchers also suggest that future generations of nurses may repeat this behavior as a result of the unacceptable treatment they received following graduation from nursing school in their first year of clinical practice.

From a cultural vantage point, Leong and Crossman (2016) state that some cultures tend to expect compliance in hierarchical relationships, and that nurses from these cultures are more accepting of unequal power and control in relationships compared to nurses from other cultures. Novice, newly licensed nurses with limited experience are the biggest targets of lateral violence in health care. Many new nurses lack the knowledge, confidence, and expertise to defend themselves and stand-up to a nursing bully (Chu and Evans, 2016). Sadly, although any nurse experiencing prolonged bullying may resign from employment or exit the nursing profession, new graduates are three times more likely to terminate employment or permanently leave the nursing profession (Ekici, 2011). The American Association of Colleges in Nursing (2008) also reports that an astounding thirty-five to sixty percent of new nursing graduates exit their first position as a result of inadequate workplace social support in situations such as bullying by a coworker.

Many definitions of workplace bullying exist in the literature. According to Wilson (2016), this phenomenon is often initially viewed as subtle, insidious, or rude behavior that is trivialized or dismissed by the target, supervisors or fellow team members. The behavior often progresses to overt and deliberate destructive interactions that become recognized and acknowledged as bullying behavior directed at the target. Johnson et al. (2015) describe workplace violence as a dysfunctional interaction between the perpetrator and the intended victim which originates from an unresolved conflict, personal differences, or a breakdown in interpersonal communication.
Bullying is highlighted by a wide range of aggressive acts that may include public criticism, spreading malicious rumors on the nursing unit, ostracizing, ignoring, or making fun of a coworker (Johnson et al., 2015). Additional actions may include sabotaging a nurse’s ability to complete his or her assignment by withholding information or preventing access to patient care supplies, equipment, telephones or computer terminals (Wilson, 2016). Some forms of workplace violence observed by this author may escalate to aggressive behaviors such as shouting at the nurse target, and threatening or committing acts of physical abuse.

Sadly, managerial or supervisory bullying behaviors are common and may include withholding positive performance feedback or failing to give credit where due. Other behaviors include micromanagement of all aspects of the individual’s work, obsessive control, or assigning of trivial or unpleasant tasks (Johnson et al., 2015). Public humiliation through outright aggression or rude behavior has a cumulative effect, and this repeated behavior increases stress levels, demoralizes the nurse, and eventually destroys the nurse’s self-confidence and sense of self-worth (Chu and Evans, 2016).

In addition to diminished confidence, personal consequences of bullying can lead to adverse patient care outcomes, burnout resulting in increased turnover, and higher costs to the organization. In a recent graduate thesis completed by Christine Howell at the University of Alberta (2016), she suggests that unresolved bullying may result in diminished physical and emotional health of the target of bullying. Health impacts may include chronic stress, alcohol abuse, post-traumatic stress disorder, and increased blood pressure that may result in an increased risk of developing cardiovascular disease. Wilson (2015) found the main effect of unresolved workplace bullying among nurses is psychological distress and depression that may lead to post-traumatic stress disorder (PTSD).
Organizational consequences highlighted in the literature include increased rates of sick time and absenteeism, and lower levels of employee engagement that may result in decreased job satisfaction and increased turnover (Cerevolo, Schwartz, Foltz-Ramos, and Castner, 2012). In a time already punctuated by a shortage of available nursing professionals, it is critical to note that nurses often resign their positions or leave the nursing profession following prolonged bullying by their nursing colleagues. Wilson (2016) suggests that consequences of bullying may create an erosion in organizational culture and a decrease in not only the nurse’s commitment to the health care entity but his or her relationship with patients. Wilson (2016) believes that the reduced engagement of the nurse may have an adverse impact on motivation, energy levels, and collaboration with others, which can clearly impact patient safety and decision making. In addition to turnover, Duffield et al. (2014) suggests that organizations may suffer from significant economic impacts related to employee turnover and nurses who make the decision to exit the health care setting at an estimated cost of $48,790 per Registered Nurse.

Like it or not, leaders set the culture and tone within an organization. Consistent and effective leadership is essential for organizations that promote and maintain supportive and nurturing environments. An organization with a culture of caring and safety has zero tolerance for lateral violence and bullying (Bourdan, 2015). The characteristics, behavior, beliefs and practices of leaders often set organizational tone and tolerance for incivility in the workplace. Action or inaction taken by leaders and managers in response to allegations of lateral violence and bullying are noted to be a significant enabler or deterrent to future bullying behavior. Wilson (2016) suggests that hierarchical management structures that do not leave employees feeling empowered may contribute to workplace violence. Silence and inaction by nurse managers and leaders only serve to perpetuate the abusive behavior, rather than supporting team members who
become the target of bullying. When bullying does occur, incidents must be thoroughly investigated and fully resolved in a manner that supports the victim of lateral violence (Johnson et al., 2015).

**Current State of Knowledge and Best Practices**

A concerted and multidimensional approach should be employed by nursing and health care leaders when developing programs to identify and combat workplace bullying. The literature points to several possible interventions to counteract the individual and organizational damage created in a culture punctuated by bullying among nurses. Suggested interventions include education and training of senior and front-line leaders on the identification and reporting of lateral violence. It is my belief that nursing leaders should partner with their human resource or social service departments to educate nurses on this important issue, similar to the training and education mandated by licensing, certification, and accreditation agencies regarding patient abuse prohibitions. My organization has a well-established zero-tolerance policy for any form of patient or team member abuse, and team members are mandated to report any observations of abuse, neglect or mistreatment. As suggested by Chu and Evans (2016), leaders can incorporate cognitive rehearsal techniques and role-playing to illustrate how to respond to uncivil encounters in the workplace directed at patients or team members. To facilitate an effective anti-bullying policy there must be enforcement of the policy and clear consequences for the employee violating the policy.

Additional interventions include collaborative efforts to create a positive work environment that promotes teamwork, wellness, and stress reduction. As suggested by Allen, Holland, and Reynolds (2014), employees should be encouraged to take advantage of paid time off, and utilize work breaks in a healthy way. It is suggested that whenever possible, employees
leave the assigned unit, “switch off,” and attempt to psychologically detach from work to reduce stress and decrease the potential for burnout. Singleton (2016) also recommends that nurses complete due-diligence when applying for a new job. This may assist the nurse to gain insight on the culture of the new team they will be joining or the leadership style of their new manager. Singleton (2016) advises that we avoid the temptation of taking home the stress and pressure of the work environment, as this can have negative consequences on personal relationships with family members and friends.

Organizations should provide clear communication about the availability of internal and external employee assistance programs, and measures to identify, report, and mitigate the risk of bullying. As recognized by Chu and Evans (2016), many employees fail to report bullying behavior because of fear of retaliation or a false assumption that bullying is “part of the job,” and will not be handled appropriately by supervisors.

A healthy work environment includes visible nursing leaders who encourage professional practice and acknowledge and value the contributions of nurses. Other key factors related to a healthy work environment repeated throughout the literature review include collaboration and communication, shared decision making, accountability, and adequate staffing patterns that promote safe and effective nursing practice.

As indicated by Ganz et al. (2015), the higher the prevalence of bullying within an organization, the less likely preventative measures are in place to combat this phenomenon of workplace incivility. Health care organizations with toxic work environments that focus solely on financial performance or work environments attenuated with bullying behaviors create extremely stressful conditions for vulnerable novice nurses, as well as their experienced coworkers who become a party to these disruptive behaviors (Berry et al., 2016).
Potential Implications for Clinical Practice, Education and Policy

Bullying has existed in our practice settings for many years. These behaviors have a direct and severe impact on patient care outcomes, patient safety, and patient satisfaction. Bullying also plays a role in job satisfaction, individual and team communication and collaboration, as well as retention of nursing professionals in an already challenged workforce. Efforts to educate nurses, promote “Bully-Free” zones, and create zero tolerance policies regarding these behaviors may have a positive impact on reducing work-related stress and creating healthy work environments that support the growth and development of professional nursing practice (Robinson and Dodd, 2014).

Nurses have a responsibility to resolve professional conflict and identify stress triggers that may illicit emotional responses when responding to perpetrators of workplace bullying. In addition, individual nurses and health care organizations have an obligation to adopt and reinforce zero-tolerance attitudes when confronted by or observing the actions of a nursing bully. At the macro level, it is critical that health care organizations proactively address the divisive nature of lateral violence among nurses through policy development, education, leadership development, and implementation of orientation and mentor programs for novice nurses and those who may be returning to our nursing profession.

Whether directed at themselves or their coworkers, no nurse is immune to the psychological distress associated with workplace bullying. It not only exists but threatens to undermine the physical and psychological safety, health and well-being of our dedicated nurses and the patients for whom they are entrusted to provide care and services.
References


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Case Study on Nurse Bullying

“Jennifer” does not remember a time in her childhood when she did not dream of becoming a nurse. Her grandmother and mother were registered nurses, and she remembers attending childhood Halloween parties dressed in a white dress, proudly wearing her mother’s nursing cap on her head and Mom’s stethoscope around her neck. In grade school, Jennifer served as a candy-striper volunteer in a nursing home located in her neighborhood. When she became 16 years old, she assumed a paying job in the nursing home as a part-time housekeeper. Jennifer loved the interaction with her geriatric patients and jumped at the opportunity to become a nursing assistant when approached by the community Director of Nursing (DON). The DON told Jennifer that she believed she was destined for a career in nursing, and often applauded Jennifer for the patience and compassion she demonstrated toward the aging adults who lived in the nursing home. Jennifer adored her grandparents and great-grandparents, and her heart already belonged to nursing and the care of aging adults. The praise and reinforcement from this respected DON only heightened Jennifer’s resolve to become a nurse.

Jennifer was not from a wealthy family and decided to complete a local one year Licensed Practical Nursing program as her first step toward becoming a Registered Nurse. The LPN program allowed Jennifer to gain experience and income as a nursing assistant while attending the LPN program. Jennifer graduated at the top of her LPN class and was very excited about becoming a staff LPN in the nursing home where she already worked as a nursing assistant. Several of the RNs and LPNs who worked with Jennifer strongly encouraged her to get at least a year of acute care experience in the local hospital. They firmly believed that enhanced clinical skills would serve her well as she continued her education to become an RN.
Although she hated to leave the elderly adults she had come to know and adore in the nursing home, Jennifer reluctantly accepted a night shift position at a large teaching hospital in her community. Because she was a new graduate, she took a full-time night shift position on the Oncology Unit. As an LPN on the night shift, she would be assisting RNs with patient care. Most of her fellow nurses were new BSN graduates from the local university. The night shift RN Supervisor was completing her MSN at a local and well-respected Jesuit university. Jennifer was excited about what these nurses could teach her as she continued her studies to become an RN the following semester.

The trouble began Jennifer’s first week when she arrived at her assigned unit at the hospital. During her first night on the job, the RN Supervisor introduced Jennifer as the new “Go-To Gomer Nurse.” Although Jennifer did not understand what that reference meant, the other nurses laughed uncontrollably. Only later did one of the nurses tell her that most of the unit nurses hated caring for elderly adults and that Jen would likely be assigned anyone over the age of 65. In the following weeks, that prediction did come true. Jennifer provided nursing care to the elderly adults who were patients on the unit, and she was often assigned to be a “private sitter” for older patients who had behavioral issues.

The RN Supervisor often told her that she was not a “real nurse,” and until she had an RN behind her name, she would be “serving” the more educated nurses on her assigned unit. In one change of shift report, the RN addressed Jennifer as “the nurse with the toilet paper degree.” Later that week, the Supervisor also met with Jennifer and told her that because she was an LPN, they had decided that Jennifer would be responsible for all the bowel protocols and administration of all pre-op enemas that attending physicians ordered for patients on the unit. She further explained that none of the other nurses had obtained Baccalaureate nursing education.
to assist patients with bedpans. Although Jennifer accepted this position to gain clinical skills and expertise, she enjoyed her elderly patients and became attached to a few of the patients who had been on the unit for several weeks. One gentleman diagnosed with colon cancer often requested Jennifer as his nurse. He had no family of his own and appreciated the kindness and patience Jennifer displayed when providing his care. The fact that he specifically requested Jennifer as his nurse seemed to bother some of the RNs on the unit, and they began to refer to her as “Joseph’s pet.”

Before leaving for a long weekend off, the RN Manager informed Jennifer that because she was “only an LPN” she would now be responsible for transporting bodies to the morgue following any night shift deaths on the oncology unit. Jennifer was only 19 years old and had never been with anyone who had died. She explained this to her supervisor, who told her she was ridiculous, and that an LPN from another unit would be teaching her how to complete this procedure. An LPN from the burn unit quickly explained where Jennifer could find the cart, and how to prepare the body for transport. She accompanied Jennifer to the large morgue in the basement of the hospital and opened a few of the refrigerated sections to show the young LPN how to maneuver the lift to place the body in the compartment. An amputated leg was in one refrigerator, and a perfect baby was in the next. Jennifer quietly observed the process and left that shift questioning why she had become a nurse.

She returned to work following a relaxing weekend away and looked forward to concentrating on all the things she loved about being an LPN. Following night shift assignments Jennifer proceeded to care for her patients. At 2:30 am, the RN Supervisor told Jennifer that the patient in Room 215 needed her assistance. Jennifer was not assigned to this room but entered to assist the patient. When she walked in the hospital room, a sheet was covering the patient’s body
and head. She pulled back the sheet, and it was her deceased and much adored patient Joseph. She began to sob quietly, and a familiar voice behind her said, “This is what happens to new LPNs who become the favorite nurse on our unit.” Jennifer prepared Joseph with dignity and compassion, and quietly transported him to the hospital morgue. Following completion of her shift, she presented the human resource department her letter of resignation, silently vowing that she would never again return to an acute care setting in any capacity as a nurse. Sadly, Jennifer’s short career as a hospital nurse had ended.