

Lateral violence: Calling out the elephant in the room

By Ann Kettering Sincox and Michelle Fitzpatrick, RN, MS, CPNP

For the last eight years, I've had the pleasure of being the MNA Consultant to the Michigan Nursing Students Association (MNSA) Board. Although each Board has had its own personality, there are some similarities. Individual members are all swamped with schoolwork. They are all amazed at what it takes to plan an annual convention. And, they all have horror stories of verbal abuse from some of the nurses they've met during clinical rotations.

And with good reason. Nursing students are one of the primary recipients of lateral violence, or nurse-to-nurse aggression. Whether it's considered hazing, or a rite of passage, ("This happened to me when I was a new nurse so I'm just passing it along.") or the real or perceived imbalance of power, nursing students are frequent targets of lateral violence. Cynthia Clarke PhD, RN notes that the consequences of lateral violence or incivility in nursing education include disrupted student faculty relationships, problematic learning environments, and increased student stress, as well as the potential for violence. In addition to nursing students, newly licensed nurses, along with newly hired nurses, temporarily assigned nurses, float nurses, and nursing assistants or aides also commonly experience the backlash of lateral violence.

In a recent presentation on lateral violence called "Incivility and Interactive Workplace Violence: Addressing Lateral Violence in Nursing," co-author Michelle Fitzpatrick, RN, MS, CPNP, noted that, "Lateral violence continues in nursing, because it can." Like "the elephant in the room," nursing



generally fails to acknowledge its existence. Some experts on the topic of lateral violence in nursing have even referred to the phenomenon of lateral violence as "nursing's dirty little secret." Educational institutions and healthcare organizations may also fail to acknowledge lateral violence, and frequently do not have measures in place to address it. Additionally, too often, there is a tendency to 'blame the victim'.

Lateral violence in nursing can consist of a variety of behaviors; from unintentional, thoughtless acts to purposeful, intentional, destructive acts meant to harm, intimidate or humiliate another group or individual(s). Lateral violence can range from random instances to a pattern of repeated behaviors. Collectively, these behaviors have the effect of creating an environment of hostility. Any time there exists a 'we versus they' attitude, or an imbalance of power, conditions are 'prime' for lateral violence to occur.

In its extreme form, lateral violence can manifest itself as bullying. Bullying, as defined by Barbara Coloroso (2003), is "a conscious, willful, and deliberate, hostile activity intended to harm, induce fear through threat of further aggression, and create terror" (p.13). Regardless of how bullying masquerades itself, three elements will always be present. These include an imbalance of power, an intent to harm, and the threat of further aggression. When bullying is left unchecked, a fourth element comes into play; terror in, or intimidation of the target.

A new page has been added to the MNA website as a resource for those wishing to learn more about lateral violence. It can be accessed at www.minurses.org by clicking on "MNA Programs," then "Nursing Practice." Please send any resources that you find to Ann Kettering Sincox, Editor, at ann.sincox@minurses.org. Resources already posted include a master's thesis on lateral violence "Adult Bullying Within Nursing Workplaces: Strategies to Address a Significant Occupational Stressor" by Michele R. Haselhuhn, RN, BSN, MSN, CCRN, CEN, EMT-P and a link to a continuing education module on lateral violence from the American Nurses Association. An extensive biography used with this article is also available.

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Martha Griffin, RN, PhD, a nationally recognized expert on lateral violence, has identified ten of the most common forms of lateral violence in nursing. These include:

- 1) Nonverbal innuendo
- 2) Verbal affront
- 3) Undermining actions; unavailability
- 4) Withholding information
- 5) Sabotage; “setting up to fail”
- 6) Infighting
- 7) Scapegoating
- 8) Backstabbing
- 9) Failure to respect privacy
- 10) Broken confidences

A recent editorial in *Critical Care Nurse* (June, 2007) also identified inequitable assignments, belittling gestures, unwarranted criticism, fault finding, segregation, isolation, and elitist attitudes regarding work area, education, and experience as additional expressions of lateral violence which denigrate an individual nurse's professional identity.

Lateral violence is tough on the body, too. The stress it creates can result in a number of physiological and psychological symptoms including: headache, stomach disorders, weight changes, hypertension, cardiovascular disease, stress, anxiety, panic, anger, embarrassment, depression, insomnia, fatigue and rumination. Post traumatic stress disorder (PTSD) can occur not only as the result of being a recipient of lateral violence, but also secondary to observing aggression being inflicted on to other nurses. Nurses suffering from lateral violence can have conflicts in intimate relationships, engage in substance abuse and experience social isolation and phobias. Ultimately, there may be a loss of income and career damage and in extreme cases, suicidal or homicidal thoughts and behaviors.

Lateral violence takes its toll on the workplace as well. In an article in *NurseWeek* (November 2006), Griffin stated that her “research shows that 60% of nurses new to practice leave their first positions within six months because of some form of lateral violence being perpetrated against them.” Feelings of frustration and dissatisfaction contribute to decreased organizational commitment, and increased staff turnover and nursing shortages. Oftentimes there is increased absenteeism and stress related illnesses and, of course, decreased job satisfaction.

Patients are also harmed by unchecked lateral violence. Nurses stressed by the effects of a hostile environment are more likely to make errors. Dissatisfied nurses projecting their feelings onto others can also negatively impact patient satisfaction. When negative interactions among nurses are

witnessed or sensed by patients, lateral violence ultimately undermines patient trust in the health care team.

Calling Attention to the Elephant

In order to address and resolve lateral violence in nursing, we need to stop pretending that it doesn't exist. We must develop and implement measures to deal with the problem. Both short term interventions directed at problem resolution, as well as long term interventions directed at changing organizational culture are necessary. Griffin (2007) noted that a “zero tolerance”, “top down-bottom up” approach is necessary to effectively address lateral violence in nursing. Nurse executives and nurse educators must set the example for respectful behavior. Furthermore they must hold individuals accountable for demonstrating respectful behavior both in the workplace, and in the academic and clinical learning environment. Staff nurses also must be empowered to speak up and help each other out. Too frequently individuals become bystanders, passively observing, or even ignoring the interactions going on around them. Nurses must seek support for each other.

The present generation of nurses is responsible for stopping the cycle of lateral violence from continuing into the next generation of nurses. Formal education sessions to increase awareness of the problem are necessary. First, we must name the problem and acknowledge its existence. But eventually, what must change are the group norms and values. Each nurse who feels they are a victim of lateral violence should keep accurate records to help document and track the problem. However, it's not enough just to keep good records. If there are institutional policies about lateral violence, those should be found and utilized if necessary. Workplaces must develop and formalize a system for reporting. Additional options to address lateral violence include creating workplace violence teams and developing or updating institutional policies.

A culture of safety is the ultimate goal; one which is characterized by a healthcare environment which encourages and permits open and respectful communication in order to ensure the provision of safe patient care.

“The myths that abound in our society about targets – weak and pathetic, frail, insecure, loner, in a ‘dance’ with the bully, asking to be bullied, had it coming, deserving of what they got, ‘losers deserve to lose’ – all feed into the rationalizations kids (and many adults) make for not putting the onus for the bullying on the bully, for joining in, for turning away from targets, or worse, for blaming the targets for what happened to them. No one deserves to be bullied.” (Barbara Coloroso, *The Bully, the Bullied, and the Bystander*, 2003, p. 42) ✱