Understanding Lateral Violence in Nursing

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The concept of lateral violence (LV) also is known as horizontal violence, bullying, or aggression (Griffin, 2004). Other terms in the literature relating to this concept are horizontal hostility, verbal abuse, or “nurses eating their young” (see Figure 1). The phenomenon has been described in nursing literature for more than 25 years (Farrell, 1997; Roberts, 1983). The literature defines LV as nurses overtly or covertly directing their dissatisfaction inward toward: (a) those less powerful than themselves, (b) themselves, and (c) each other (Griffin). The lack of a universal term to encompass these actions makes integrating research on LV difficult (Bartholomew, 2006). LV manifests itself in a variety of unkind, antagonistic interactions that occur among nurses at the same organizational hierarchy (AlsSpach, 2007); these interactions may be overt or covert (Bartholomew; Griffin). Because most communication is nonverbal, covert behaviors have the biggest impact (Bartholomew).

LV is an act of aggression that is perpetrated by one nurse against another. The common manifestations of LV have been described by Griffin (2004) as nonverbal innuendo, verbal affront, undermining activities, withholding information, sabotage, infighting, scapegoating, backstabbing, failure to respect privacy, and broken confidences (see Table 1). Typically, LV is verbal or emotional abuse, but it also can become physical abuse (Longo & Sherman, 2007). LV is an issue throughout nursing and practice settings (Stanley, Dulaney, & Martin, 2007; Woelfle & McCaffrey, 2007).

Origins of Lateral Violence

As sensitivity and caring (Bartholomew, 2006) are the focus of the nursing profession, LV occurring at all is ironic (McKenna, Smith, Poole, & Coverdale, 2003; Woelfle & McCaffrey, 2007). Although other theories describe why LV occurs, the most cited theory to describe the origins of LV can be found in the oppressed-group model (Roberts, 1983). The model suggests that nurses are an oppressed and powerless group dominated by others (DeMarco & Roberts, 2003). Oppression exists when a powerful and dominant group controls and exploits a less powerful group. Nursing has been described as an oppressed group because the profession is mostly women, and nurses report to mostly male physicians and administrators (Farrell, 1997). Cherished nursing characteristics, such as sensitivity and caring, are viewed as less important or even negative when compared to those of medical practitioners, who often are seen as the central culture in health care (Woelfle & McCaffrey).

The literature supports this view, stating that nurses lack autonomy, control over their work, and self-esteem and subscribe to submissive-aggressive syndrome to affect change (Freshwater, 2000). Submissive-aggressive syndrome is a term that describes when nurses feel they have lost their power (submissiveness), and react by overpowering others through aggressiveness (Bartholomew, 2006). Roberts (1983, 2000) has described the application of Freire’s (1971) oppression theory to nursing. The theory explains that members of an oppressed group display common behavioral characteristics, such as low self-esteem and self-hatred (Roberts, 1983; Woelfle & McCaffrey, 2007). LV among nurses evolves from feelings of low self-esteem and lack of respect from others in the work environment (Longo & Sherman, 2007). Oppression theory proposes that nurses perceive themselves as powerless and oppressed in the healthcare setting. As an oppressed group, nurses feel alienated and have little control of their practice. This leads to a cycle of low self-esteem and feelings of powerlessness (DeMarco & Roberts, 2003). Rather than confronting the issue (and risking retaliation by leadership in the healthcare system), the oppressed group manifests their frustration on other nurses lateral to them. LV behaviors are not directed at the individual nurse but rather are a response to the practice environment. The practice environment is seen as “emotionally, spiritually, and psychologically toxic” (AlsSpach, 2007, p. 12). These toxic work environments often are a result of downsizing, aggressive management styles, and increasing internal and external competition (Rowell, 2005). Nurses exhibiting LV believe it is a safer manifestation of stress. The nurse committing the LV is unable to effectively confront the oppressor, so the anger is directed at a safer person; however, LV causes the recipient of the behavior to become a victim and, feeling hurt and vulnerable, reinforces powerlessness (Longo & Sherman, 2007). The victim of LV is practicing in what they perceive is an oppressive healthcare setting; the fear of retribution from those considered more powerful prevents the individual nurse from taking action that could break this cycle. Nurses in such a workplace lack the solidarity to effect change (DeMarco &
Roberts, 2003). Over time, staff can come to believe that LV behaviors are normal (Longo & Sherman); LV can become part of a unit’s culture. New staff may believe that this manner of relating to each other is “just how things are done around here.” The result is a group of nurses who are afraid to ask for help from their coworkers, increasing the possibility of errors (Longo & Sherman). Tolerance for some forms of LV have become so institutionalized they are viewed as a right of passage (Buback, 2004).

**Task and Time Theory**

Nurses tend to see their work in terms of rules, tasks, and time (Ramos, 2006); when the number of tasks to perform is overwhelming, depersonalization of care can occur (Bartholomew, 2006). Nurses may view patients (Farrell, 2001) and coworkers (Bartholomew) as objects if they feel stressed for time and may lash out against another nurse in frustration through LV.

**The Role of Gender**

The presence of LV in nursing may be partly because of the profession’s predominantly female workforce. This theory states that LV occurs because women have not been socialized to appreciate themselves or the role they play (Rowell, 2007). During childhood, girls are socialized to be nurturers and to swallow or suppress anger. According to Martin, Stanley, Dulaney & Pehrson (2008), women are more likely to deny or minimize their hurt feelings if they believe that expressing them could harm a relationship. Unexpressed anger can come to the forefront when nurses are feeling frustrated and believe they are not equal in power. Nurses with this belief system tend to vent this frustration laterally or to those with less power (Rowell, 2007). This passive-aggressive behavior is exhibited covert (Martin et al.) and overt.

**The Special Case of the New Graduate**

Newly registered nurses are especially at risk for LV. According to Griffin (2004), new nurses face many obstacles in their quest for knowledge development and skill acquisition. Today’s new graduates are practicing with patients who are more acutely ill than in the past and in a work setting that may not have adequate staffing (Bowles & Candela, 2005). A study by McKenna et al. (2005) of 551 newly registered nurses in New Zealand found that many of the new graduates experienced LV. In addition, the researchers reported that LV was widespread across all clinical settings and overt forms of interpersonal conflict were experienced by 34% of the respondents. The respondents experienced comments that were rude, abusive, or humiliating. Sexual harassment was experienced by 5% and inappropriate racial comments and gestures were reported by 4% of the respondents. More than a third of the respondents had learning opportunities blocked, felt neglected, and felt they were given too much responsibility without appropriate support. The distress from experiencing this abuse resulted in absenteeism and respondents who wanted to leave nursing; unfortunately, almost half of the events were not reported. In the United States, the Price-waterhouseCoopers Health Research Institute (2007) found that the average nurse turnover rate in hospitals was 8.4%; however, the average voluntary turnover rate for first-year nurses was 27.1%. Given the perceived vulnerability of new graduates, LV may play a role in the turnover of these nurses.

**Effects on Staff, Patient Safety, and Economic Cost to the Organization**

The United States currently is in the midst of a nursing shortage that threatens the health and well-being of all citizens in the United States. Because of the current and impending shortage of nurses, the question is raised, “Can nursing afford to lose any more nurses because of LV?” As a result of the growing severity of the nursing shortage and issues of patient safety, many healthcare organizations, accrediting bodies, and professional nursing organizations are examining the working environment of nurses. A serious barrier in the delivery of safe care (Alspach, 2007; Rowell, 2005; Woelfle & McCaffrey, 2007) and the ability to keep nurses in the profession (Thomas, 2005) is the incidence of verbal abuse and other disrespectful behavior received from coworkers and peers.

**What Are the Costs of Lateral Violence?**

LV causes a downward spiral that is costly to individual nurses (Stanley et al., 2007). Nurses can experience physical symptoms, such as weight loss or gain, hypertension, cardiac palpitations, and irritable bowel syndrome (Rowell, 2007). The outcome of working in this type of environment is job dissatisfaction and psychological distress (Longo & Sherman,
2007). The psychological consequences can range from increased stress to mental illness, such as depression, acute anxiety, and posttraumatic disorder (Rowell, 2005). The victim of LV can develop low self-esteem and poor morale, feel disconnected from other staff members, exhibit depression, and use excessive sick leave (Bartholomew, 2006). Continued exposure to LV drains nurses of their enthusiasm for the nursing profession; nurses who report the greatest degree of conflict with other nurses also report the highest rate of burnout (Thomas, 2003). The family and friends of nurses who are victims of LV also suffer as stress, anxiety, and anger build in the victim. Nurses will leave the workplace and the nursing profession, some permanently, when conflict among coworkers become unbearable (Thomas).

LV among nurses that is allowed to continue also is costly to an organization (Longo & Sherman, 2007; Stanley et al., 2007). Nurses will leave a workplace that allows LV to continue (Stanley et al.), which ultimately will impact retention of qualified staff. Approximately 60% of newly registered nurses leave their first position within six months of employment because of some form of LV (Griffin, 2004). Recent studies of the economic cost of nurse turnover have reported $22,000 to more than $64,000 per nurse (Bland-Jones & Gates, 2007). For staff remaining on the unit, trust is eroded, resulting in diminished teamwork, which further leads to a negative impact in patient care (Stanley et al.). LV can affect the recruitment of new staff if an organization that has developed a reputation for tolerating LV, resulting in new nurses not wanting to join particular organizations (Bartholomew, 2006).

In addition, LV that is allowed to continue can be harmful to patients. The organization becomes a place were staff lack the initiative to do their job well (Woelfle & McCaffrey, 2007). The impaired personal relationship among nurses at work can cause errors, accidents, and poor work performance (Farrell, 1997). The Institute for Safe Medication Practices (2004) surveyed 2,000 healthcare providers and found that almost half of the respondents experienced intimidation that caused them to change the way they handled an order. About 40% of the respondents accepted an order because they feared the intimidation by the prescriber. Although the study indicates that prescribers may intimidate, other clinicians also could intimidate through a range of behaviors from the use of subtle questioning of professional judgment to explicit threatening behavior. Intimidation can lead to high-stress conditions, resulting in nurses not being able to perform at their optimal, and the result can be poor patient care (Woelfle & McCaffrey).

In addition, patients and their families make more complaints in organizations where LV is allowed to continue (Rowell, 2005).

Why Does Lateral Violence Continue?

Stanley et al. (2007) asserted that LV seems to “ebb and flow” with events that produce nursing shortages, during reorganization, and because of the shifting requirements for managerial positions. The pressures to produce high-quality care using a minimal budget can cause a situation where only negative outcomes are the impetus for improving nurse working conditions. Preventing LV loses its position on the priority list.

DeMarco and Roberts (2003) stated that to change the cycle of negative behavior entails a process that involves personal reflection as well as professional considerations. They posit several stages: (a) unexamined acceptance where the oppressed environment is considered normal, (b) an event that serves as a learning experience and makes the group aware of the social inequality of the situation, (c) a connection stage that allows nurses to grow and have pride in themselves and appreciate nurse colleagues; and (d) increased positive, professional identity, resulting in working with others to make change.

### Table 1. Types of Lateral Violence and Their Manifestations

<table>
<thead>
<tr>
<th>TYPE</th>
<th>MANIFESTATION</th>
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<tr>
<td>Nonverbal cues (covert and overt)</td>
<td>Raising eyebrows, rolling eyes, or making faces in reply to a question</td>
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<td>Verbal remarks (overt)</td>
<td>Snide, rude, and demeaning comments</td>
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<td>Actions (overt)</td>
<td>Actions that undermine the victim's ability to perform in the healthcare setting (e.g., hiding or hoarding limited patient care items from other nurses). Not being available to help the other nurse with difficult care issues</td>
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<td>Withholding information (covert and overt)</td>
<td>The information can be about a patient or a procedure (e.g., deliberately not telling another nurse that a patient has limited sight on the right side, that the suction set up in an outpatient room is not working).</td>
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<td>Purposefully sabotaging (overt)</td>
<td>This serves to set up the other nurse for negative situations. A circulator does not tell a new nurse who is scrubbed that she knows the shunt the surgeon has selected has fallen to the floor (Anonymous, 2007).</td>
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<tr>
<td>Group infighting (overt)</td>
<td>Nursing cliques</td>
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<td>Scapegoating (overt)</td>
<td>Excluding other staff members</td>
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<td>Passive-aggressive behavior (overt)</td>
<td>Blaming negative outcomes on one identified nurse</td>
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<td>Broken confidences and not respecting privacy (covert)</td>
<td>Also characterized as gossiping; sharing information that is meant to be private. For example, a nurse has failed the Oncology Nursing Certification and plans to sit for the test again but does not want her coworkers to know that she failed. She tells her mentor in confidence that she failed the certification test and this has caused her great pain. The mentor shares this story with coworkers during downtime on the unit.</td>
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*Note: Based on information from Freshwater, 2000; Griffin, 2004.*
Actions to Stop the Cycle of Lateral Violence: The Individual Nurse

According to Woelfle and McCaffrey (2007), professional relationships among nurses can improve if nurses make an effort to care about each other and acknowledge the part they play in the LV cycle. Recognizing these behaviors is an important first step if nurses are to overcome LV in the workplace. Changing the cycle of negative behavior will entail professional reflection with evidence-based practices and personal reflection. Two techniques cited in the literature are cognitive rehearsal and “carefronting.” Carefronting (Kupperschmidt, 2008) uses biblical concepts of respect, forgiveness, and courage to confront hostility in the workplace. In carefronting, personal needs of an individual are integrated with the wants and needs of others; it involves caring enough to confront the person and situation in a responsible manner.

An example of professional reflection based on scientific evidence is observed in the process of cognitive rehearsal, as described by Griffin (2004) in an exploratory study of 26 newly licensed nurses. In the study, the nurses attended a two-hour specialized education offering concerning the concept of LV and then practiced techniques to confront the LV behavior. Each subject was given cue cards identifying 10 common forms of LV with constructive actions to take for each one. The study found that knowledge about LV allowed the newly licensed nurse to depersonalize it, thus allowing them to ask questions and continue to learn. In addition, the retention rate of nurses was positively affected.

Thomas (2003) cited six general principles that an individual or small group of nurses can do to remedy LV issues: (a) defuse intense anger, temper angry thoughts by using relaxation techniques and mediation and, after emotions have subsided, have a discussion about the incident; (b) resolve to release anger, holding onto these feelings accomplishes nothing; (c) consult an expert when conflict is festering in the workplace (e.g., have a psychiatric clinical nurse specialist lead group meetings); (d) demonstrate care and compassion for your coworkers and reach out to those who are struggling with personal issues; (e) compliment rather than complain; and (f) cultivate a team spirit by including socialization outside of the workplace, such as celebrating birthdays and certifications, and make sure new nurses feel welcome.

Actions to Stop the Cycle of Abuse: Management

Canada, the United Kingdom, and Scandinavian countries have laws protecting workers from LV; however, the United States offers little protection except for sexual and racial harassment (Rowell, 2005). This means that action to stop LV must be taken by nursing management. Farrell’s (2001) conceptual model of interpersonal conflict in nursing requires a comprehensive analysis of the organizational structure, workplace practices, and the interactional nature of interpersonal conflict. Many of these factors are controlled by the nurses themselves.

Longo and Sherman (2007) suggest that the manager should first analyze the culture of the workplace, assessing for verbal and nonverbal clues of LV. When the behaviors are observed, the issue should be named and raised at staff meetings, and staff should be allowed to share their stories. Training on conflict management and educational offerings that describe how to defend against LV can be instituted.

What Other Organizations Are Doing

The American Association of Critical-Care Nurses (AACN) conducted a survey asking RNs if they had personally experienced verbal abuse from another RN while working as a nurse during the past year (Alspach, 2007), and 18% indicated they had. Although it should be noted that critical care RNs rate their interactions with other RNs highest when compared to others, AACN leadership was concerned about the 25%–32% of instances in which nurses reported interactions as fair-to-poor quality (Alspach). AACN leadership has made LV one of their top priorities.

Conclusion

Although specific research about the incidence of lateral violence in oncology nursing is lacking at this time, it is reasonable to assume that LV does occur in the specialty given the growing body of research on the topic (Woelfle & McCaffrey, 2007). Oncology nurses and the patients they care for are at risk for the same physical and emotional issues that result from lateral violence.

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### What Are Your Thoughts on Lateral Violence?

Do you feel that lateral violence is an issue for oncology nursing? Do you have a story about lateral violence in oncology nursing you would like to share? Contact the author at lvinnursing@comcast.net with copy to associate editor at jeannet_albert@mountainstarhealth.com. All information will be kept in the strictest confidence. No names or any type of identifiers will be used in any future publications or presentations about lateral violence.