LIVED EXPERIENCES OF NEW NURSES WITH LATERAL VIOLENCE AND THEIR DECISION TO REMAIN IN THE NURSING PROFESSION

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Lorraine Ann Hover

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The Dissertation Committee for Lorraine Ann Hover certifies approval of the following dissertation:

LIVED EXPERIENCES OF NEW NURSES WITH LATERAL VIOLENCE AND THEIR DECISION TO REMAIN IN THE NURSING PROFESSION

Committee:

Gail Williams, PhD, Chair

Donna Taliaferro, PhD, Committee Member

Ela-Joy Lehrman, PhD, Committee Member

Gail Williams

Donna Taliaferro

Ela-Joy Lehrman

Hinrich Eylers, PhD
Vice Provost, Doctoral Studies
University of Phoenix

Date Approved: 5/14/2020

ABSTRACT

The issue of lateral violence, or nurse-on-nurse violence, is a major factor in why new nurses leave the nursing profession within the first two years of professional practice. There is considerable research into mitigating factors, why nurses leave, and programs to address lateral violence, however, little to no research has been conducted on why nurses choose to remain in the profession despite their experiences. This lack of research necessitates the need for further study into the lived experiences of new nurses with lateral violence and their decision to remain in the profession. This qualitative descriptive phenomenological study helps to address this need. One-on-one interviews with nine recent graduates of pre-licensure baccalaureate programs who had experienced lateral violence and had chosen to remain in the nursing profession were conducted. Data were collected through in-depth, semi-structured interviews, which were audio-taped and transcribed verbatim. Manual data analysis was conducted to reveal the essence of the lived experience of these nurses. Six major themes emerged from the data: the patients, needed the experience, I got counseling, there was an end, I cried, and nothing changed. These themes are discussed and defined by the words of those interviewed. Recommendations for nursing education, transition of new nurses to independent professional practice, and for management are provided, including the need to implement and enforce strict zero-tolerance policies and provide more resources to aid newly graduated nurses into professional practice to improve retention and patient care.

DEDICATION

"It is not how much you do but how much love you put in the doing".

Mother Teresa

This dissertation is firstly dedicated to the glory of God and in thanksgiving to Him for giving me the skills and dedication to be a nurse.

I dedicate this to my beloved husband John, who has been supportive, has put up with the many hours of writing, editing, ignoring him, and whose shoulders much of the responsibility for the household has fallen upon. He has always supported me in my quest to further my education. Thank you not only for the last 10 years, but the last 35 years!

To my parents and grandparents who taught me the value of education and striving for goals. Grammy and Papa, you made me always believe in myself – and instilled the view that college was always in my future. Your love of education has rubbed off. I hope I have made each of you proud. I was, indeed, blessed to be raised by a wonderful extended family. To my Pooh, thank you for "Are you dissertating today?"

I also dedicate this to my dear family and friends who have kept me encouraged and supported over these past 10 years. There are so many to list, so I will not for fear of forgetting someone – you know who you are! Each of you know how much I love and appreciate you. This dissertation has been accomplished because of your love, support, and prayers not just the last 10 years, but throughout my entire life.

Finally, I dedicate this research to all nurses, especially those who have suffered lateral violence and have come out the other end to be strong and amazing people and nurses. Each nurse brings love through what they are doing to better the lives of those we serve. You inspire me to do my part to improve our profession.

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Introduction

Nurses, and the nursing profession, have a *dirty little secret* (Brunworth, 2015; Schwarz & Leibold, 2015). This *secret* goes by many names; bullying, eating our young, incivility, lateral violence, and many more (Boyle & Willis, 2016; Castronovo, Pullizzi, & Evans, 2016; Center for American Nurses, 2008; Griffin, 2004). The names only hint at the chaos beneath. Lateral violence, in its many forms and described with its many names, is not just an American problem; it is described as an international problem at epidemic levels (Bambi et al., 2014; Gupta, Bakhshi, & Einarsen, 2017; International Council of Nurses [ICN], 2008, 2009b; Karatza, Zyga, Tziaferi, & Prezerakos, 2016).

Lateral violence behaviors can range from ignoring someone to outright physical violence (Berry, Gillespie, Fisher, Gormley, & Haynes, 2016; Castronovo et al., 2016; Griffin, 2004). The behaviors affect the individual nurse on many levels, including various psychological issues ranging from fear and anxiety to depression; loss of caring and engagement with patients; intent to, or actual, leaving of positions; leaving the nursing profession, or the most tragic, suicide (Davidson, Mendis, Stuck, DeMichele, & Zisook, 2018; Quine, 2001; Thew, 2018; Trépanier, Fernet, & Austin, 2015; Wallace & Gipson, 2017). These behaviors affect nurses, organizations, patients, the nursing profession, and the healthcare industry itself due to poor patient outcomes, decreased staff morale, increased costs associated with injuries and absenteeism, high turnover, higher insurance and indemnity costs, and monetary and personal costs associated with errors committed which may result in permanent injury or death (Fountain, 2017;

Hutchinson & Jackson, 2013; ICN, 2009a; Longo & Hain, 2014; McNamara, 2010; Painter, 2010).

Nurses provide care to the sick and infirm, educate individuals, families, and communities on health promotion. Nurses help to bring life into the world and are there to smooth the way as life leaves this world. Nurses work at all levels of healthcare and, in some states, can practice autonomously as Advanced Practice Registered Nurses (APRN). Nurses collaborate with other healthcare professionals to achieve optimal patient outcomes (Longo & Hain, 2014; McNamara, 2010). Nursing is the most trusted profession in the United States as shown by polling 17 years straight (Brenan, 2018). The public views nurses as honest and ethical altruistic angels of mercy (Brenan, 2017, 2018; Ketchem, 2016).

Background of the Problem

Lateral violence is nursing's dirty little secret and has been a hidden problem with significant implications for the healthcare industry as well as the nursing profession. Anecdotal evidence dates to 1909 when a New York Times article drew attention to the actions of head nurses' abuses of power and persecution of the nurses and students they directed at a New Jersey hospital. Dr. Leon Harris (The New York Times, 1909) had been quoted in the article that while the American young woman boasted of independence, she needed to be subservient at the hospital due to harsh and restrictive rules. Dr. Harris described the rules and regulations as being compared favorably to Siberian prisons. The rules and harsh working conditions seriously imperiled the lives of patients. A New York physician had written in response to Dr. Harris' letter to the New York Times thanking him for his courage for exposing the harsh nursing practices and

confirming that such practices had also been witnessed in the hospitals he had practiced medicine (New York Times, 1909). While it can be presumed lateral violence occurred prior to this time, it has been well established since. Research reported that up to 90% of nurses have experienced some form of lateral violence, making this a profound and pervasive issue in the nursing profession (Alameddine, Mourad, & Dimassi, 2015; Bambi et al., 2014; Buck-Hooper, 2018; Griffin, 2004; Pfeifer & Vessey, 2017; Smith & Cowie, 2010).

Roberts (1983) used Freire's Oppressed Group Theory (OGT) and associated behaviors as a theoretical basis and foundation to explain lateral violence. This was the first attempt to theoretically underpin lateral violence in nursing. Roberts (1983) was the first nurse scholar to describe that nurses exhibited oppressed group behaviors. Oppressed group behaviors found in nursing noted by Roberts (1983) included lowered self-esteem and self-worth, lack of professional identity, passive-aggressive behaviors with authority figures, self-hatred, and distrust of other nurses. As the oppressors imposed their values upon the oppressed, a cycle of lateral violence occurred, a cycle that created a hatred turned inward onto self and onto the profession (Roberts, 1983).

Smythe (1984) published the first academic paper analyzing negative characteristics of nurses and the behaviors which have become to known as lateral violence. The author examined nurses' response to, impact of, and the origin of stress as it related to the nurses and the nursing profession. Smythe focused on management of stress associated with negative behaviors experienced in the workplace as a measure of self-care and self-awareness needed to survive in nursing.

Nurses have historically been viewed as “handmaidens” of physicians, perceived to have little to no power (Barbara Bates Center for the Study of the History of Nursing, 2018; Center for American Nurses, 2008; Price, Doucet, & McGillis-Hall, 2014; Royal College of Nursing North West Region [RCN], 2016; Weinand, 2010). Nursing was established at a time of social reform when health-related care-giving behaviors needed to be taught to the lower classes and those considered to be underlings requiring demanding and controlling instructive demeanors (Barbara Bates Center for the Study of the History of Nursing, 2018; Stevens, 2002). Hospitals and other healthcare organizations developed a patriarchal hierarchy in which the male dominated medical field held the power and the female dominated nursing field did as they were instructed, needing little critical thinking or problem-solving skills (Barbara Bates Center for the Study of the History of Nursing, 2018; Matheson & Bobay, 2007; Purpora & Blegen, 2012; Purpora, Blegen, & Stotts, 2012). Physicians developed the first nursing curricula (Barbara Bates Center for the Study of the History of Nursing, 2018). Nurses were expected to stand in the presence of physicians and give up their seats when physicians entered the nursing station (Barbara Bates Center for the Study of the History of Nursing, 2018; Center for American Nurses, 2008; Johnson, 2009; Kelly, 2006; Stanley, 2010; RCN, 2016).

Nurses currently have some autonomy in the care they provide, but without advanced degrees and additional licenses, nurses are legally bound to carry out the orders of physicians, physician assistants, and nurse practitioners (American Nurses Association [ANA], 2017a). This hierarchy continues within the nursing units themselves from staff nurse, charge nurse, head nurse, manager, Director of Nursing, to the Chief Nursing Officer. The paternalistic healthcare system and hierarchical structure on which it is built

has been seen to oppress the female dominated nursing profession (Adams & Maykut, 2015; Christie & Jones, 2013; Farrell, 1997; Griscti, Aston, Warner, Martin-Misener, & McLeod, 2017; Moya, Backes, Prado, & Sandin, 2010; Roberts, 1983; Sanner-Stiehr & Ward-Smith, 2014; Smythe, 1984).

Some theorize that behaviors associated with lateral violence have become normalized and encultured into nursing, the abused have become the abusers (Dzurec, Kennison, & Albataineh, 2014; Leong & Crossman, 2016; Vogelpohl, Rice, Edwards, & Bork, 2013; Walrafen, Brewer, & Mulvenon, 2012). Giving a tough assignment, not answering questions, withholding information, only pointing out mistakes, or speaking harshly can be viewed by some as "toughening up" or use of "tough love" with new nurses. This is a "sink or swim" mentality to determine which new nurses can survive on various units (Leong & Crossman, 2016). This rite of passage may be a means to indoctrinate new nurses into the profession, like hazing incidents seen with university fraternities and varying levels of sports teams (Brown & Middaugh, 2009; Simons & Mawn, 2010; Thompson, 2016; Townsend, 2012). New nurses may feel powerless to speak up or fear repercussion, others do not want to be viewed as weak or fear being labeled a tattle-tale; others simply want to survive until they can become competent enough to seek another job (Ebrahimi, Hassankhani, Negrandeh, Jeffrey, & Azizi, 2017; Rudman & Gustavsson, 2010; Thompson, 2015; Thompson & George, 2016). Those who witness such behaviors may fear becoming victims themselves.

Long-term exposure to stress, such as lateral violence, is known to negatively affect psychological and physical health, and cause relationship discourse. Nurses who experience or witness lateral violence exhibit a variety of psychological and physical

symptoms ranging from minor to life-altering or life-ending. Nurses have reported feelings of stress, guilt, fear, loss of control, loss of self-identity, and powerlessness; even suicidal ideation (Corney, 2008; Cottingham, Johnson, & Erickson, 2018; Davidson et al., 2018; Quine, 2001; Sauer & McCoy, 2017; Thew, 2018; Zacharová & Bartošovič, 2016). Decreased overall physical and mental health have been reported (Trépanier et al., 2015; Ward-Smith, Hawks, Quallich, & Provance, 2018; Workplace Bullying Institute [WBI], 2012, 2017). The Workplace Bullying Institute (2012) reported that 29% of victims contemplated suicide and 16% had a distinct plan in place to carry it out. Statistics on rates of nurse suicide in the United States are sorely outdated and incomplete (Davidson et al., 2018; Sofer, 2018). Statistics from the United Kingdom (UK) from 2011 to 2015 reported that nurses were four times as likely to commit suicide than others who did not work in healthcare, female nurses were 23% more likely to commit suicide than women in general (Office of National Statistics, 2017, 2018). No further analyses were available. Additionally, nurses have a higher rate of divorce than the national average and have a higher divorce rate than physicians and other healthcare professionals (Chanchlani, & Goodhand, 2015; Ly, Seabury, & Jena, 2014; Nanda, Wasan, & Sussman, 2017).

The Joint Commission (2016) reported that the creation of hostile work environments impedes effective communication and disrupts the delivery of safe, effective, and quality care to patients. The Institute for Safe Medication Practices published a similar report citing poor communication and lowered quality care (Cohen & Smetzer, 2016; International Centre for Human Resources in Nursing. 2007; Institute for Safe Medication Practice [ISMP], 2013, 2016, 2017). Healthcare facilities must consider

other long-term effects related to lateral violence such as low staff morale, absenteeism, staff illness from stress, and difficulty in recruitment of new staff members (Academy of Medical-Surgical Nurses [AMSN], 2016; American Association of Colleges of Nursing [AACN], 2017; ANA, 2017c; Hassard, Tech, Visockaite, Dewe, & Cox, 2017; Houck & Colbert, 2017; Jackson, Clare, & Mannix, 2002; Malone, 2016; Occupational Safety and Health Administration [OSHA], 2016; Purpora, Cooper, & Sharifi, 2015; Speroni, Fitch, Dawson, Dugan, & Atherton, 2014).

Trépanier et al. (2015) found that recurrent and prolonged exposure to lateral violence and the resulting hostile workplace resulted in the nurse being unable to meet their own basic psychological needs. This prolonged exposure led to decreased overall mental and physical health. Additionally, a decreased work engagement was reported, which in turn disrupts the ability to function at the required level to provide proper professional care to patients. Nurses who are not engaged with their patients and workplace are more likely to deliver sub-par care.

The United States is facing a continued nursing shortage made more serious by the aging workforce. The aging of the nation not only means that the patients are aging and needing more care, nurses are also aging and retiring (AACN, 2017; ANA, 2017c; National Council of State Boards of Nursing [NCSBN], 2016). Grant (2016) reported that there are approximately one million RNs currently older than 50-years of age. This equates to one-third of the nursing workforce retiring within the next 15 years. In addition to replacing the retiring nurses, one million nurses are projected to be required to meet the growing needs of the populous by the year 2024 (ANA, 2017c; Oslund, 2016; U.S. Bureau of Labor Statistics [BLS], 2018a, 2018b, 2019).

Victims of lateral violence are more likely to not only leave their positions but leave the nursing profession (Armmer & Ball, 2015; Berry et al., 2016; Simons, 2008; Ward-Smith et al., 2018). The impact of lateral violence will continue to negatively affect nurse retention and number of nurses entering or choosing to remain in the profession. This will further exacerbate the nursing shortage (ANA, 2018b; Laschinger, Leiter, Day, & Gilin, 2009; Montana State University, 2015).

As the shortage of nurses grows, the ability to recruit and retain the best staff will be hindered by a reputation of a hostile work environment (American Association of Critical-Care Nurses, 2016). Long after the facility addresses lateral violence, the poor reputation may remain and continue to affect recruitment of all professionals and staff members. During times of shortage it is often the employee who has greater choices of where to work, thus facilities with poor reputations may face longer periods of potential use of travel or temporary staffing nurses and face increased costs for recruitment and retention (Berry, Gillespie, Gates, & Schafer, 2012; International Centre for Human Resources in Nursing. 2007; Press-Ganey, 2016; Punshon et al., 2017: Society for Human Resource Management [SHRM], 2016). Stanley (2010) also discussed the damage to a facility's reputation, but more importantly, the damage to the nursing profession's image. The nursing profession already battles a negative media image in many popular television shows. Adding reports such as workplace violence, bullying, and lateral violence may deter many men and women from becoming nurses (Kelly, 2018; National Conference of State Legislators [NCSL], 2012; Punshon et al., 2017: Rodwell & Demir, 2012a; Stanley, 2010; Szutenbach, 2013; Thompson, 2014; van Bekkum & Hilton, 2013).

Problem Statement

According to the NCSBN there were 4,751, 203 professionally active RNs in the United States as of June 27, 2019. Studies (Berry et al., 2012; BLS, 2018a; Chipps, Stelmaschuk, Albert, Bernhard, & Holloman, 2013; Roberts, 2015; Simons & Sauer, 2013) reported that approximated 85-90% of nurses had experienced lateral violence. Using the 85% statistic, in the United States alone, it can be estimated that 4 million RNs were abused from January – June 2019. This statistic does not include the nearly 1 million Licensed Practical Nurses (LPNs). Lateral violence and associated behaviors occur at all levels of nursing, in all practice environments, encompassing clinical, academic, and research entities. It is a global threat reaching near epidemic levels (Gupta et al., 2017; ICN, 2009b).

The Robert Wood Johnson Foundation (RWJF) reported that 20% of nurses leave the profession entirely during their first year of professional practice and approximately one-third leave within the next two years (2009, 2014, 2016). Johnson and Rea (2009) reported that victims of lateral violence were twice as likely to report intent to leave their position and three times as likely to leave the nursing profession when compared to those who were not victimized. Those who were bullied reported an intent to leave the nursing profession within the next two years three times more often than those who were not bullied. Berry et al. (2016) found that 40% of new nurses had left their positions within the first three years of practice. The United States is facing a nursing shortage, which is being worsened by nurses leaving the profession due to lateral violence. The U.S. Bureau of Labor Statistics (2018b) has projected that the U.S. will need more than an additional 1 million nurses by 2024.

Nurses who reported experiencing lateral violence had decreased mental and physical health (Felblinger, 2008; Trépanier et al., 2015; WBI, 2012; Ward-Smith et al., 2018). The ability to effectively perform the needed skills of the job are impaired, resulting in errors, impaired interdisciplinary collaborations, diminished engagement, and less than optimal patient outcomes (AMSN, 2016; Joint Commission, 2016; Reynolds, Kelly, & Singh-Carlson, 2014). Nurses who experience lateral violence report decreased workplace engagement, thus a decreased ability to experience empathy and connect with their patients (Fountain, 2017). United Kingdom statistics revealed that nurses were more likely to commit suicide than the general public (Office of National Statistics, 2017, 2018).

Lateral violence is a pervasive and profound phenomenon and problem in the nursing profession. Behaviors associated with lateral violence can be classified as either overt or covert (Gilbert, Hudson, & Strider, 2016; Griffin, 2004; Pfeifer & Vessey, 2017). (Appendix A). Covert behaviors can be subtle and difficult for outsiders to detect with the victim often denying being targeted (Centers for Disease Control and Prevention (CDC), 2018; Griffin, 2004; U.S. Department of Health and Human Services (HHS), 2018). Covert behaviors can include eye-rolling, making faces behind another's back, rude hand gestures, unfair assignments, sarcasm, exclusion, withholding information necessary to do one's job, sabotage, refusing to work with a specific co-worker, isolation, betraying trust, failure to respect privacy, undermining, and downplaying accomplishment or taking credit for another's work (Embree & White, 2010; Gilbert et al., 2016; Griffin, 2004; Pfeifer & Vessey, 2017). Overt behaviors are more readily identifiable and often termed "traditional" violence (Dudley, 2015; Etienne, 2014; Gilbert

et al., 2016; Griffin, 2004; Pfeifer & Vessey, 2016). Personal attacks, name-calling, intimidation (physical, psychological, or cyber), ethnic jokes or slurs, verbal threatening, physical threats of violence, scapegoating (such as blaming everything on one person), snide remarks, belittling and frequent humiliating or ridiculing in front of others are just some of the overt lateral violence behaviors seen in nursing (Dudley, 2015; Etienne, 2014; Gilbert et al., 2016; Griffin, 2004; Pfeifer & Vessey, 2016).

A study of the lived experiences of new nurses who are within two year of starting their professional practice, who have experienced lateral violence and have decided to remain in nursing may allow further knowledge and understanding of the experiences of new nurses facing lateral violence, an aspect of the global phenomenon of lateral violence in nursing. Gaining this knowledge may help supply a clearer, more effective foundation for policies and procedures regarding retention of new nurses, and ways to use the findings identified to strengthen support of new nurses in the workplace.

Purpose of the Study

The purpose of this qualitative descriptive phenomenological study is to understand the lived experiences of new registered nurses who have graduated from a pre-licensure Bachelor of Science in Nursing (BSN) or Bachelor of Arts in Nursing (BA) program within three years, who are within two years of starting professional practice, who have experienced lateral violence, and have decided to remain in the nursing profession.

After an extensive literature review, four studies were found that reported reasons why new nurses decided to remain in professional practice after experiencing lateral violence. Pellico, Brewer, and Kovner (2009) conducted a secondary analysis of a

national study of NLRN (Newly Licensed Registered Nurses). The parent study surveyed 3266 NLRN to understand factors which promote retention and those factors which contribute to turnover. The secondary content analysis of 612 NLRN comments regarding their work life was conducted, in the anecdotal comments two part-time RNs stated that despite the lateral violence they experienced, they remained working as RNs due to financial concerns and the flexible opportunities unavailable to them in other fields. Secondary content analysis using the Krippendorff's technique discovered five themes; colliding expectations, the need for speed, you want too much, how dare you, and change is on the horizon. The themes were consistent with the results of the parent study in that NLRN were concerned about the work environment, unrealistic expectations, time management, verbal abuse from physicians, lateral violence from fellow nurses, and academic preparation for their first position. The secondary analysis revealed deeper understanding of the themes of concerns of the NLRN, particularly regarding being pushed to carry a full load too soon or being off orientation or RN Residency too soon due to budgetary or staffing concerns. The secondary analysis also revealed the theme of optimism that change can be accomplished by nurses and that the majority of NLRN showed strong resiliency, themes not revealed in the parent study. Dotson, Dave, Cazier, and Spaulding (2014) conducted a survey of 861 RNs from southeastern U.S. to investigate the effects of stress, economic factors, altruism, and value congruence on job satisfaction and intent to leave. The sense of altruism was found to have significant impact on job satisfaction and the decision to remain either in a specific job or the profession. When the sense of altruism is affirmed, nurses are more likely to remain. Berry et al. (2016) and Simons and Mawn (2010) mentioned potential reasons why nurses

remain in the profession in the anecdotal comments. No study was located which focused on why new nurses decided to remain in their positions or profession despite being victims of lateral violence or bullying behaviors.

Multiple studies (Cottingham, Johnson, & Erickson, 2018; Dzurec, Kennison, & Albataineh, 2014; Magee, Gordon, Robinson, Reis, Caputi, & Oades, 2015; Sauer & McCoy, 2017; Török et al., 2016) exist on the many aspects of lateral violence in nursing, including negative effects on health, prevalence (Chipps, Stelmaschuk, Bernhard, & Holloman, 2013; Etienne, 2014; Evans, 2017; Layne et al., 2019; Pfeifer & Vessey, 2017; Roberts, 2015; Simons & Sauer, 2013; Taylor, 2016; Workplace Bullying Institute [WBI], 2017), and why nurses leave the profession (Armmer & Ball, 2015; Berry, Gillespie, Fisher, Gormley, & Haynes, 2016; Dellasega, Volpe, Edmonson, & Hopkins, 2014; Evans, 2017; Johnson & Rea, 2009; Mazurenko, Gupte, & Shan, 2015; Rodwell, Brunetto, Demir, Shacklock, & Farr-Wharton, 2014). Other studies (Blegen, Spector, Lynn, Barnsteiner, & Ulrich, 2017; Brewer, Kovner, Greene, & Cheng, 2009; Flinkman, Isopahkala-Bouret, & Salanterä, 2013; Kovner, Brewer, Fatehi, & Jun, 2014; Kovner, Brewer, Greene, & Fairchild, 2009; Pellico et al., 2009; RWJF, 2014; 2016) indicated that approximately 20% of new nurses leave the profession within the first year of practice and up to 30-40% leave by the end of their third year of professional practice. New nurses cited lateral violence as the main reason for deciding to leave the nursing profession (Becher & Visovsky, 2012; Chang & Cho, 2016; MacKusick & Minick, 2010; Rainford, Wood, McMullen, & Philipsen, 2015).

The potential normalization or encultured nature of some of the lateral violence associated behaviors and unfamiliarity with all that lateral violence entails may mean that

some or all the participants are unaware that they have experienced these events (Dellasega, Volpe, Edmonson, & Hopkins, 2014; Simons, 2008; Vessey, DeMarco, & DiFazio, 2010; Vessey, DeMarco, Gaffney, & Budin, 2009). The participants may be unaware of actively deciding to remain in the profession. Semi-structured, one-on-one interviews will be conducted to gain understanding and insights into the lived experiences of each participant as it pertains to their experiences with lateral violence and their decision to remain in nursing. Through the creation of a safe environment, a dialogue will be created in which the participant will be able to share information and details, therefore the individual's meaning of the experience will come forth (Earle, 2010).

Population and Sample

The population for this qualitative descriptive phenomenological study included new registered nurses within 36 months of graduation from a baccalaureate pre-licensure program at an accredited school of nursing, and within 24 months of starting their professional practice. The participants were recruited from central and southern Arizona via a blast email through the Arizona Nurses Association asking for their voluntary participation. The scope of this study was learning about the lived experiences of new nurses with lateral violence and their decision to remain in the nursing profession. The sample size was limited due to the nature of the phenomenological study method. A sample size of nine participants was obtained.

Significance of the Study

Nurses touch the lives of every person every day in some way, directly or indirectly (Pappas & Welton, 2015). Nurses work to influence healthcare policy on the local, state, national, and international levels (ANA, 2017a; Edmonson, McCarthy, Trent-

Adams, McCain, & Marshall, 2017). Nurses care for persons of every age and within every socio-economic status; caring for the poorest of the poor with the same respect and skill as they care for the rich. “In its healing relationships with individuals, families, colleagues, communities, and populations, nursing first and foremost respects and upholds the inherent dignity and worth of all persons” (College of St. Scholastica, 2018, ¶ 4).

Lateral violence negatively affects those healing relationships lending itself to distrust, fear, and a culture of fear and silence (Berry et al., 2016; Castronovo et al., 2016; DeMarco, 2002; Jones, 2016). Poor patient outcomes and reports of near misses increased as rates of lateral violence increased (Wright & Khatri, 2015). The Joint Commission (2016) found that in approximately 75% of sentinel events investigated in the first half of 2015 that involved medical errors, communication failures were a leading causative factor. While not identified in the Joint Commission report, the influence of lateral violence as a significant influence can be inferred from current nursing research.

Lateral violence is a phenomenon of international proportions, it is profound and pervasive in nature. It is the primary reason new nurses leave the profession within the first three years of professional practice, the majority leaving within the first year (RWJF, 2016). Multiple studies (Berry et al., 2012; BLS, 2018b, 2019; Chipps et al., 2013; Roberts, 2015) reported that 85-90% of nurses experience lateral violence during their careers. It can be estimated by using the number of RNs in the United States and the 85% figure that approximately 4 million RNs have experienced lateral violence from January – June 2019. This multi-faceted issue within the nursing profession and healthcare industry requires further enquiry to fully understand.

This qualitative descriptive phenomenological study is important to the nursing profession and healthcare as there is a gap in the literature on understanding the lived experiences of new nurses with lateral violence and their decision to remain in the nursing profession. Research into lateral violence has concentrated on the theoretical underpinnings, effects, potential causative factors, and the resulting lived experiences of nurses who have experienced these behaviors, and on those who have left the profession. There is limited research into why nurses who have experienced lateral violence have decided to remain in the nursing profession. Pellico et al. (2009) conducted a secondary content analysis of 612 NLRN to understand issues contributing to turnover and the experiences of entering professional nursing practice. In the anecdotal comments two part-time RNs stated that despite the lateral violence they experienced, they remained working as RNs due to financial concerns and the flexible opportunities unavailable to them in other fields.

The concentration of research into the phenomenon of lateral violence has been on theory, effects, causation, and why nurses choose to leave the profession. There is a lack of research into understanding why nurses decide to remain in the profession despite experiencing lateral violence. This lack of information is a distinct gap in research and the nursing body of knowledge. Researching why new nurses choose to remain in the profession, despite experiencing lateral violence, may provide valuable insights into lateral violence.

This study will be unique as no other studies have addressed why new nurses who have experienced lateral violence have decided to remain in the profession. This study might not capture all the experiences of those new nurses who experience lateral

violence and decide to remain in the profession. This study, however, does have the potential to contribute to the research literature by filling a gap in the body of nursing knowledge and encouraging further enquiry. This study may add to the nursing profession by discovering themes regarding the reasons why new nurses who have experienced lateral violence have decided to remain in the profession. This knowledge may aid in the development of retainment protocols.

The United States is facing a nursing shortage worsened by nurses deciding to leave the profession due to lateral violence (Armmer & Ball, 2015; Berry et al., 2016; Simons, 2008; Ward-Smith et al., 2018). It has been reported (Montana State University, 2015) that organizations which have developed reputations for hostile work environments have harder times recruiting and retaining staff at all level within the organization. Additional studies (Berry et al., 2012; BLS, 2018a, 2019; Chipps et al., 2013; Oslund, 2016; Roberts, 2015) reported that 85-90% of nurses in the U.S. experience or witness lateral violence and most will have resulting decreased physical and mental health issues. These issues result in a lowered ability to give adequate care to patients (AMSN, 2016; Bambi et al., 2014; Christie & Jones, 2013; OSHA, 2016; Pfeifer & Vessey, 2017; Taylor, 2016).

This study has significance to society because the nursing profession itself has significance to society. Nurses are involved in the care, care decisions, or healthcare policies of every member of society worldwide (ANA, 2017a; World Health Organization [WHO], 2018). Mary Adelaide Nutting, the world's first Professor of Nursing, stated in 1925 that compassion motivates the nurse, however, it is knowledge that is the power behind that compassion (College of St. Scholastica, 2018). Nurses strive

for compassion towards all and strive to gain knowledge to provide compassion in a skilled and effective manner. The United States is facing a nursing shortage worsened by nurses choosing to leave the profession within the first two years of beginning their professional practice, in part due to lateral violence. A lack of nurses translates into a lack of healthcare services (ANA, 2017b; 2017c; 2018b; WHO, 2018).

Lateral violence is a multi-faceted phenomenon requiring a multi-faceted approach to deal with it. Lacking insight into every aspect prevents a full viewpoint; potentially preventing effective policies, procedures, and other measures from being developed and implemented. Only through clear vision may one truly see a problem. A quote by physicist Erwin Schrödinger is apropos "The task is...not so much to see what no one has yet seen; but to think what nobody has yet thought, about that which everybody sees" (Fosvis Ex curiositate scientia, 2018, ¶ 7).

Nature of the Study

This study is a qualitative descriptive phenomenological study focusing on the lived experiences of new nurses within two years of starting professional nursing practice with lateral violence and their decision to remain in the nursing profession. It used one-on-one interviews to allow the researcher to explore the phenomenon with the participants. The qualitative methodology allowed the emerging core themes to be revealed, bringing forth a description of the lived experiences of these new nurses.

The phenomenological research method aims to describe the lived experiences of persons and understand the meaning within the context of these persons' lives (Driessnack, Sousa, & Mendes, 2007). This research method lends itself to many phenomena which are difficult to quantify, events frequently experienced in the nursing

profession. According to the Center for Innovation in Research and Teaching (CIRT) (2018) phenomenological research is centered on what the person experiences without regard to preconceived ideas such as culture, socio-economic status, or traditions. Phenomenology seeks to find a deeper understanding, to note if any themes are apparent in the overall picture of the emerging data. The methodology provides a means to both transform and create new perspectives by showcasing the uniqueness of personal experiences and perspectives (Pratt, 2014). Personal meaning is found when researcher and participants co-construct a meaningful, interactive dialogue through an intimate and socially constructed relationship (Denzin & Lincoln, 1994; 2007; 2011).

The research process is inductive in nature and the researcher must be open to hearing, listening, and seeing what the participants are conveying to them (Driessnack et al., 2007; Earle, 2010). Researchers must pay close attention not just to the words, but body language, voice inflection, tone, and timbre of the voice. The participants' words are not the only data to be collected as each detail may reveal a clue (Driessnack et al., 2007; CIRT, 2018).

The phenomenological method is the appropriate choice due to the nature of data sought. The data sought is not able to be quantified. Rather, the richness of an experience and perceptions of thought are the data to be gathered, the lived experiences of a specific phenomenon. This type of data cannot be captured through quantitative measures and cannot be researched in data files.

Research Question

In qualitative phenomenological studies the researcher looks for the lived experience of a group. The question to be answered involves seeking the meaning,

structure, and essence of the lived experience of the phenomenon by an individual or by many individuals (McCaslin & Wilson-Scott, 2003). McCaslin and Wilson-Scott also recommended considering if a phenomenological study is the best fit for what answers are being sought by asking what single lived experience, phenomenon, or quality is desired to be explored or discovered. The phenomenon is lateral violence in nursing and the decision to remain in the profession.

The research question for this qualitative phenomenological study is:
What are the lived experiences of new registered nurses, within two years of beginning professional practice, who have experienced lateral violence, and have decided to remain in the nursing profession?

Theoretical Framework

The use of theory is vital to the development of knowledge and to the practice of the profession of nursing. A theory acts as a road map to direct as to where one should go and yet does not constrain to just a single "road". Theory acts to help focus on what is important and yet offers freedom to explore (Krumboltz, 2009). An appropriate conceptual framework or model paves the way for the testing of theories and provides a logical and orderly manner in which to visualize the research into practice (Mock et al., 2011).

The first nursing theorist was Florence Nightingale who purported that nurses themselves should be the primary researchers into nursing issues (Karimi & Alavi, 2015; Selanders & Crane, 2012; Shetty, 2016; Smith, 2009). Since Nightingale's time nursing theory has moved from theoretical underpinnings based on medical models, to theories dependent on other professions and disciplines, and finally breaking out into true nursing-

based evidence-based practice models (Karnick, 2016; Mackey & Bassendowski, 2017; Nilsen, 2015; Stevens, 2013). Nursing is realizing the gap between creating new theories and knowledge with translating and using them effectively in the clinical and educational settings (Stevens). The Doctor of Nursing Practice (DNP) has been one recommended solution to bridge the gap between research and practice implementation (AACN, 2015).

Freire's Oppressed Group Theory was first applied by Rogers in 1983 as an underpinning to nursing and lateral violence. Nursing and healthcare were founded on, and continues to be based on, a foundation of a hierarchical structure (Franklin & Chadwick, 2013; Freire, 1970; Iacono, 2014; Roberts, DeMarco, & Griffin, 2009; Röing, Holmström, & Larsson, 2017). This hierarchy has allowed an oppression of those with limited power, or at least a belief of limited power. The continued oppression has caused a cycle of self-hatred and the resulting behaviors we now term lateral violence. This cycle has been perpetuated by the culture of silence and fear which exists in the profession of nursing (Berry et al., 2016; Castronovo et al., 2016; DeMarco, 2002; Jones, 2016). Oppression perpetuates the victims' belief of poor self-worth, low self-esteem, and no power, limiting the group's ability to unite for change.

Conti-O'Hare (2002) introduced her Theory of the Nurse as Wounded Healer (NWH). The theory is based on the belief that the nurse's healing abilities or power results from the nurse's own wounds, from trauma in his/her past (the wounded self). NWH is based on awareness of trauma, such as lateral violence, occurring and mindfulness that a healing process is needed by staff and management to promote the healing of the person and the work environment. The destructive behaviors we know as lateral violence result when nurses are unable to recognize and deal with personal trauma

(Christie & Jones, 2013; Conti-O'Hare, 2002; Newcomb, Burton, Edwards, & Hazelwood, 2015; Zaghini, Fida, Caruso, Kangasniemi, & Sili, 2016).

Both Freire's Oppressed Group Theory (OGT) and NWH support the study of lateral violence and will be used as the conceptual frameworks to describe and analyze the destructive nature of the lateral violence associated behaviors and why they occur. Freire's OGT underpins how lateral violence developed and helps to describe behaviors. Conti-O'Hare's NWH underpins why and how lateral violence behaviors occur; additionally, the theory underpins the progression nurses may take to heal the wounds of trauma to transcend to the level of wounded healer. The Oppressed Group Theory as described by Roberts in 1983 and further in 2009 (Roberts et al.) and Conti-O'Hare's Nurse as Wounded Healer (2002; Christie & Jones, 2013) will be the theoretical frameworks for this study.

Definition of Terms

The perception of a phenomenon is influenced by how it is labeled, thus the standardization in language used in naming the behaviors which encompass the range of severity involved in the phenomenon of lateral violence allows all involved to fully understand the phenomenon being discussed and decreases confusion (Boyle & Willis, 2016; Johnson, 2018).

Lateral Violence: a pattern of workplace conflict in which overt or covert behaviors are targeted at one person by another in a repetitious manner, across time, involving emotional, psychological, physical, or sexual abuse (Rainford et al., 2015).

New Nurse: a person within 36 months of passing the RN licensure examination, and 24 months of beginning professional practice (Hickson, 2013).

Pre-Licensure Nursing Program: a four-year program that is specifically designed for students who do not currently hold a state nursing license and have no prior nursing experience or education (Grand Canyon University, 2018).

Professional Nursing Practice: the use of one's knowledge in a profession. It includes, in the case of the field of nursing, professional activities related to healthcare and the actual performance of the duties related to the provision of patient care under proper licensure (U.S. National Library of Medicine, 2018).

Assumptions

An assumption for this qualitative descriptive phenomenological study is that all participants will be honest and open in their answers to the questions asked of them. Participants will share descriptions of their experiences with lateral violence and their decision to remain in the nursing profession to the best of their abilities; with the reasonable guarantee of confidentiality allowing participants the freedom to be more candid in sharing their experiences.

It is assumed that researcher bias will be minimized, and no transfer of actions or behaviors will affect the answers provided by the participants. To prevent researcher influence, the following measures will be taken: semi-structured interviews, an interview guide will be followed, interviews will be voice-recorded and transcribed verbatim to prevent interjected bias, field notes will be taken regarding body language, voice inflection, etc. to augment the voice-recording and capture nuances of meaning. A

reflective journal will be kept to further reduce potential researcher bias. Verbatim transcripts will be verified by the participant for accuracy.

Limitations

Limitations to qualitative studies include the dependence on the honesty and candor of the participants and the inherent small size of the study. The potential negative emotions which this topic may bring up is another limitation to a qualitative study. The areas of central and southern Arizona have a uniquely diverse population which may limit transferability to other populations. A limitation that is present in all research using voluntary participants is the potential missed data of those who choose not to take part in the study. The use of a qualitative method may limit the ability to transfer to other populations, however the richness of the lived experience can only be brought forth through such candid and close communication between participant and researcher found in this research method.

Delimitations

Delimitations are those parts of the study which are directly under the control of the researcher (Guba & Lincoln, 1994; Lincoln & Guba, 1985). In this study, a key delimitation is length of time in which the RN has been out of school (up to 36 months) and in which they have been practicing as a professional nurse (no more than 24 months). The reason for this lag time between graduation from school and start of professional practice is that it may take some newly graduated nurses time to either take their NCLEX-RN examinations or find their first nursing position. The Arizona Nurses Association (2018) has reported that it is not unusual for new RN graduates in Arizona to take up to a year to find their first nursing position.

Chapter Summary

Lateral violence and associated behaviors are experienced by almost every nurse during his or her career. Multiple studies (Berry et al., 2016; BLS, 2018b, 2019; Chipps et al., 2013; Roberts, 2015; Simons, 2008) have reported that up to 90% of nurses have experienced lateral violence at some point in their careers. Approximately 1/3 of new nurses will leave the profession within the first three years of professional practice, citing lateral violence as the primary causative factor (RWJF, 2016). Lateral violence is not strictly an American phenomenon, it is an international one. Lateral violence is profound and pervasive in nature affecting every level of healthcare.

The purpose of this qualitative descriptive phenomenological study was to understand the lived experiences of new registered nurses who have graduated from a pre-licensure baccalaureate program within the past 36 months, who are within 24 months of starting professional practice, who have experienced lateral violence, and have decided to remain in the nursing profession. The results of this study may provide a missing piece of information regarding the phenomenon of lateral violence, providing a more complete view. The results may help improve the nursing body of knowledge and improve the lives and working environments of nurses and thus patient outcomes.

Chapter 1 has presented an overview of the research study showing the increasing awareness of the serious nature of lateral violence. The history, effects, prevalence, and statistical data were presented and discussed. The nursing shortage was also discussed. The significance and nature of study, significance to nursing and society, and research questions were presented. The conceptual framework, definition of terms, assumptions, scope, limitations, and delimitations were also included.

Chapter 2 provides an historical review of the literature as it related to lateral violence in nursing. Discussions regarding the difficulties faced regarding research of lateral violence were presented. The chapter provides a review of intent to leave both positions and the profession, effect on both psychological and physical health, and the effects to the nursing profession, the nurse, and the new nurse. The chapter also provides a review of the prevalence of lateral violence, both in the United States and internationally.

Chapter 2

Literature Review

The purpose of this qualitative descriptive phenomenological study was to address the lack of knowledge and understanding regarding the lived experiences of new nurses in the first two years of professional practice with lateral violence and their decision to remain in the nursing profession. A review of the literature on lateral violence in the nursing workplace was conducted. This literature review aided in supporting the significance of this study.

Chapter 2 includes (a) Title Searches and Documentation, (b) Historical Overview and Content of Lateral Violence in Nursing to include Defining Lateral Violence in Nursing; Prevalence of Lateral Violence in Nursing; Development of Toxic Work Environment; Effects on Nurse Work Effectiveness, Performance, Engagement; Effects on Patient Care, Outcomes, Safety; Effects on Nurse Health and Wellness; Effects on Nursing Intent to Leave or Stay; Effects on New Nurse Intent to Leave or Stay, (c) Current Content to include Prevalence of Lateral Violence in Nursing; Development of Toxic Work Environment; Effects on Nurse Work Effectiveness, Performance, Engagement; Effects on Patient Care, Outcomes, Safety; Effects on Nurse Health and Wellness; Effects on Nursing Intent to Leave or Stay; Effects on New Nurse Intent to Leave or Stay, (d) Theoretical Framework Literature, (e) Methodology Literature, (f) Research Design Literature, (g) Conclusions, and (h) Chapter Summary.

The historical review reveals the long-standing nature of this issue. The incidence/prevalence of lateral violence, while not finitely quantified, is revealed as consistently present in the nursing profession and correlated to negative effects on patient

outcomes, organizational goals, and nurse well-being. While the research reveals cause for attrition due to lateral violence, there is a distinct lack of research into why new nurses decide to remain in the profession. The discovery of this knowledge may help to improve the overall view of new nurses who have experienced lateral violence and have decided to remain in the nursing profession.

Title Searches and Documentation

Chapter 2 includes a comprehensive literature review using the computer databases of CINAHL (Cumulative Index of Nursing and Allied Health Literature) Plus, Ovid, Academic Search Complete, and ProQuest from the University of Phoenix online library and the Grand Canyon University Faculty Online Research Library. Search terms used were lateral violence, horizontal violence, bullying, workplace violence, nurse-on-nurse violence, nursing, nurse, novice nurse, new nurse, newly graduated nurse, newly licensed nurse, RN, Registered Nurse, healthcare, health care, eating their young, eating our young, Freire, Oppressed Group Theory, Oppressed Group Behavior, Nurse as Wounded Healer, phenomenology, and qualitative research. After an initial return of over 900 editorials, peer-reviewed, and non-peer reviewed articles and research, websites, newspaper articles, books, dissertations, and blogs, the search terms were refined. The search was narrowed to include only peer-reviewed articles, professional websites, books, or dissertations returning with at least two of the requested search terms.

Criteria for inclusion were professional websites, books, peer-reviewed articles, qualitative or quantitative research dated from the year 2008 or later (except for seminal studies); registered nurses in active professional practice; and those items which focused on lateral (nurse-on-nurse, or nurse-initiated) violence in the healthcare workplace.

Exclusion criteria were items focused solely on intervention or prevention strategies to mitigate and/or prevent the effects of lateral violence in the workplace; items focused solely on academia, nursing education, students, or clinical education of student nurses; items focused solely on non-nurse-initiated (patient, visitor, or healthcare worker/professional) violence in the workplace.

Three hundred eleven peer-reviewed articles, books, professional websites, and research studies were located containing two or more search terms. Nine studies were excluded due to being unavailable in English (three Greek; one Hebrew; two Romanian/Russian; two Spanish, and one Chinese/Taiwanese). Sixty-two items were found to be duplicates and were removed from the listing. Thirty-one studies and peer-reviewed articles focused solely on interventions to prevent or mitigate lateral violence impact or prevalence and were excluded. One peer-reviewed article was excluded as it was a narrative on the author's first day as a professional nurse. Fourteen studies and peer-reviewed articles were excluded due to focusing on non-nurse-initiated workplace violence (patient, family members, stranger, and police). Thirty-seven studies and peer-reviewed articles focused solely on the academic setting, students and faculty and thus excluded. One 1909 newspaper article was kept due to historical anecdotal evidence of lateral violence in nursing.

The bibliography of each of these items was reviewed to find any further pertinent studies to add further information to this study. Other studies were located from bibliographies of articles of interest and secondary searches of Medscape, the American Nurses Association (ANA), and Sigma Theta Tau International Nursing Honor Society (STTI) websites. When a pertinent peer-reviewed or research article meeting the search

criteria was located, the computerized databases were reviewed to find the original article. The article was then reviewed according to the same criteria as noted in Table 1. Many of the older research studies were excluded in the literature search; other than seminal studies. Current literature supplies up-to-date statistics on prevalence of lateral violence, attrition rates, and other data which can lend understanding to this study. Table 1 shows the items included.

Table 1

Summary of Literature Search

Phenomenon of Interest	***Peer-Reviewed Articles***	***Professional Websites***	***Books***	***Dissertations***	***Totals***
New Nurse	49	1		2	52
Prevalence of LV in Nursing	31	3		1	35
Effects of LV in Nursing	43	1	1	1	46
Eating Our Young	27	2	1		30
Freire/Oppressed Group Theory or Behaviors	11		2		13
Nurse as Wounded Healer	9	2	2		13
Phenomenology as a research method	15	1	1	1	18
Totals	184	10	7	5	207

Historical Overview and Content of Lateral Violence in Nursing

Anecdotal evidence shows a history of lateral violence reported in the American media for over a century (Castronovo et al., 2016; New York Times, 1909). An August 22, 1909 New York Times article quoted Dr. Leon Harris describing the deplorable conditions at the hospital in which he worked; witnessing behaviors now known as lateral violence or workplace violence. Dr. Harris stated head nurses were imposing such

outrageous persecutorial punishments and dictatorial abuses of power on those under their direction that the very welfare of the patients was in peril.

Roberts (1983) applied Freire's Oppressed Group Theory as explanation for abuses in nursing. Roberts focused on how the hierarchy of power within the healthcare industry and the nursing profession developed and worked to oppress the power of nurses. Nurses have historically been perceived as the physicians' "handmaidens", holding little to no power, often regarded as having little to no critical thinking abilities (Center for American Nurses, 2008; Price, Doucet, & McGillis-Hall, 2014; RCN, 2016; Weinand, 2010). This imbalance of power and oppression resulted in behaviors later recognized as lateral violence (Roberts, 1983; Roberts et al., 2009; Walrafen et al., 2012). Roberts' 1983 work laid the core groundwork for multiple studies concerning lateral violence; allowing expansion of and additions to the theoretical basis to occur (Christie & Jones, 2013; Mendez, 2011; Roberts et al., 2009; Walrafen et al., 2012).

Defining Lateral Violence in Nursing

William Shakespeare wrote in Romeo and Juliet, Act II, Scene II, "What's in a name? That which we call a rose by any other name would smell as sweet". While this might be true in terms of Capulets and Montagues, it is not true when researching and defining a human behavior as multi-faceted as lateral violence. Having well-defined terms allows all stakeholders to have a concise and common nomenclature to enhance understanding (Yamada, Duffy, & Berry, 2018). The act of naming and defining a phenomenon makes it distinctive, researchable, and identifiable (Ballard & Easteal, 2018a; 2018b; Johnson, 2018; Read & Laschinger, 2013; Yamada et al., 2018).

Meissner (1986) coined the phrase “eating our young” in an article written concerning lateral violence behaviors seen in the nursing education arena. The author referred to lateral violence as a type of cannibalism and used “eating our young” as a call to action for her colleagues to stop the literal tearing apart of students and inexperienced nurses. The article created great controversary. The term has remained in use despite the uproar.

The term lateral violence was initially coined to define workplace conflict between co-workers on the same or similar job levels, the term transitioned to encompass a more global meaning. Rainford et al. (2015) defined lateral violence in nursing as a pattern of workplace conflict targeting one person, overt and/or covert behaviors repeated over time, involving abuse of an emotional, physical, psychological, or sexual nature. The terms mobbing, and bullying have been in use since the 1980’s; mobbing used more predominantly in Europe, bullying used more in the United States (Davenport, Schwartz, & Elliot, 1999; Duffy & Sperry, 2014; Einarsen, Hoel, Zapf, & Cooper, 2011; Yamada et al., 2018; Yildirim & Yildirim, 2007; Yildirim, Yildirim, & Timucin, 2007). Additional labels and terms associated with this phenomenon have included horizontal violence (Vessey, DeMarco, Gaffney, & Budin, 2009); relational aggression (Dellasega, 2009); incivility (Clark, Ahten, & Macy, 2013; Pearson & Porath, 2009); disruptive behaviors (Joint Commission, 2008, 2016); and hazing (Longo & Sherman, 2007; Thompson, 2016).

Other terms have come in use and become virtually interchangeable in research, articles, and professional discussions; horizontal violence, lateral violence, nurse-on-nurse violence, workplace violence, disruptive behaviors, incivility, bullying, and others.

Meanings often overlap despite nuanced differences in the distinct meaning of each term (Boyle & Willis, 2016; Fink-Samnick, 2016; Rodwell & Demire, 2012a; Thobaben, 2007). There are many additional definitions of terms used in reference to lateral violence (Appendix B). The lack of a standardized language has been recognized as a contributing factor into the difficulties encountered by researchers. Standardizing nomenclature enhances understanding, allows all involved to fully understand the phenomenon being discussed, and decreases confusion. Standard nomenclature also facilitates research and allows all stakeholders to gain a better understanding of the phenomenon (Crawshaw, 2009; Etienne, 2014; Boyle & Willis, 2016; Johnson, 2018).

Einarsen et al. (2011) purported that there are minor differences in the varying terms and concepts regarding the phenomenon of lateral violence in nursing and rather than concentrating on such minor differences, the systematic behaviors should be concentrated on. Other researchers disagreed and stated that distinct definitions and terms are essential to avoid cultural and conceptual confusion (Duffy & Sperry, 2014; Martin & Pena Saint Martin, 2012). These researchers viewed definitions and common nomenclature as vital to consistent recognition and reporting by victims; valid responses in research; and understanding by the public.

Viewing the phenomenon of lateral violence in nursing in totality reveals a set of key behaviors common to each term or label. Each behavior, term, or label consists of a negative act or acts against a person; the intent of a perpetrator; frequency and duration over time; negative impact on the victim; the number and position of the persons involved (i.e. target); and power imbalance (Duffy & Sperry, 2012; Einarsen et al., 2011; Namie & Namie, 2009; Rooddehghan, Yekta, & Nasrabadi, 2015; Yamada et al., 2018).

Prevalence of Lateral Violence in Nursing

The need to quantify the prevalence of lateral violence was addressed by a group of researchers at the University of Bergen in Norway. In 1994 the Negative Acts Questionnaire (NAQ) was introduced (Einarsen, Hoel, & Notelaers, 2009). Validity and reliability have been established through multiple studies, including revisions for the NAQ-R (Negative Acts Questionnaire – Revised) in 2009 and the Short Negative Acts Questionnaire (SNAQ) in 2018 (Einarsen et al., 2009; Simons, Stark, & DeMarco, 2011; Notelaers, Van der Heijden, Hoel, & Einarsen, 2018). This has become one of the most widely used instrument for measuring select lateral violence behaviors in research worldwide. Some researchers have come to believe that NAQ-R is too lengthy and have worked to develop other survey instruments including Nurse Workplace Behavior Scale or NWS (DeMarco et al., 2008) and Lateral Violence in Nursing Survey or LVNS (Nemeth et al., 2017). Specialty area surveys have been developed, and NAQ-R has also been modified for the needs of some specialty areas (Nemeth et al., 2017).

Park, Lee, and Park (2017) analyzed 19 instruments and found that all areas in bullying and lateral violence were not comprehensively surveyed in any one tool currently available. The development of survey instruments is also evolving to better meet the needs of researchers to define the problem, access needed data, and determine the mitigating factors associated with lateral violence. A single assessment tool, or even a handful of tools, is an inefficient and ineffective manner to study such a multi-faceted phenomenon.

Research into lateral violence is limited by the accessibility researchers have to appropriate samples. Nurses are regulated at the state rather than national level (National

Council of State Boards of Nursing [NCSBN], 2018). Researchers must use databases from professional organizations or certification boards, or advertisements through educational institutions or journals to reach potential participants. Data may be skewed due to the specialized nature of some of these organizations (Johnson & Rea, 2009; Purpora et al., 2012). Added difficulties obtaining accurate or consistent prevalence rates relate to varied methods of research, differences in use of terms and survey instruments, perception of phenomenon, varied time frames (past week, past six months, past year), and variations in workplace setting and/or geographic area studied. Despite these limitations, the body of knowledge these studies present have supplied a valuable and consistent trend in data (Dellasega, 2009; Purpora et al., 2012; Varekojis et al., 2014). Prevalence has been consistently reported at approximately one-third of registered nurses experiencing lateral violence at least twice weekly in the six months prior to the study in question (Walrafen et al., 2012; Chipps et al., 2013; Spector et al., 2014; Etienne, 2014; Roberts, 2015).

Lateral violence is often referred to as nursing's "dirty little secret" and has been a hidden problem with significant implications for the nursing profession and the healthcare industry. The first descriptive survey on the extent of lateral violence across the United States was conducted by Vessey et al. in 2009. This was also the first comprehensive study to look at national prevalence of lateral violence. Volunteers were recruited from across the country and from a variety of work settings, educational backgrounds, and range of ages. The study used an internet linked survey to ask nurses (n=303) about their perceptions of the frequency and patterns of lateral violence. Seventy percent of nurses reported having experienced lateral violence, 90% reported moderate to

severe stress levels related to the experiences. Key findings revealed nurses on medical/surgical units and those new to the profession were the most likely victims of lateral violence. Most nurses did not use formal avenues to report the abuse for a variety of reasons mainly due to lack of trust in the system or fear for their job. The study was quantitative in nature though respondents were given an opportunity to provide comments to clarify their responses or provide additional information. While statistical calculation of the responses and identifying information of the respondents was accurately conducted using appropriate software, statistical significance had not been established through appropriate testing. The low rate of respondents for a national, quantitative study decreases the ability to generalize the findings. The authors did not break down data per geographic area which would have provided added insights. The authors did acknowledge that the lack of a common verbiage related to the phenomenon of lateral violence limited their research. This study added to the body of nursing knowledge by being the first of its kind to look at the national prevalence of lateral violence and encouraging further enquiry.

A 2009 ethno-phenomenological study of nursing professionals working in public hospitals in Cape Town, South Africa was conducted by Khalil (2009). A non-probability sampling of 471 nurses from varied backgrounds, professional settings, and experience levels formed the study participants. A four-stage analyses of data were conducted to name the levels and types of violence, propensity to engage in violence, and similarities and differences among the eight public hospitals in Cape Town. Over half of the participants agreed that violence among nurses was a reality, while under 10% disagreed with this statement. The most commonly identified type of violence was psychological

(92%), followed by vertical (66%), horizontal (64%), covert (64%), overt (55%), and physical (36%) violence. The author identified three main factors which contributed to the violence, ineffective communication, lack of respect, and inadequate training, particularly anger management. The impact of such violence was not discussed in this study. There were no details about the validity or reliability of the data collection tool used, or how the tool was developed. The unique factors of Cape Town, South Africa, including continued racism and tensions between ethnic groups despite the end of apartheid, and the use of only public hospitals in Cape Town, make the results not transferable to other populations. Despite the lack of description of methods of the study, the results lend support on the international nature and prevalence of nursing workplace violence.

Prevalence of lateral violence is consistently reported at approximately one-third of registered nurses experiencing lateral violence at least twice weekly (Walrafen et al., 2012; Chipps et al., 2013; Spector et al., 2014; Etienne, 2014; Roberts, 2015). While the actual numbers of those who have been victims of lateral violence may never be fully quantified, the research has given clues into the persistent and pervasive nature of lateral violence in the nursing profession.

Development of Toxic Work Environment

The rise in violence in the workplace, as well as society in general, has prompted nurse-led initiatives to combat violence against nurses, including lateral violence. The ANA has developed #EndNurseViolence and a dedicated Advisory Panel, Council and Committee consisting of nurses from across the nation to provide insight and guidance on steps to combat all levels of nursing violence, including legislative initiatives (ANA,

2017c, 2018a, 2018b). The ANA Position Statement on Incivility, Bullying, and Workplace Violence issued in 2015 stated that every nurse is required to "create and sustain a culture of respect, which is free of incivility, bullying, and workplace violence" (¶ 1). The ANA Code of Ethics for Nurses (2015a) Provision 1 stated that nurses are to act with compassion and respect in all professional relationships. This directive on professional behavior is not followed by nurses as evidenced by the consistent nature of lateral violence seen throughout the nursing profession.

An Australian cross-sectional study (Rodwell, Brunetto, Demir, Shacklock, & Farr-Wharton, 2014) examined the role of abusive supervisors in a nurses' (n=250) intent to leave, psychological effects, and job satisfaction. Participants were employed at five general acute hospitals within the same network. The sample was representative of the general nursing population in Australia. Recruitment of participants was accomplished through online survey invitation sent to nurses of varied positions within the network. A 33% response rate was achieved. Data analyses was completed by use of SPSS 19 and Amos version 19 software (Arbuckle, 2010). Validity and reliability were reported in the study as within the required limits. Findings of the study revealed that there was an indirect relationship between personal attacks by a supervisor and a nurse's intent to quit. However, a direct relationship between personal attacks by abusive supervisors and increased psychological stress and decreased job satisfaction reported by nurses was noted. Task-oriented attacks by supervisors were directly related to increased intent to leave and indirectly related to nursing position satisfaction. The authors theorized, via the Appraisal Theory, that the type of attack impacted the nurse related outcome; thus, personal attacks resulted in negative impacts on the nurse's personal health and task-

oriented attacks resulted in negative work-related outcomes such intent to quit. Strengths of this study were a good response rate, representation of the demographics of the nursing profession in Australia and use of quality data collection and analysis tools. One limitation to the study was confinement to one healthcare network preventing generalization to other facilities in Australia and internationally. Additionally, the study did not explore other reasons for leaving or intending to leave nursing positions and did not explore personal factors such as resiliency or previous experiences with lateral violence or abusive supervisors as a part of the nurse's response to the current abusive supervisor. Previous research on this topic was lacking, thus this study may provide impetus for further research into the effects of abusive supervisors on the ability of nurses to perform their jobs. This study can be used as support for workplace education and policies of zero-tolerance of any type of abuse committed by any member of the healthcare team, and a means to encourage complete reporting of such episodes to aid in accurate data collection and analyses. This study helped support the pervasive nature of lateral violence/abuse in the nursing profession and the negative effects such abuses have on the ability of the nurse to perform his/her professional duties due to an unsafe or toxic work environment, and the nurse's intent to leave.

Effects on Nurse Work Effectiveness, Performance, Engagement

Yildirim (2009) studied the effects of bullying/lateral violence on nurses (n=286) in a teaching hospital in Ankara, Turkey using a cross-sectional and descriptive study. Data regarding workplace bullying behaviors was collected using a 33-item tool developed in 2008 by Dilek and Aytolan. Workload data were collected with an 11-item tool developed by Duxbury and Higgins in 1994 and adapted for use in Turkey by Aycan

and Eskin in 2005. Work hours data were collected simply by asking participants to estimate their work hours per week. Organizational effects data were collected using a questionnaire developed by the authors and adapted from a variety of research tools, including the Negative Acts Questionnaire – Revised (NAQ-R). The Beck Depression Inventory was used to assess participants' depression status. Each tool used had reported validity and reliability and internal consistency was reported within accepted protocols. Statistical data analysis was conducted using the SPSS, version 11.5 program. Descriptive statistical analysis, analysis of variance (ANOVA), correlational and regression analysis were each used to analyze the data collected. A frequency rate of bullying/lateral violence behaviors of 82% was reported. Twenty-one percent of participants reported to have been directly exposed to intensive bullying/lateral violence behaviors. Of those who reported direct exposure to bullying/lateral violence, 40% reported the perpetrator of the behaviors were members of administration; 34% reported the perpetrator as being a colleague/co-worker; 5% reported the perpetrator as being a subordinate. Additional results were reported as showing a positive correlation between bullying/lateral violence behaviors and work overload and total years of experience as a nurse. Bullying/lateral violence behaviors was negatively associated with a nurse's age. Regression analysis revealed that 45% of nurses experiencing bullying/lateral violence behaviors were affected by workload and 15% were affected by being younger. The effect on the nurses' job performance was most notable in the areas of job motivation, energy level, and commitment to the work and workplace. Bullying/lateral violence behaviors was positively associated with depression, work motivation, concentration, productivity, and relationship with patients and colleagues. Forty-five percent of

participants reported moderate to severe levels of depression; a positive correlation was noted between bullying/lateral violence and level of depression. The results revealed that younger nurses are more frequently victims of bullying/lateral violence behaviors. The negative impact of bullying/lateral violence was revealed to not only be on the physical and psychological health of the nurse, it also negatively impacted the nurses' ability to connect with patients, ability to work with colleagues, and decreased the levels of productivity and commitment to the professional practice of nursing. Strengths of this study included the reported validity and reliability of tools used and the rigorous nature of the statistical analysis. Limitations of this study included the small sample size and missing data on forms. The authors also noted a limitation related to the length of the survey which may have made some nurses reluctant to respond. This study involved a single hospital in Ankara, Turkey; this makes the results unable to be generalized to other populations. Despite these limitations and inability to generalize the findings, this study was important in that it lends support for younger nurses being a more likely victim of bullying/lateral violence and that bullying/lateral violence affects not only nurses personally, it negatively impacts the relationship with, and care of, the patient. Nurses who experience bullying/lateral violence directly were reported to have decreased levels of engagement, productivity, and commitment to the profession and to their patients.

A mixed-methods systematic review of literature examined the relationship between "hostile clinician behaviors" and patient care (Hutchinson & Jackson, 2013). The authors examined 30 qualitative, quantitative, and mixed-methods research studies for the time period 1990-2011 after an extensive search of eight electronic databases. All articles were in the English language without regard to country of origin. Studies on

faculty incivility and cross-sectional studies not specifying hostile clinician behaviors and patient care were excluded. After applying strict criteria for inclusion, a total of 19 survey studies, 2 mixed methods studies, and 9 qualitative studies were reviewed. The Joanna Briggs Institute (JBI) MAStari appraisal instrument was used for quantitative studies and the JBI-QARI checklist was used to assess qualitative studies. Studies of poor methodological quality were excluded from the review. Content analysis was used to categorize the studies based on common concepts and experiences with hostile clinician behaviors and patient care. The final analysis of the categories revealed results which showed an association between verbal abuse of nurses (by other nurses or physicians) and lowered quality of care to patients; a quality relationship between nurses and nurses and physicians resulted in a higher quality of care with reduced adverse events. Physician-initiated hostilities played a significant role in whether nurses spoke up about questionable medication orders and resulting medication errors. Nurse-on-nurse bullying, intimidation, and lateral violence behaviors resulted in decreased communication, teamwork, and level of patient care. The presence of lateral violence and associated hostile behaviors was also associated with decreased trust among nursing colleague resulting in higher rates of poor patient outcomes. In one study (Sofield & Salmon, 2003) 13% of nurses reported a direct relationship between verbal abuse and making medication errors and 41% reported productivity was decreased. Four studies identified the erosion of patient trust was perpetuated by verbal abuse and other hostile behaviors occurring in front of patients and/or family members. The authors noted in their results that there is little robust research into the extent hostile clinician behaviors impact patient care citing that the majority of studies were small and weak to moderate in methodological quality.

Additionally, the authors also noted that data collection tools used in studies were insufficiently developed and refined to fully research the issue of clinician hostile behaviors and patient outcomes. Most tools used in such studies have mainly been developed in North America/United States, while the majority of studies were conducted in Europe and Australia which may have led to poor quality of data, miscommunication due to non-universal nomenclature, and cultural differences impacting the data collection itself. Strengths of this study included a review of literature from across the world; rigorous literature review techniques, and strict inclusion and exclusion criteria. Limitations of this study lie in the lack of direct research into the issue of impact of hostile clinician behaviors on patient care and the variability of data collection tool validity. This study is important due to the revealing of poor-quality research, lack of common nomenclature, and the need for further enquiry into the impact hostile behaviors/lateral violence has on the quality of patient care. The authors noted that this study revealed that the issue of hostile clinician behaviors/lateral violence and the impact on the quality of patient care may be much deeper and complex than previously believed.

Effects on Patient Care, Outcomes, Safety

Disruptive behaviors (lateral violence) and the resulting effects on communication, collaboration, and patient care/outcomes were examined and assessed by Rosenstein and O'Daniel (2008) through use of a survey study. Physicians and nurses (n= 4,530) were both surveyed. The respondents all worked at a wide range of hospitals which were part of a national alliance of not-for-profit hospitals. Hospitals ranged from urban teaching hospitals to rural community hospitals. The authors developed a 22-question survey tool due to no prototype surveys being found. The survey tool was field

tested at two different hospitals (Mayo Clinic in Scottsdale, AZ and Barnes-Jewish-Christian Hospital in St. Louis, MO) and revisions made to refine the tool. Validity and reliability data were not reported. Accepted protocols and standards were followed in the analyses of data. Physician observed disruptive behavior was reported at 51% and nurse observed disruptive behavior reported at 88%. Over 75% of respondents linked disruptive behaviors by either physicians or nurses with medical errors and patient mortality. Seventy-one percent of respondents linked disruptive behaviors with decreased quality of care; over 50% felt patient safety was compromised due to such behaviors. Twenty percent of nurses and 12% of physicians reported being aware of specific adverse events related to disruptive behaviors. Loss of concentration, reduced team collaboration, reduced information transfer, reduced communication, impaired nurse/physician relationships were all reported by at least 87% of respondents. Strengths of this study include the nationally representative respondent pool and the large number of respondents. This study may not be transferable to all populations, but the wide range of hospital sizes, types, and geographic location make the results more representative of the healthcare system. The data were reported was not differentiated fully between nurses and physicians, making comparisons to other studies imprecise. The study lends support to the link between lateral violence/disruptive behaviors and negative patient outcomes. The study examined physician and nurse self-reported perceptions and recollections of events which can lead to under-, over-, or mis-reporting of events. Objective data on the impact of physician and staff behaviors, impaired communication, and collaboration on patient safety and outcomes would substantiate the subjective data. Further studies are recommended to assess the severity and frequency of disruptive behaviors in all

healthcare professionals, not only nurses and physicians, and to assess healthcare systems in other geographic locations. Further studies may also further validate the tool created by the authors.

Effects on Nurse Health and Wellness

Yildirim (2009) conducted a cross-sectional and descriptive study, it was reported that those nurses who experienced bullying/lateral violence behaviors had higher rates of depression. Bullying/lateral violence was positively correlated with level of depression; 45% of the participants reported moderate to severe depressive symptoms. Bullying/lateral violence behaviors was positively associated with depression, work motivation, concentration, productivity, and relationship with patients and colleagues. Forty-five percent of participants reported moderate to severe levels of depression; a positive correlation was noted between bullying/lateral violence and level of depression.

Effects on Nurse Intent to Leave or Stay

A convenience sample of 249 members of the Washington State Emergency Nurses Association (WA-ENA) was used to describe nurses' experiences with workplace bullying/lateral violence (Johnson & Rea, 2009). This descriptive study measured workplace violence using the Negative Acts Questionnaire – Revised (NAQ-R), a recognized valid and reliable tool used internationally. Results revealed that 27.3% of participants had experienced workplace violence in the previous six months. Workplace bullying was revealed to be significantly associated with a nurse's intent to leave their current position and the nursing profession; bullied nurses were twice as likely to report intent to leave as those who were not bullied. The analyses of data were conducted using recognized protocols and techniques; SPSS version 14.0. The study was limited to nurses

in Washington state and members of the WA-ENA. The respondent sample was not reflective of the general nursing population as the educational levels and number of male respondents were higher. The study did not provide data related to years of experience of respondents. While this study was not representative of the nursing population, it revealed the significant impact workplace bullying or lateral violence had on a nurses' intent to leave either their current position or the nursing profession.

The factors influencing the decision of RNs to leave nursing practice and the nursing profession were studied by MacKusick and Minick (2010). An interpretive hermeneutic phenomenological study using a purposive sample of ten RNs with at least one year of clinical practice who had left the nursing profession and lived in southeastern U.S. formed the study. Semi-structured interviews were conducted. Field notes, audiotaping, verbatim transcription, and participant review of each interview were completed as per standard and accepted protocols. Study results, using interpretive analysis, revealed three main themes regarding the decision to leave the nursing profession: unfriendly workplace, emotional distress related to patient care, and fatigue/exhaustion. All participants reported unfriendly workplaces consisting of overt and covert lateral violence behaviors; each related the unfriendly workplace with their fatigue, exhaustion, and decision to leave the profession. The study had a small sample size, which is consistent with the phenomenological method. While the study lends support to the association of lateral violence and the decision to leave the profession, the results may not be generalizable to other populations or able to be replicated in larger studies. The authors encouraged further studies exploring the concept of why nurses leave the profession in more detail. This study did not address why nurses might have

stayed in their positions or the nursing profession and thus revealed the need for further research into this aspect of the phenomenon of lateral violence.

Registered Nurses (n=861) from the southeastern region of the U.S. were surveyed to investigate the effects of a range of factors on the intention to leave positions and the nursing profession (Dotson et al., 2014). The survey tool was created by the authors and a pilot study was performed to assess effectiveness of the tool. Each question and area on the tool were reviewed for validity and reliability based on Cronbach's α reliability coefficient; all but one area scored above the required threshold. Altruism scored just below the required threshold of 0.7 but was considered usable for the study, though this area was considered less consistent than the other areas. Data collection was completed using an online survey from a single regional health agency in southeastern United States. Data were analyzed using the SEM Model which was used to estimate latent forces and constructs. Reliability and validity were reported. Job stress, including work environment and incivility and bullying (lateral violence), were the strongest and most common factor related to intent to leave either the nursing position or nursing profession. Altruism had the strongest effect on position satisfaction, and it was reported to keep a nurse either in his/her nursing position or in the nursing profession. The reported findings revealed that a nurse not satisfied with pay or one who had elevated stress levels might stay in a nursing position due to a satisfied sense of altruism. When the nursing position is no longer desirable, altruism might keep the nurse in the profession but looking for a different position. Value congruence also had significant impact on both position satisfaction and intent to leave; nurses who felt their position and employer were congruent to their values as a nurse were reported to be more likely to

remain either in their nursing position or the nursing profession. The economy had no significant effect on intent to leave except as it related to job satisfaction. The tool was newly developed, and the authors indicated that the tool needed further refinement related to the concept of altruism. The study was balanced between urban and rural hospital settings and was confined to the southeastern region of the U.S. making the demographics potentially nonrepresentative of the nursing profession nationally. Results may not be able to be generalized to all populations but offers clues to why nurses do or do not remain in their positions or the profession. The demographic population was reported by gender, age, experience level, education, work setting, and type of employment; however, the results were not differentiated by these same groupings. Of note, experience was reported as zero to ten years as the lowest experience level. While this study did not directly research lateral violence and did not address new nurses, the results remained important as it related to why a nurse might choose to remain in either their position or the nursing profession despite negative factors within the workplace itself.

Effects on New Nurse Intent to Leave or Stay

A cross-sectional selection of newly licensed RNs (NLRN) (n=612) from 34 states and the District of Columbia (D.C.) was used in a secondary analysis to explore the thoughts and perceptions of the work environment and work life (Pellico et al., 2009). An overall response rate of 37% was reported. The reported anecdotal comments included two part-time NLRNs who stated they remained in the nursing profession due to the flexibility of schedule and financial rewards not available elsewhere. No other comments or research findings were reported regarding why NLRNs chose to remain in the nursing

profession. This study helped support the need for further investigation of why NLRNs choose to remain in either their nursing positions or the nursing profession.

Simons and Mawn (2010) presented the qualitative findings of a survey study of newly licensed registered nurses (n=187) from across a single American state to examine the experience of bullying/lateral violence in the workplace. Data were collected through a mailed survey using the NAQ-R (Negative Acts Questionnaire – Revised). Open-ended questions invited participants to share their insights and experiences at the end of the survey. Four themes were revealed after analysis of data: structural bullying, nurses eating their young, feeling out of the clique, and leaving the job. One hundred thirty-nine nurses conveyed they had personally experienced workplace violence/lateral violence and 14 conveyed that they witnessed other nurses being bullied. Nineteen nurses' comments included the term "nurses eat their young". Nurses conveyed experiences of manager/administrative abuses, being "kept in the dark" regarding important information for patient care, being ignored, and some reported that the bullying/lateral violence began when they were still students. Thirty-nine nurses specifically wrote about bullying/lateral violence experienced during orientation. The authors noted that this initial employment period appeared to be an especially vulnerable time for new nurses. Many nurses wrote of the extensive negative impact workplace bullying/lateral violence had on their health, well-being, and ability to perform their nursing duties effectively and efficiently. Many nurses conveyed that they had or were actively planning on leaving their nursing position and others conveyed that they had given serious consideration to, or they had, left the nursing profession. Many commented that they thought of leaving either their nursing position or the nursing profession almost daily due to workplace violence/lateral

violence. One nurse commented that the only way she would leave nursing was if patient care was compromised, no other comments about why a new nurse might remain were provided. The authors noted that the study was not initially intended as a qualitative or mixed-methods study, rather simply offering nurses an opportunity to share further details regarding their answers to the quantitative survey. In-depth interviews or other means of verifying information were not deployed thus this was a limitation of the study. Another limitation was that bullying/lateral violence was not defined and nurses were not asked about their own definition of what these terms meant to them. The sample size was small, a common characteristic of qualitative research methodology. The sample was not representative of the nursing population as a whole; combined with a small sample size made the results unable to be transferred to other populations. This study revealed many aspects of how bullying/lateral violence negatively impacts the new or novice nurse. This study added to the body of knowledge supporting the need for more detailed research into the negative effects of bullying/lateral violence and the examination of the lived experiences of new nurses to expand the understanding of this complex phenomenon.

A descriptive study of newly licensed RNs (*n*=135) from five northwest Ohio nursing schools who had graduated between 2007-2010 was used to investigate bullying/lateral violence in the workplace (Vogelpohl, Rice, Edwards, & Bork, 2013).Data were collected using the Negative Acts Questionnaire – Revised (NAQ-R) and New Graduate Nurses Relational Questionnaire, which have reported validity and reliability. Data analysis was conducted using descriptive statistical methods. Reported results revealed that 20.5% of new nurses had been a victim of bullying/lateral violence; 46.7% of new nurses had seen someone be a victim of bullying/lateral violence within the

previous six months, 31% reported bullying/lateral violence had a negative effect on the performance of their duties and interactions with patients and colleagues. Nearly 30% of new nurses reported that they intended to leave the nursing profession. Of the new nurses who had experienced bullying/lateral violence, 35.4% had changed jobs and reported a high level of intent to leave the nursing profession. The results were similar to Simon's 2008 study in Massachusetts where 31% of new nurses reported intent to leave their nursing positions due to bullying/lateral violence. Sixty percent of new nurses reported that they had a mentor in the workplace. Just over 35% reported that management/administration were not supportive of those who were bullied or experienced lateral violence. Forty percent of new nurses reported nursing supervisors, mangers, and administrators as perpetrators of bullying/lateral violence behaviors and 63.9% reported that nursing peers perpetrated bullying/lateral violence behaviors. Bullying/lateral violence was more frequently perpetrated by peers, followed by supervisors/managers, physicians, and finally by patients. Strengths of this study were the use of internationally accepted survey tools with high reliability and validity, and appropriate statistical analyses. Limitations of the study included the low response rate to the survey, a common issue with survey type studies. The authors theorized that the small sample size may have been related to many of the potential participants not receiving the survey due to not checking their school related emails on a regular basis; potential participants who were victims of bullying/lateral violence behaviors may have chosen to not respond due to the sensitive nature of the study topic; and the historical low response rate to this type of survey. The results may not be generalizable to other populations in the U.S. or internationally due to small sample size and defined geographical area. The

results supported the fact that new nurses are experiencing high rates of bullying/lateral violence which increases the likelihood of burnout, leaving nursing positions or leaving the nursing profession. The results also lend support to the need for management to be supportive of victims of bullying/lateral violence. It is recommended that future studies include larger sampling of new nurses in diverse geographical areas to more fully examine the issues surrounding lateral violence and the effect on the new nurse.

Current Content

Currently there are no federal regulations regarding workplace protections for nurses and other healthcare workers who experience or witness lateral violence. According to the ANA (2017c; 2018b) eight states require employers to run workplace violence programs; California, Connecticut, Illinois, Maryland, Minnesota, New Jersey, and Oregon, while New York requires this only for public employees. Washington state requires reporting of workplace violence incidents. Forty-two states have established penalties for assault of nurses, seven states (Florida, Georgia, Hawaii, South Carolina, South Dakota, Kentucky, Oklahoma) designate these penalties only for emergency department, mental health, or psychiatric nurses. Kansas designates only mental health personnel; Mississippi designates only public health nurses. Ohio requires hospitals to post warnings regarding violent behaviors against nurses (ANA, 2017c). Hawaii has passed a resolution which urges employers to develop standards of conduct and policies mandating ways to reduce workplace bullying and ways to promote safe and healthy workplace environments (ANA, 2018a; 2018b).

Prevalence of Lateral Violence in Nursing

Reports of lateral violence in nursing have been increasing. It has not been determined if the increase in the reports is related to increased awareness or if the increase is in actual numbers of victims. Researching the prevalence of lateral violence in nursing is hampered by the multiple data reporting tools, victims reticent to participate in research due to the difficult nature of the topic, and low response rates to research. Transferability and generalizability of research is also hampered by these same factors, making comparisons across populations imprecise at best, nearly impossible at worst.

A descriptive correlational study to determine a relationship between an organization's culture and nursing workplace violence in South Korea was completed by An and Kang (2016). A convenience sample of 297 female, full-time nurses completed the Korean version of the NAQ-R questionnaire, a recognized standardized valid and reliable data collection tool. Data analyses, conducted via accepted protocols, revealed that nurses who identified organizational culture as hierarchy-oriented reported the highest level of workplace violence/bullying (22.2%). The lowest reported levels of workplace violence/bullying (8.4%) were from organizations identified as relation-oriented. Task-oriented organizational cultures had a reported rate of 20.8% and innovation-oriented organizations had a reported rate of 9.7%. The overall prevalence rate of workplace violence/bullying was 15.8%; a consistent finding to earlier South Korean studies. Type of organizational culture was the only variable identified that increased the odds of workplace bullying. This study revealed that the rate of workplace violence/bullying in South Korean hospitals had been consistent; hierarchy-oriented cultures had a nearly three times reported rate of workplace violence/bullying when

compared to other culture types; and that nursing workplace violence/bullying was a persistent problem internationally. The results are unique to South Korea and may not be generalizable to other populations. However, the information on organizational culture and workplace bullying is suggestive of the need for further study in other populations to aid in identification of workplace violence/bullying.

A cross-sectional study of nurses (n=200) in Nepal (Pandey, Bhandari, & Dangal, 2017) showed that two-thirds of nurses were victims of some type of workplace violence; 61.5% experienced verbal abuse, 15.5% physical abuse, and 9% sexual abuse in the past six months. Perpetrators of the reported violence were a combination of patients, relatives of patients, colleagues, and visitors. Colleague-, management-, or hospital employee-initiated violence were reported to be 21.6% physical abuse, 20.3% verbal abuse, and 55.6% sexual abuse. Findings reported that younger, less-experienced, and single nurses; those working on the medical-surgical units; and those working rotating shifts were at highest risk for workplace violence. Data collection was conducted using a tool developed and validated in 2003 by the World Health Organization (WHO), International Council of Nurses (ICN), International Labor Organization (ILO) and Public Services International (PSI). Data analyses were conducted following accepted standards using standardized, valid, and reliable methods. This study was conducted in one city and one hospital in Nepal making results not generalizable to other populations. This study does reveal that nursing workplace violence (lateral violence) occurs internationally. The study also lends support that younger, less-experienced nurses are the most common victims of lateral violence.

A study in Hong Kong (Cheung & Yip, 2017) reported that 44.6% of nurses (n=850) had experienced workplace violence in the past year. Data collection was conducted using a questionnaire developed and validated by WHO, ICN, ILO, and PSI. Data were analyzed using bivariate and univariate analyses and statistical analyses using standardized and reliable analysis software. The cross-sectional survey showed the most common forms of violence were verbal abuse/bullying (39.2%), physical assault (22.7%), and sexual harassment (1.1%). The perpetrators of the violence were most commonly patients and their relatives with 14% of all reported violence being perpetrated by colleagues and supervisors. Male nurses were more often victims of workplace violence than female nurses. Organizations with zero-tolerance policies and formal complaint processes had fewer reported incidents of workplace violence. Nurses who experienced any type of workplace violence reported high levels of anxiety, desire to harm self, and a desire to leave the facility or the profession. The study had a low response rate of just over 5%, which is common for voluntary questionnaires. The authors felt that despite the low response rate, results were investigational and could encourage further research into the types, causes, and prevalence of nursing workplace violence in Hong Kong and other locations. This study lends support of the pervasive and international nature of nursing workplace violence and further supports the need for clearly defined reporting processes and zero-tolerance policies to be implemented. The study's results, while limited to Hong Kong, provided support for the need for proper interventions by any organization to decrease nursing workplace violence and support nurses who have experienced such violence. The study also provided support that nurses experiencing lateral violence

experienced a range of psychological and physiological side effects and are more likely to leave their positions or the nursing profession.

A quantitative review of nursing literature was conducted following a meta-analysis protocol to estimate exposure rates of nursing violence by type, setting, and region of the world (Spector, Zhou, & Che, 2014). The literature search was conducted using three databases and varied time frames to the point of initiation of the study: CINAHL (Current Index of Nursing and Allied Health Literature) from1976; Medline from 1946; and PsycInfo from 1860. Specific parameters for inclusion in the review were established, including search terms, written in English, two or more empirical results reported, and incidence reported. A total of 136 articles were reviewed from international sources. Over 37% of nurses reported being bullied, over 50% reported general violence, nearly 30% reported sexual harassment. One-third of nurses reported being physically injured due to workplace violence. Non-physical workplace violence, including bullying, occurred most frequently in psychiatric units and the emergency departments. While physical violence was most frequently perpetrated by patients, families or visitors, other healthcare professionals accounted for the majority of non-physical violence, including bullying. Physical and sexual harassment rates were noted to be highest in Anglo regions of the world; non-physical violence and bullying were reported at a higher rate in the Middle East regions. This study, while comprehensive in nature, was limited by the very nature of research into nursing workplace violence including the lack of universal nomenclature, varied time frames, varied research methods, and the lack of research in certain regions of the world. Additionally, nurses from certain regions of the world are more open in discussing issues such as bullying and physical/sexual assault, in some

regions speaking of these issues is either taboo or looked upon as an afront to leadership which can lead to under-reporting of such incidents. The impact of the violence was not addressed by this study. This research revealed the universal and international nature of nursing workplace violence, including bullying. This review of literature also revealed the further need for a universal nomenclature and a standardized method of measuring the various forms of workplace violence, including bullying (lateral violence).

Groenewold et al. (2017) analyzed workplace violence injury data from 106 U.S. hospitals participating in the Occupational Health Safety Network (OHSN) using bivariate incidence rate ratios. The data were from the years 2012 – 2015. The OHSN was established by the National Institute for Occupational Safety and Health (NIOSH) and participation was voluntary. Reporting facilities were diverse regarding geographic location, urban versus rural settings, teaching facilities, and facility size and type. The authors noted that the make-up of reporting facilities were not representative of the national healthcare system. Data collected by OHSN included all types of healthcare worker injuries, including trips, falls, musculoskeletal, and workplace violence; the analyses conducted by Groenewold et al. was focused on workplace violence for all healthcare workers in reporting facilities regardless of direct patient care duties. During the time period in question, 3263 OSHA (Occupational Safety and Health Administration) recordable workplace violence events were reported. Results revealed that nurses sustained 40.2% of the reported injuries with 66.4% of all injuries sustained by females. The highest level of reported injuries occurred on general adult units (29.1%), adult critical care units (7.4%), and psychiatric/behavioral health units (7.4%). The reported severity of injuries was not always included in the submitted data; of those

reports including severity, 48.3% were severe enough to result in lost work days, job restrictions, or reassignment to a different unit. The reported workplace violence categories were unspecified (52%), verbal assault (0.3%), assault against property (0.4%), and physical assault (47.3%). Occupation and type of ownership (private versus public) were significantly associated with workplace violence rates. Nurses and nursing assistants were 70% more likely to experience workplace violence than all other healthcare workers. Privately owned facilities had a 70% increased rate of workplace violence when compared to publicly owned facilities. The overall incident rate of workplace violence increased 23% each year of the study. The authors theorized that this increase was related to increased awareness and improved reporting practices associated with familiarity with the collection tools and not necessarily an increase in actual rate of occurrence. Strengths of this study were the diverse facilities across the United States and the time span in which data were collected (four years). The data were collected by a nationally recognized organization and the statistical analysis was conducted using accepted standards. Limitations of this study included the non-random sampling of facilities, voluntary participation and reporting practices, data regarding many issues (severity, type of assault, assailant data) were missing or were listed as unspecified, and small sample size. The authors reported that due to the voluntary nature of reporting it was possible that only those facilities with best-practices reported data resulting in an overall rate of violence being significantly under-reported. Additionally, department specific rates could not be calculated as some data were reported per unit and other data reported per the hospital as a whole, this resulted in unit-based data being solely dependent upon event counts. The lack of specific data on assailant types limited the

ability to determine which events were associated with patient or family-initiated violence and healthcare worker-initiated violence. This study demonstrated the need for improved data collection techniques, extensive research, and improved reporting of results to the nursing profession. Data collection and research would be enhanced by collection tools which differentiate the job status of victims, levels of severity, identity of assailant (i.e. patient, visitor, physician, nurse), and more specifics regarding type of violence committed. This study revealed the risk nurses face regarding workplace violence.

Development of Toxic Work Environment

Registered Nurses, respiratory therapists, and imaging professionals (*n*=170) from a single organization in southeastern North Carolina were surveyed to examine the prevalence and frequency of exposure to lateral violence/uncivil behaviors as it related to turnover intentions (Evans, 2017). The cross-sectional survey reported that pilot testing was conducted to establish reliability and validity of data collection tools and method of analyses. Data were conducted using standard, internationally recognized, valid, and reliable measurement tools. A 13% return rate was noted, a rate common for survey type research. Data analysis was conducted using descriptive statistics to describe the sample; a chi-square test was used to test for significance in differences in exposure to uncivil behavior, and Cochran-Mantel-Haenszel statistics were used to test for associations between variables and calculated raw sum scores as a new method of analysis of the NAQ-R (Negative Acts Questionnaire – Revised). This new method of analysis allowed for the development of categories related to the magnitude or severity of uncivil behavioral exposure. The demographic information for all respondents revealed an

average age of 38, with a range of 20 to 68 years; over 47% held an associate degree in their field and nearly 39% held a bachelor's degree or higher. The majority of all respondents were female (93.62%), Caucasian (86.32%) and RNs (73.68%). The study found for all respondents, exposure to lateral violence was not dependent upon such factors as age, race, or educational level. Lateral violence/uncivil behaviors were found in all areas of the organization by all the respondents. Reported rates were higher on medical-surgical units and lower in the respiratory and imaging units. Over 50% of RNs self-identified as victims of severe bullying, while only 19% of respiratory therapists or radiology professionals self-identified themselves in the same manner. This supported earlier research that nurses are the most frequent victims of lateral violence/uncivil behaviors (Carayon & Gurses, 2008; Dellasega, 2011; Roche, Diers, Duffield, & Catling-Paull, 2010; Vessey et al., 2009). The author suggested that the difference in perception occurred due to baccalaureate nursing programs being required to meet AACN (American Association of Colleges of Nursing) essentials, most significantly Essential VI which includes collaboration and effective interpersonal communication to achieve optimal patient outcomes. Leadership and management courses are part of the curricula of baccalaureate programs, but not a usual part of associate degree program curricula. Findings revealed a lack of exposure to bullying/uncivil behaviors or lateral violence was a significant predictor of the participants' intention to remain in their job and the organization. This finding supported earlier research (Apker, Propp, & Ford, 2009; Coomber & Barriball, 2007; van der Heijden, van Dam, & Hasselhorn, 2009), which revealed that work environment had a far greater impact on intent to leave or stay than individual demographics. This study supported the need to create and maintain healthy

work environments in order to retain staff and promote collaboration between professionals. The limitations of this study included small sample size, lack of diversity in the participant population, exclusion of other healthcare professionals, and use of a single organization within a defined geographical area, thus making the results unable to be generalized to other populations. Of note, the lack of diversity was representative of the make-up of the general nursing profession. The study did not differentiate demographic information for profession and work location of respondents. While findings were differentiated for rate and severity of bullying between RN and the other professionals (respiratory therapists and radiology), the differentiation between those working as respiratory therapists and those in radiology were not reported. The study supported earlier research (Apker et al., 2009; Carayon & Gurses, 2008; Coomber & Barriball, 2007; Dellasega, 2011; Roche et al., 2010; van der Heijden et al., 2009; Vessey et al., 2009) in key areas, specifically the impact of workplace environments on the intent to leave or stay in the current position, and potentially the profession.

Pfeifer and Vessey (2017) performed an integrative review of 11 articles on nurse related workplace bullying and lateral violence (BLV) in Magnet® designated facilities. A total of eight quantitative and three qualitative studies from 2008 to 2016 were reviewed. The authors noted that several of the studies had data compiled from both Magnet® and non-Magnet nurses which resulted in difficulties in differentiating the responses. An extensive literature search was completed using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Statement as a guide to determine appropriate articles for the review. Of note, the 11 articles represented a total of eight different tools for data collection and eight different terms used to examine the

topic. None of the articles revealed use of a Level 1 experimental designs, two studies used Level II quasi-experimental designs of fair or low quality, and one study used aspects of a descriptive study (Level III) and a quality improvement project (Level V) but were of good quality and considered rigorous in nature. The final eight studies used non-experimental (Level III) designs, two were considered of high quality and six of good quality. Of the four studies researching the prevalence of BLV in both Magnet® and non-Magnet® hospitals none used the same nomenclature or data collection tool. This lack of precise terminology, common nomenclature and data collection tools limited the ability to compare data and impeded the research process and affected the results. Results of the review revealed that working in Magnet® designated facilities had only marginal impact of perception and incidence of BLV. Four themes were noted from the studies regarding increased levels of BLV: lack of policy development and consistent implementation; lack of education and skill-based training of staff; lack of effective surveillance and reporting of data; and a lack of accountability and trust. This integrative literature review was the first extensive review of literature regarding Magnet® designated facilities. The review revealed the need for rigorous and extensive research using common nomenclature regarding the phenomenon of BLV. Additionally, BLV is revealed a complex issue which is embedded into the very history and culture of the nursing profession. Strengths of this review were the extensive literature search using a reliable guide for determining studies to include in the review and the review of method rigor and validity of each study. Limitations of the review involved the lack of research available. The authors encouraged future researchers to analyze organizational context in order to effectively investigate the incidence of BLV and to ensure rigor and validity in the research process. The lack of

research regarding BLV in Magnet® designated facilities is troubling in that this designation is aimed at empowering nurses to develop healthy and effective work environments and collaborative interdisciplinary relationships.

Effects on Nurse Work Effectiveness, Performance, Engagement

A multi-center, descriptive and correlational study of nurses (n=87) was conducted in Portugal by Maio, Borges, Abreu, and Queirós (2016) to examine bullying and engagement levels among nurses and analyze the correlation between the two variables. Data were collected using NAQ-R (Negative Acts Questionnaire – Revised) and UWES (Utrecht Work Engagement Scale), both internationally accepted valid and reliable tools. Findings revealed a significant correlation and negative association between bullying and nurse engagement. Increased levels of bullying/lateral violence were associated with undervaluing of work and decreased work effectiveness. Male nurses (n=9) reported significantly more incidents of exclusion, work overload, and undervaluation of work; whereas female nurses (n=77) reported significantly higher levels of concerns with vigor and dedication. Nurses who worked fixed shifts and had defined work contracts were reported having experienced significantly less intimidation and undervaluation of work. The study did not report how data were analyzed or details about participant recruitment or selection. The sample size was small, no data were supplied about response rates. The low numbers of male nurses compared to female nurses in this study may have skewed results. However, the ratio of male to female nurses is representative of the nursing profession demographics in this area of the world. The study cannot be generalized to other populations as it is defined to one country and a

specific geographical area. The study does lend support to the correlation between bullying/lateral violence and decreased nurse engagement.

Olsen, Bjaalid, and Mikkelsen (2017) conducted a cross-sectional, web-based survey of registered nurses (n=2946) in four public hospitals in Norway. The reported survey response rate was 40%, an excellent response rate for this type of survey. Data collection was accomplished using a web-based survey. Different survey tools were used to collect data on various aspects: Negative Acts Questionnaire – Revised (NAQ-R) to measure bullying; Copenhagen Psychosocial Questionnaire (COPSOQ) to measure competence development, social support, and task-oriented leadership; Cooper's Job Stress Questionnaire (CJSQ) to measure institutional stress; and QPS-Nordic (General Nordic Questionnaire for Psychological and Social Factors at Work) to measure job performance, job satisfaction, and work ability. Validity and reliability of the tools were not discussed. Each tool is recognized as valid and reliable in previous research as each was used in this study (Arbuckle, 2012; Cooper, 1981; Einarsen et al., 2009; Elo et al., 2000; Kristensen, 2000; Nielsen et al., 2009; Nielsen et al., 2010; Rugulies, Aust, & Pejtersen, 2010; Tuomi, Ilmarinen, Jahkola, Katajarinne, & Tulkki, 1994; Yukl et al., 2002). Data analyses were completed using a range of valid and reliable methods, including descriptive statistics, Cronbach's alpha, correlations, and structured equation modelling. Results revealed that colleague support and the development of competence in the area of practice reduced bullying and improved job performance, satisfaction, and ability. The availability and amount of job resources inversely affected the presence and severity of bullying. Task-oriented leadership had a significant impact on job satisfaction unrelated to other variables. Bullying had a significant negative influence on the work

ability of nurses and was significantly correlated to decreased job performance. However, bullying was not shown to have a direct negative influence on work performance. The authors deduced that bullying negatively affected job performance due to its negative impact on the registered nurses' work ability and that while bullying caused negative effects, the lack of direct influence on job performance may be a factor in why bullying behaviors are allowed to continue in the healthcare setting. The authors noted that while the survey tool used to measure job performance was shown to be valid and reliable and adequate for the study, the effect of bullying might have been shown to be different with the use of another survey tool. Limitations of the study included potential measurement bias due to the self-reported nature of the surveys; factors influencing the areas measured as institutional factors were not exhaustive in nature and other institutional factors remaining unexplored; and the study only sampled Norwegian hospitals in defined healthcare regions which limited the generalizability of the findings. Strengths of this study included the response rate, large sample size, participants were recruited from multiple regions of Norway, use of multiple analytical and survey tools, and the validity and reliability of the tools used. This study supported the negative influence bullying had on the ability of the nurse to be satisfied with his/her work and function at optimal levels. It can be deduced that if nurses are not satisfied with their work and feel that their job performance is sub-par, engagement with patients is diminished resulting in negative influences on patient outcomes. Further research in other geographical and institutional settings might further validate these findings.

Data from three secondary data sources, the Penn Multi-State Nursing Care and Patient Safety Survey of RNs from California, New Jersey, Pennsylvania, and Florida;

the American Hospital Association (AHA) Annual Survey of Hospitals; and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient survey data, were used as part of a cross-sectional, observational study by Kutney-Lee et al. (2016). The objective was to examine nurse engagement in shared governance and determine relationships between nurse engagement and either patient or nurse outcomes. The sample for analyses consisted of 20,674 RNs working in 425 non-federal acute care hospitals across the U.S. Data analyses were completed using ordinary least-square regression models and using accepted statistical methods. Findings reported that hospitals classified as having the most engaged nurses had significantly lower patient-to-nurse staffing ratios and scored 14% higher in the category of patients who would "definitely recommend" the hospital compared to least-engaged hospitals. Nurses who were classified as most engaged reported nursing position dissatisfaction at 13%, nurses classified as least engaged reported at 43%. Least engaged nurses also reported twice the rate of burnout and three times the rate of intent to leave their position when compared to most engaged nurses. Additionally, least engaged nurses reported significantly higher rates of considering the quality of care and patient safety on their units as poor or failing. Twice as many least engaged nurses reported not being confident that patients being discharged from their units would be able to care for themselves and not confident management would resolve concerns and issues related to patient care. Nurse engagement was shown to have significant effect on HCAHPS scores. This study was limited by the voluntary nature of participants' decision to provide data to calculate HCAHPS scores and the fact that not every patient from each organization is recruited to participate in the HCAHPS surveys. The study was also limited using only non-federal acute care hospitals

rather than a sampling of all types of healthcare facilities across the U.S. Causal inferences regarding the relationship between nurse engagement and outcomes were limited by the study's methodology. Strengths of the study included the quality of data collection through the secondary sources, the high number of participants from participating hospitals, and the national nature of the data. This study lends support to the concept of nurses' engagement impact on both quality patient care and nursing position satisfaction, which includes intent to leave or remain in their current nursing position.

Fountain (2017) surveyed RNs (*n*=210) working in hospitals across the U.S. to examine the effects of bullying/lateral violence on nurse engagement. This was a descriptive, cross-sectional correlational survey completed using Utrecht Work Engagement Scale (UWES-9) and the Workplace Bullying Inventory, both valid and reliable standardized tools. Data analyses were conducted using recognized valid and reliable statistical analyses software (SPSS version 24) and a three phase analyses through use of descriptive statistics, bivariate testing to determine predictor variables, and multivariate analysis with a multiple regression model to examine what predictor variables were related to work engagement (WE). Results indicated moderate exposure rates and modest amount of perceived bullying; 30.5% of RNs reported being bullied at work. There was a significant statistical relationship between incidence of bullying/lateral violence and nurse engagement. Nurse engagement was significantly higher in those RNs who worked at least 40 hours per week; RNs working on medical-surgical units reported significantly lower rates of nurse engagement. There were no statistically significant differences in rates of nurse engagement based on race, gender, or presence of a bullying/lateral violence policy in the organization. RNs who had no exposure to

bullying/lateral violence had significantly higher rates of nurse engagement than those reporting moderate to substantial bullying/lateral violence exposure. Moderately bullied nurses were reported to be more susceptible to such negative effects as increased call-ins, resignation, physical and mental distress, and poor engagement. Limitations of the study involved the low number of participants, use of one publisher to announce the recruitment of participants, and the potential for self-selection bias. The study did have a 45% response rate, a high rate for a mailed survey. A strength of this study was the nation-wide recruitment of participants. The use of the Workplace Bullying Inventory may have limited the comparison to data obtained from other data collection tools such as the NAQ-R (Negative Acts Questionnaire – Revised). The use of a cross-sectional study does not allow for longitudinal examination of the phenomenon, however that was not the intent of this study. The author encouraged further studies which are longitudinal in nature and the use of larger sample sizes. This study added to the concept of the negative impact of bullying/lateral violence on nurse engagement and, in turn, patient outcomes. More extensive research regarding nurses in a variety of care settings is needed to provide further insights and correlation between bullying/lateral violence, nurse engagement, and patient outcomes. Such research may provide key insights into effective policies to prevent bullying/lateral violence in the future, stopping bullying/lateral violence before it can begin.

Effects on Patient Care, Outcomes, Safety

Wright and Khatri (2015) surveyed nurses (n=241) working in three hospitals within a single university healthcare system in the Midwest of the U.S. to examine the relationship between nurse-initiated workplace bullying/lateral violence and patient

outcomes. Valid and reliable tools were used to gather data. Data were collected using the Negative Acts Questionnaire – Revised (NAQ-R) and the Rosenstein and O'Daniel modified scales, recognized standardized valid and reliable instruments. Results revealed that person-related bullying had a significant positive relationship with psychological responses and medication errors and was positively associated with age of the nurse. It was also reported that male nurses experienced higher rates of workplace bullying than female nurses. The results are suggestive that workplace bullying increases psychological responses such as anxiety and fear, which in turn results in increased medication errors. A low participation rate was reported, not uncommon for survey related research. Any research related to bullying/lateral violence may have created sensitivity in the participants which may account for the low participation in such research, or under-reporting of the phenomenon. The study did not include other potential sources of bullying behaviors such as physicians, patients, and/or family members/visitors. The topic of bullying behaviors and their effect on medication safety was limited. The results cannot be generalized to all populations since the participants were from a single healthcare system within a defined geographical area. However, the results lend support to the impact of nurse-initiated bullying and the negative effect on patients and patient care, specifically medication safety.

Malone (2016) reported the Institute for Safe Medication Practices (ISMP) survey on intimidating behaviors by healthcare professionals (doctors, nurses, pharmacists) (n=2,095) and medication safety. Respondents were from across the U.S. Nearly 40% of respondents reported that rather than experience abusive/intimidating behaviors from medication prescribers they assumed a questionable order was correct and 34% accepted

that an order was safe based on the reputation of the prescriber despite their own uneasiness with the order. Forty-nine percent felt pressured to accept, dispense, or administer a medication despite voicing concerns over the safety or efficacy of the order. The data were compared to a survey conducted by the Institute for Safe Medication Practices (ISMP) in 2003 and showed little to no improvement in the reported behaviors. The data collection and analyses processes, as well as validity and reliability data on collection tools, were not reported. While one can presume that data collection and analysis were conducted in accordance to accepted protocols and standards due to the ISMP reputation for quality research, such data were not reported and thus were study limitations. This study does, however, lend support to the link between intimidating behaviors and lateral violence, and the negative work relationships and potential for adverse patient outcomes.

Effects on Nurse Health and Wellness

The first critical literature review (n=9) regarding suicide among nurses since the 1999 study by Hawton and Vislisel was conducted by Alderson, Parent-Rocheleau, and Mishara (2015). The purpose of the more recent review was to examine the knowledge on the risk of suicide among nurses and on the contributing factors which place nurses at higher risk for suicide. The Hawton and Vislisel review looked at studies in the United Kingdom, United States, Canada, Iceland, and Sweden; however, this more recent study examined literature published in either French of English between 1999 and 2014, regardless of country of origin. A thorough search from a variety of databases was conducted. While the search resulted in 719 articles, 702 were discarded as unusable. Of the remaining 17 articles, nine were chosen as usable and meeting criteria, including

being published in a peer-reviewed journal. Of these nine remaining articles, two focused solely on nurse suicide, six examined various occupational groups, including nurses and one examined suicide solely among nurses and physicians. Eight of the nine studies were retrospective studies using databases and interviews with surviving relatives to determine the personal characteristics of the person who had committed suicide. The authors concluded that there was a high prevalence of nurse suicide. The nature of the healthcare work environment increased both stress and the risk of suicide. Studies revealed that nurses are at a higher risk for committing suicide when compared to the general populous. The increased risk for nurses was at or above twice the general populous. This increased rate was consistent with findings from the Hawton and Vislisel review. The contributory factor most often studied in the reviewed articles was that of knowledge of methods and nurses' access to medications. Nurses used medications as the means to commit suicide three times more often that the general populous. The factor of pre-existing psychiatric/psychological disorders had been gaining attention. In a British study, almost 82% of nurses who had committed suicide were diagnosed with depression, less than 1% were diagnosed with bipolar disorder. Overall, the presence of depression prior to committing suicide significantly increased the risk of nurses committing suicide. Nearly half of nurses who committed suicide had excessive alcohol consumption, used illegal substances, and/or smoked. In comparison, 20% of the general populous who committed suicide had these contributory factors. Nurses who reported severe or minimal personal or occupational stress were at higher risk for suicide than those with moderate levels of stress. Studies did not examine the make-up of stress and did not clearly define stress. The authors of the studies theorized that the minimal reported stress levels were

indicative of loss of meaning in their professional life, a complete disengagement from work, denial of the stressors, and/or undiagnosed depression or other psychiatric/psychological disorder. It was noted that those with reported high levels of professional stress were at a five times increased risk of suicide when compared to those with reported light levels of professional stress. These findings are consistent with the Hawton and Vislisel review. In the 15 years since the 1999 study, the only new research conducted on new or different populations of nurses were conducted in Australia and New Zealand. The authors of this more recent study encouraged further research into the issue of nurse suicide, including contributory factors, suicidal ideation or suicidal attempts and behaviors, and using a wider range of research methods. Strengths of this study were the extensive nature of the literature search and stringent criteria for inclusion in the analysis. Limitations were the limited number of articles/research available for review; only two studies conducted in North America; and the differing ways prevalence of nurse suicide were researched and defined. Additionally, imprecise data were available due to the incomplete nature of data reported by the sources of information, such as public registers having missing or erroneous data regarding demographic information and means/methods of suicide. The authors also noted that two studies reviewed may have shared overlapping data. The authors concluded that the reported suicide rate among nurses, while known to be increased over the general population and other healthcare professionals, has been underestimated. This makes more complete data collection methods and research into the varying aspects of nurse suicide, including work-related factors, essential to fully understand this issue. This study did not specifically identify lateral violence as a contributory factor. However, it identified increased

professional/occupational stress as a contributory factor in nurse suicide. Further research into the contribution of lateral violence on nurse suicide is an essential part of understanding the true impact of lateral violence on nurses and the nursing profession. With limited to absent data collected on nurse suicide, there is a critical need for effective data collection techniques and research to ascertain prevalence of nurse suicide.

A Canadian longitudinal study was conducted by Trépanier, Fernet, and Austin (2015) to gain insights into how workplace bullying/lateral violence related to nurses' psychological health (including nurse-work engagement) and job attitude (including intent to quit) over time by examining the role satisfaction of basic needs had on each issue and their relationship to each other. The authors conducted a two-wave study of nurses (n=508) working in the public health sector in Quebec, Canada; data were collected at two points in time in October of 2011 and 2012. All data collection tools were administered in French. The Negative Acts Questionnaire – Revised (NAQ-R) French version was used to assess workplace bullying/lateral violence. This tool has been extensively reported as a valid and reliable tool in international literature. The data concerning need satisfaction were assessed using the Work-Related Basic Need Satisfaction scale which was shown to be a valid tool by Van den Broeck et al. in 2010. Emotional exhaustion and cynicism subscales of the Maslach Burnout Inventory General Survey (MBI-GS) were used to assess burnout. Validity and reliability were reported. The vigor and dedication subscales of the Utretch Work Engagement Scale (UWES-9) were used to assess work engagement. Turnover intent/intent to quit were assessed with a tool adapted from the O'Driscoll and Beeler's scale. Previous studies (O'Driscoll & Beeler, 1994; Richer et al., 2002) reported high internal consistency of this tool.

Statistical analyses were accomplished through use of Comparative Fit Index, the Tucker-Lewis Index, the Root Mean Square Error of Approximation; Standardized Root Mean Square Residual; and cross-lagged analysis. Reported results revealed that workplace bullying negatively predicted the satisfaction of the needs for competence and autonomy, however, it showed no relevance to the need for relatedness. Workplace violence/lateral violence was positively related to burnout and negatively related to work engagement. Results also showed that a nurse's need for relatedness and the satisfaction of that need negatively predicted turnover intention/intent to quit, however, was unrelated to work engagement. Work-related bullying/lateral violence negatively predicted the satisfaction of the nurses' need for autonomy. The results suggested that the exposure to workplace violence/lateral violence prevented the satisfaction of basic psychological needs and fostered burnout and intent to leave. However, when such exposure to violence was controlled, basic need satisfaction and workplace engagement were enhanced; intent to leave was decreased. The authors noted that when these results are combined, they demonstrated the importance of need satisfaction to enhance the nurses' ability to function. Limitations of this study include the nature of the cross-lagged analyses, the authors suggested that the use of a multivariate design might provide a more comprehensive understanding of the relationships examined in the study and that further studies using three time points would be required to validate the findings of this study. The sample taken from the public health sector in Quebec, Canada may prevent generalization of results to other populations. The authors recommended further studies to replicate findings in other work settings and among other populations. Strengths of this study were the time-lagged nature of the study, rigorous statistical analyses, and use of

valid and reliable data collection tools. This was the first study to research the temporal effects of workplace violence/lateral violence on job attitudes and health concerns. This study adds to the body of knowledge by adding to the understanding of the health and job-related negative aspects of exposure to workplace violence/lateral violence.

Nursing literature were reviewed to explore nurse bullying behaviors in the United Kingdom (UK) and other countries (Wilson, 2016). The literature search was conducted using three databases (CINAHL, Medline, and PsycInfo) with no limitations placed on date of publication. Search parameters included peer-reviewed, English text, and selected search/key terms. Twenty-eight articles met parameters and were reviewed. Results reported 20-25% of nurses internationally experienced bullying at work. This bullying resulted in a range of psychological symptoms including depression and anxiety and resulted in 25% of bullied nurses leaving the profession. Factors which were found to contribute to bullying behaviors included the hierarchical nature of healthcare and management, feelings of not being empowered, non- or under-reporting of incidents, colleague silence, and management allowing behaviors to continue. The research reviewed articles from the United Kingdom, United States, Brazil, Turkey, Canada, and Australia. Limiting articles to these countries may offer skewed results and not present a true international picture of nurse bullying behaviors (lateral violence). The author concentrated on rules and regulations, issues, and potential interventions in and for the United Kingdom. Interventions presented may, however, be applicable to other countries. This review supports the international nature of bullying/lateral violence in nursing; however, it did not supply a thorough or complete international viewpoint. This study further provided support for the negative impacts of bullying/lateral violence, including

psychological distress and up to 25% of nurses leaving the profession due to such behaviors, mostly within the first year of beginning professional practice.

Registered nurses (*n*=345) from a single state in southeastern U.S. were recruited to examine prevalence of lateral violence in a variety of workplaces, the influence of resilience on the effects of lateral violence/bullying; and describe the relationship of lateral violence with overall health of nurses (Sauer & McCoy, 2017). A cross-sectional descriptive study was performed. An anonymous online survey was used to collect data. Data collection tools were Negative Acts Questionnaire – Revised (NAQ-R); Short Form Health Survey (SF36); Perceived Stress Scale (PSS), and the Resilience Scale (RS25). Validity and reliability were reported. Data analysis was performed using descriptive statistics and following industry protocols. The study had a response rate of 15.3%, common for survey type research. The average length of experience as RNs was 8.3 years; the majority of respondents were female (89%); 57% held a bachelor's degree or higher; 78% worked full-time; and 80% worked in direct patient care positions. The reported results revealed that 40.1% of the nurses had experienced bullying in the previous six months; 22.8% experienced severe bullying, and 68% had witnessed a colleague being bullied. The authors noted that there were no statistical differences in reported rates and severity of bullying/lateral violence between Magnet® and non-Magnet® facilities, or between those who worked part- or full-time. The reported physical health of the nurses corresponded with the general public, however, 26.6% of nurses reported high levels of psychological stress, much higher than the general public. Nurses who had witnessed lateral violence/bullying episodes were reported to be more likely to be victims of lateral violence/bullying. Nurses who experienced lateral

violence/bullying reported significantly higher rates of psychological stress and significantly lower rates of resiliency when compared to nurses who had not experienced lateral violence/bullying. Nurse resilience was reported as not being a mediator of lateral violence/bullying on physical and mental health. The study's findings revealed that nurses continued to experience lateral violence/bullying and experienced negative effects on their physical and mental health. This study had similar findings to previous research regarding physical and mental health impact from lateral violence/bullying (Einarsen et al., 2011; Karatza et al., 2016; Vessey et al., 2011). This study did not explore whether lateral violence/bullying contributed to decreased work productivity or lowered patient outcomes. Strengths of this study included the representative nature of the sampling to the nurse population in the state in which the study was conducted; sampling from a variety of workplaces; use of reliable and valid data collection tools; use of a variety of data collection tools to examine multiple areas regarding lateral violence/bullying; and the appropriate data analyses. Limitations of this study were the limited geographic location of participants; low response rate; and the self-reported nature of the data. The authors noted that while the SF36 survey used to measure health was an appropriate measurement for general health, a tool more specific to physical and mental stressor would have enhanced the understanding of the consequences of lateral violence/bullying. While the results of this study may not be generalizable to other populations, it lends support to the pervasive nature of lateral violence/bullying and the negative impacts such behaviors have had on nurses of all experience levels and workplace settings.

Effects on Nurse Intent to Leave or Stay

In the Trépanier, Fernet, and Austin (2015) longitudinal study, reported results included workplace violence/lateral violence being positively related to burnout and negatively related to work engagement; and that a nurse's need for relatedness and the satisfaction of that need negatively predicted turnover intention/intent to quit. The study results suggested that the satisfaction of basic psychological needs was prevented by exposure to workplace violence/lateral violence and this increased rates of burnout and intent to leave. When exposure to lateral violence was controlled, satisfaction of basic psychological needs and workplace engagement were improved, and the intent to leave was diminished.

The first cross-national study of nursing employees in the U.S. (n=341) and Italy (n=313) was conducted by Viotti, Converso, Hamblin, Guidetti, and Arnetz (2018). The purpose of the study was to examine the relationship between incivility by colleagues with the workplace environment, workload, and intent to leave. The authors believed that it was vital to determine whether factors involved in incivility/lateral violence can be generalized across cultures, or if cultural differences are relative to how incivility/lateral violence is perceived and reported. Data were collected via mailing surveys to nurses from a Midwestern hospital system. In Italy, a survey was given to nursing employees during their shift. Completed surveys were to be placed in a secure location on each unit of the two medium-sized hospitals in Northwestern Italy. A 24.5% return rate was achieved in the USA; 56.1% in Italy. Nurses and nursing assistants comprised the final samples for each country. Organizational efficiency and nursing workload were measured using the Quality-Work-Competence questionnaire (QWC) developed in 2011. Colleague

incivility/lateral violence were measured using a scale adapted in 2012 by Stilter et al. Intent to leave was measured via a single question using a five-point Likert type scale response. Demographics (gender, age, and occupation) were also collected and were reflective of the nursing populations of their respective country. The American sample was younger in age and had a larger sample of nursing assistants compared to the Italian sample. Registered Nurses made up 76.8% of the American sample and 92.2% of the Italian sample. Analyses of data were performed using SPSS 22 and AMOS (Arbuckle, 2006) software and descriptive analyses. Bootstrapping analysis of the data were performed to minimize risk of Type I errors. Reported findings included a negative association between workload, incivility/lateral violence, and intent to leave in both country's samples. A positive and significant association between incivility/lateral violence was noted in both samples. Workload was reported as positively association with incivility/lateral violence and intent to leave in the American sample only. The workload, in the American sample only, had a reported association with both incivility/lateral violence and intent to leave. The authors noted that there was a high unemployment rate in Italy (20%) which may have contributed to Italian nursing employees accepting a high workload as a necessary and needed aspect of maintaining their current position. In comparison, the American unemployment rate was reported at 5%, which may have allowed the nursing employees to feel they had other options for employment. The authors concluded that organizational efficiency was a vital aspect in understanding incivility/lateral violence and intent to leave. The authors also concluded that the results supported previous research (Hofstede, 1984; Taylor & Kluemper, 2012) which stated that in indulgent cultures (e.g. Anglo Saxon/American) individuals were less

able to control themselves when confronted by a colleague who is rude, aggressive, or not performing their duties fully when the individual is experiencing excessive demands in either their workplace or personal lives. Limitations of this study included the cross-sectional design, which does not look at longitudinal data; the self-reporting nature of the data, which may increase bias; the vastly different response rates; and that the studies were defined to specific geographical areas and hospital systems. Another limitation was that results were not delineated by occupation. This study was important as the first to use a cross-national approach. The study also supported the international nature of lateral violence and the impact such violence has on nursing professionals. This data may be used to support interventions by organizations to enhance the work/life balance of their employees, and to encourage further research. It is recommended that further cross-national studies be completed, including longitudinal data, larger sample size, and larger geographical areas being examined. It is also recommended that data be delineated between occupation to enhance the ability to compare to other studies.

The relationship between horizontal violence and nurses' intent to leave positions or the profession was explored in a descriptive correlational study by Armmer and Ball (2015). The study consisted of 104 RNs from a midwestern U.S. hospital selected via random sampling. The data collection tools used (Briles' Sabotage Savvy Questionnaire [BSSQ] and Michigan Organizational Assessment Questionnaire [MOAQ]) were found to be valid and reliable through multiple studies conducted internationally. Data were analyzed using means and standard deviation (descriptive statistical analyses) and Pearson's Product Moment Correlation calculated relationships between various scores (BSSQ), data (MAOQ), and demographics. A significant, positive correlation between

horizontal violence and intent to leave was found. Less experienced and younger nurses were reported to have increased incidence of intent to leave due to horizontal violence when compared to older nurses with more years of experience. Nearly 30% of respondents stated they were planning to leave their position or profession within the next 12 months. Of significance, the hospital involved in this study had conducted a lateral/horizontal violence campaign; 48.1% of respondents reported participation in the lateral/horizontal violence campaign. The small sample size and the fact the study was defined to one hospital in the Midwest makes results potentially not generalizable to other populations. The results, however, supported the association between lateral violence and intent to leave, as well as newer nurses being more likely to leave their positions or profession. The authors encouraged similar studies with larger populations in a variety of urban and rural settings throughout the U.S. to further assess the association between lateral violence and intent to leave.

Mazurenko, Gupte, and Shan (2015) explored factors associated with the decision to leave either a nursing position or the nursing profession. A cross-sectional study sampled RNs from across the U.S. who had changed jobs within the previous year was taken from a secondary source, the National Sample Survey of Registered Nurses (NSSRN) conducted in 2008 by the Department of Health and Human Services (HHS). The data collection tool's validity and reliability were not reported in this study; however, the tool is recognized in other data as a reliable and valid standardized collection method (HHS, 2018). A stratified systematic sampling of the secondary data was used to randomly select RNs from each state. A response rate of 62.4% resulted in a total sample size of 36,646. Findings indicated approximately 14% (4,682) of RNs left the profession

and 14% (4,114) left their organization. Nurses who left the profession were more likely to have held a baccalaureate degree and worked in a nursing home; nurses who left their organizations were more likely to have held an associate degree and worked in the outpatient setting. Results revealed that RNs who left the profession were more likely to have reported work-related disability, high levels of physical demands, dissatisfaction with work schedules, workplace environment, and staffing concerns. RN's who left their organizations were more likely to have reported high levels of stress, dissatisfaction with management and leadership, dissatisfaction with advancement opportunities, and dissatisfaction with compensation. In contrast to previous studies (Chan et al., 2009; Camerino et al., 2006), this study revealed that older, more experienced nurses who worked in urban settings were more likely to leave the profession rather than the organization. Data analysis was conducted using SAS software. This was the first study to explore the differences between the decisions concerning leaving the profession or organization. Strengths of this study included the large sample size and nationally representative sampling of practicing RNs in the U.S. A limitation of this study was that data were dependent on recall of the participants, potentially resulting in inaccurate reporting of actual reasons for leaving either the profession or organization. This study focused on those RNs who had left either the profession or their organization already, making results unable to be directly compared to studies of RNs who remained in the profession or positions. Additional factors which might have impacted the nurses' decisions to leave were not explored, such as economy, unemployment rates, job market, and government policies. The authors recommended that longitudinal studies be

conducted to define causal relationships since this study could only suggest associations due to the cross-sectional nature of the dataset.

Ward-Smith et al. (2018) surveyed members of the Society of Urologic Nurses and Associates (SUNA) (n=173) to describe personal experiences with incivility in the workplace. Data regarding intent to remain in the present position for the next 12 months were collected using recognized standardized tools with reported reliability and validity. Over 25% of respondents reported workplace incivility severe enough to plan to leave their current position or the profession; certified urologic nurses reported less intent to leave compared to non-certified nurses. The demographic make-up of the study participants was not representative of the general nursing workforce. A lower rate of baccalaureate prepared nurses but a higher rate of master's degree and doctoral degree prepared nurses was reported. Nurses planning to leave their position or profession reported higher levels of hostile behaviors and described uncivil workplaces. Generalization of findings may be limited to other populations due to the demographic make-up and all participants having worked in a single field of nursing (urology). A strength of this study was that nurses from across the U.S. were recruited. Additionally, this study lends support for the negative impact of incivility in the workplace, including the rate of intent to leave.

Effects on New Nurse Intent to Leave or Stay

A South Korean study (Chang & Cho, 2016) of newly licensed nurses (NLN) (n=312) who became licensed in 2012 and 2013 was conducted to examine workplace violence/lateral violence. This study analyzed cross-sectional data collected approximately six months after licensure, with a range of 5-12 months, during the first

wave of a longitudinal study, and tracking NLN for three years. The NLNs worked in either hospitals or clinics. Data on workplace violence/lateral violence and job outcomes were collected using the Copenhagen Psychosocial Questionnaire second version (COPSOQ II). While no specific data were presented on the validity and reliability of this tool, the authors stated that this tool had been used with research of office workers and RNs in South Korea as well as research concerning nursing work environments internationally. Data analysis was conducted using multiple linear regression analysis for job satisfaction. Prevalence was calculated by dividing the number of positive answers by the total number of nurses in the study. Prevalence was also analyzed by organizational size and type. Nearly half of the NLNs worked in hospitals with 1,000 or more beds; over 50% worked in general units and nearly 20% worked in intensive care units. Seventy-three percent of the NLNs experienced at least one of the five forms of workplace violence/lateral violence. It was reported that 59.6% experienced verbal abuse, 36.9% experienced threats of violence, 27.6% experienced physical. Male NLNs experienced more workplace violence/lateral violence than their female counterparts. NLNs working in small organizations experienced the least amount of workplace violence/lateral violence, while NLNs working in the emergency department had the highest prevalence of workplace violence/lateral violence. The most common perpetrators of verbal abuse and bullying type violence were nursing colleagues; patients and families of patients most commonly were perpetrators of threats of violence, sexual harassment, or physical violence. Verbal abuse and bullying of newly licensed nurses were associated with job dissatisfaction; verbal abuse and bullying were significantly associated with job burnout, commitment to the workplace; bullying was significantly associated with intent to leave.

Workplace violence/lateral violence committed by nursing colleagues was significantly associated with job dissatisfaction, job burnout, commitment to workplace, and intent to leave. The results reveal the strong influence violence committed by nursing colleagues had on newly licensed RNs; the authors theorized that this was due to the lower skill set of new nurses compared to experienced nurses, the need for mentorships and supervision of new nurses by experienced nurses, and the need of new nurses to develop strong working collaborations with nursing colleagues. The number of new nurses reporting workplace violence was reported as high, suggesting that nursing colleagues, patients, and patients' families target new nurses. Strengths of the study included the use of a nationally diverse population of newly licensed RNs and the return rate of surveys (47.8% in the 2012 group and 39.3% for the 2013 group). The return rate was significantly higher than many studies of the same method. Limitations of the study included the voluntary nature of participation and the fact that the significant associations reported may not signify causal relationships due to the cross-sectional nature of the study. The authors noted that the sample demographics may not have reflected the make-up of the nursing population in South Korea thus making the results potentially unable to be generalized to nursing populations within the country of South Korea, or internationally. This study supports the negative impact of workplace violence/lateral violence on the newly licensed nurse and lends support to newly licensed nurses being more likely targets of workplace violence/lateral violence.

A time-lagged two-wave survey of new graduate nurses (n=406) in Canada was conducted to investigate what factors influenced the new graduate nurses' transition to their full professional role as RNs (Laschinger et al., 2016). The one-year study also

surveyed the new graduate nurses regarding predictors of workplace satisfaction, job satisfaction, and turnover intentions over the first year of professional practice. Nurses with less than three years of professional practice and working in direct patient care were recruited from each of the Canadian provinces. The mailed survey response rate for the first wave was 27.3% and the second wave was 39.8%. Only nurses who completed both surveys were included in the study. Standardized surveys with reported validity and reliability were used to collect data. Data analyses were conducted using descriptive statistics, correlations, and hierarchal linear regression using SPSS software. Over half of the new nurses reported high levels of emotional exhaustion; 24% witnessed incivility/lateral violence; 42% experienced incivility/lateral violence during their first of professional practice. The reported rate of incivility/lateral violence is lower than a past study by Laschinger in 2012. The new nurses reported high levels of burnout and emotional exhaustion; these results were similar in findings to previous studies by Cho et al. (2006) and Laschinger et al. (2010). This is suggestive that burnout is a consistent problem in Canadian hospital settings. New nurses reported an ever-increasing level of cynicism over the length of the study. Cynicism is a core element and component of burnout. Cynicism was a significant predictor of burnout, workplace satisfaction, job satisfaction, and turnover intentions. Job turnover intentions were similar to past findings, though slightly lower than those reported by new graduate nurses in the U.S, (Kovner et al., 2009) and higher than those reported in Europe (van der Heijden et al., 2009). Job and professional support, along with a supportive work environment, were found to enhance job satisfaction and reduced intent to leave. The new nurses' self-efficacy, level of support both at home and work, and confidence in ability to cope improved the levels of

job and career satisfaction and reduced the level of burnout, emotional exhaustion, and cynicism. This study was the first in Canada to investigate changes that influenced new graduate nurse retention over a one-year period. Strengths of this study included the time-lagged nature of the survey to study the potential changes in the new nurses and the national nature of the study. Limitations included a decreased survey response rate, the use of self-reported questionnaires which depended on personal recollection. There is a potential bias due to the tendency to answer such questionnaires in a socially proper or desirable manner. It is also possible that new nurses experiencing high levels of stress, burnout, cynicism, and emotional exhaustion may have chosen not to participate in this study. The authors noted two studies which had reported results indicating a decreasing response rate to surveys among healthcare professionals (Cook, Dickinson, & Eccles, 2009; VanGeest & Johnson, 2011). The results may not be generalizable to all populations as it is defined to the Canadian healthcare system. This study lends support to the negative effects that incivility/lateral violence have on new nurses and the need for active personal and professional support to help new nurses' transition to full professional practice and reduce the number of new nurses leaving the profession. The study also supports the need for work-life balance.

Analysis of the second phase of a two-phased sequential quantitative dominant (QUANT/qual) mixed method study of novice nurses (n=37) in three Midwestern states who remained employed at the same facility and unit they had worked in during the quantitative phase was completed in 2016 by Berry et al. The quantitative phase of the study, conducted in 2012, sampled novice nurses (n=197) who had been in professional practice less than three years. Approximately 18 months after quantitative Phase I, the

qualitative Phase II was initiated. Data were collected in Phase I via the NAQ, 10-item Perceived Stress Scale, State Trait Anxiety Inventory, and the Posttraumatic Stress Disorder (PTSD) Checklist. Each tool used had reported validity and reliability for the use indicated. Demographic information was collected. Data analyses were conducted using acceptable software (Statistical Package for the Social Sciences [SPSS] version 21). Phase I quantitative results revealed that 94.6% of respondents had experienced bullying/lateral violence episodes at least occasionally. Of those who had experienced bullying/lateral violence episodes 67.6% had infrequent experiences with bullying/lateral violence episodes while 32.4% had frequent to daily experiences. Respondents (n=12) who had experienced frequent to daily episodes of bullying/lateral violence were shown to have had significantly higher rates of anxiety, stress, and PTSD symptoms when compared to those nurses (n=25) who had experienced infrequent episodes. The authors noted that those nurses aged 29 years and younger reported a significantly lower rate of PTSD symptoms compared to nurses aged 30 years and older; no other age-related differences were noted upon analyses. The qualitative arm of this study in Phase II consisted of semi-structured interviews with those nurses (n=11) identified from the 37 nurses remaining after Phase I as having experienced lateral violence at least twice a week, or observed lateral violence, and remained with the same employer and on the same unit as during Phase I. Interviews were analyzed using accepted procedures and practices, including recording of interviews, verbatim transcription, and coding. Of the 11 nurses who were interviewed, three experienced daily episodes of bullying/lateral violence. Four themes were revealed after analyses of the interviews: the construct of bullying, a permissive culture of bullying, toxic effects of bullying, and fostering a

positive work culture. The respondents believed that nursing managers and administration minimized bullying/lateral violence and that the newest employees were the most frequent targets for bullying/lateral violence episodes. The development of a toxic work environment was reported to be expressed as personal symptoms such as suppression of emotions, reported intent to leave, and rationalizing that the nursing workplace had been stressful. Six of the 11 respondents were actively planning to leave their positions, including applying to other facilities and applying for licensure in another state. One nurse commented that she was remaining in her current position until the closing on her home and was actively applying for another position. All respondents reported that they felt family support was vital, but peer support was desired as the chief way to deal with bullying/lateral violence episodes. A significant finding of this study was that the negative effects of bullying/lateral violence such as stress, PTSD symptoms, and anxiety were unrelated to age, gender, ethnic background, educational level, prior history of bullying/lateral violence, or prior work history with the facility prior to obtaining RN licensure. Forty percent of novice nurses had left their positions in the 18 months between the two phases of the study. Sixty percent of respondents in Phase II believed they were targets for, and unable to defend or prevent, episodes of lateral violence. The authors concluded that nurses who either experienced or witnessed bullying/lateral violence episodes over a prolonged period experienced negative consequence. A strength of this study was following of novice nurses over time. Limitations included the small sample size which prevented generalization to other populations. Additionally, no data were presented on those nurses who had left prior to the current study, which made any conclusions about leaving the nursing profession

versus leaving nursing positions impossible. The study did not address impact of lateral violence on nurse engagement or patient outcomes. The authors noted that nurses experiencing bullying/lateral violence often are reluctant to participate in research, especially those who experienced frequent and/or severe episodes which may have impacted the number of nurses willing to participate in such research. This study supported the negative impacts of lateral violence on new or novice nurses over time, including the intent to leave or leaving their professional position and the psychological effects manifested via PTSD symptoms. Further studies, including longitudinal and cross-sectional studies, and the use of a more diverse and larger sample size are encouraged to further the knowledge on the effects of lateral violence on new nurses. The results supported the negative effects of lateral violence on the ability of new nurses to remain in their initial position as a professional nurse. While the results are not generalizable to other populations, the results supported the need to address lateral violence against new nurses.

Theoretical Framework Literature

Nursing was established at a time of social reform when health-related behaviors needed to be taught to the "under class" or "lower orders", requiring those teaching to assume "bossy and controlling" demeanors (Stevens, 2002, p. 190). Hospitals and other healthcare organizations developed a patriarchic hierarchy in which the male dominated medical field held the power and the female dominated nursing field did as they were instructed, needing little critical thinking or problem-solving skills. Nurses were viewed as the physician's "handmaiden" and perceived to have little to no power. Nurses were even expected to stand in the presence of physicians and to give up their seats when

physicians entered the nursing station (Center for American Nurses, 2008; Johnson, 2009; Stanley, 2010).

This paternalistic mentality led to nurses accepting this powerlessness and paternalistic pattern of behaviors. Roberts (1983) examined nursing in terms of being an oppressed group; exhibiting behaviors associated with other oppressed groups around the world. Oppression creates low self-esteem, suppressed anger, anxiety, and passive aggressive behaviors. Roberts purported that the hierarchy within healthcare facilities and the nursing profession perpetuated a continual cycle of oppression which perpetuated the oppressed group behaviors such as self-hatred and low self-esteem. The oppressed group may discuss or complain about their plight within the confines of the group itself, however, remain submissive when confronted by those who are dominant. These behaviors were again noted in a later study by Roberts et al. (2009).

Roberts (1983) contended that nurses were easily marginalized within the paternalistic hierarchical system they worked in. Leaders of the oppressed group attempt to emulate their oppressors; when nurses became managers, they aligned themselves with the power of the organization rather than remain loyal to the nursing staff. This shift in loyalty and power further perpetuated the cycle of oppression and oppressed group behaviors. This cycle creates negative outcomes as staff nurses remain silent about patient care and do not speak up about their innovative ideas, active engagement in patient care diminishes, and nurses feel devalued (Roberts, 1983).

Roberts et al. (2009) further studied the Oppressed Group Theory and suggested that understanding the oppressed group behaviors could not just explain nurses' behaviors, it could empower nurses to enact change. Oppression causes poor self-esteem.

The dominant group, the oppressors, are pushing their own agenda and values onto the oppressed, causing the oppressed to lose power, lose pride, and lose self-esteem. This fear is what leads to the behaviors that have become known as lateral violence because the group has turned in on itself, a type of self-hatred and hatred of the nursing profession. When nurses begin to value and listen to each other, the feelings of powerlessness within the oppressed healthcare system can be broken and change can be accomplished (Roberts et al., 2009). This new perspective will provide structure for nurses to break out of oppression; however, continued fear, encultured violence, tolerance of bullying, and the perception that no one cares are just a few of the reasons the cycle of oppression and lateral violence has continued (Roberts et al., 2009; Franklin & Chadwick, 2013; Iacono, 2014). Roberts stated that nurses who become leaders must help organizations break the cycle of oppression and help to empower their nurses. Facilities that empower their nurses have been shown to have lower rates of reported lateral violence (AACN, 2017; Roberts et al., 2009; Janzekovich, 2016; Press-Ganey, 2018).

The oppressed group theory has been the core of multiple studies of lateral violence, citing both historical data and the remaining female dominance of the nursing profession (Roberts et al., 2009; Mendez, 2011; Walrafen et al., 2012). Females make up 91% of nursing professionals (Kaiser Family Foundation, 2019; U.S. Census Bureau, 2016). Most research into the theoretical bases for lateral violence is based on the long history of subservience by women (Dellasega, 2009).

The introduction of more men into the profession has been viewed as positive by some, however others feel that the male presence has detracted from the profession due to the perception that only inferior men who could not “make it” as medical doctors have

simply “settled” for nursing (Dellasega, 2009; Cottingham et al., 2018). While the view of males as professional nurses has gained wider acceptance, the prejudice against males has produced a subset of lateral violence victims. Men entering the nursing profession are not welcomed by many fellow nurses, they are, instead, ridiculed, harassed, and even discriminated against (Bouret & Brett, 2017; Dellasega, 2009; Cottingham et al., 2018).

Dellasega (2011) contended that internalized oppression brought about by jealousy, envy, and harboring resentment against others who had achieved more than one’s self as reasons to keep others oppressed through lateral violence. Dellasega termed the behaviors “crabs in a pot” (p. 61), an apt visual descriptor of the tearing down of those who are reaching for the top. Nurses thus are both the oppressed and the oppressors.

Conti-O’Hare proposed an alternative, though complementary, theory in 2002. Her Theory of the Nurse as Wounded Healer (NWH) is based on the belief that the healthcare professional’s healing power results from a healer’s own wounds, the wounded self. This is loosely based on the work of Carl Jung who suggested that every person has experienced some form of trauma in their life (Christie & Jones, 2013). Conti-O’Hare developed NWH to serve as a reflective pathway to move practitioners from the wounds of the past (walking wounded), through levels of healing to arrive as the healed, though wounded healer (transcendence). NWH is based on awareness of lateral violence occurring and mindfulness that healing is needed by both staff and management to promote development of a healthy work environment for staff and patients. Destructive behaviors such as lateral violence result when the practitioner is unable to recognize and deal with the firsthand experiences of past trauma (Conti-O’Hare, 2002; Christie & Jones,

2013; Newcomb, Burton, Edwards, & Hazelwood, 2015). The NWH theory embraces the need for self-awareness and self-care, and the human need to reach out to others in need.

Croft and Cash (2012) examined the theoretical bases of lateral violence using a post-colonial feminist viewpoint. The authors challenged the singular theoretical underpinning to lateral violence; oppression due to hierarchal power struggles. The authors instead encouraged a more holistic and critical reflective examination by nurses to envision what type of nursing profession and professional world they want to work in. According to Croft and Cash, this reflective process should lead to answers about what is holding the nurse back from acting and what steps are needed to make their vision come about. The authors cautioned that there is no simple answer and that lateral violence is a complex issue needing a collective response from the nursing profession. Croft and Cash's theory might best be viewed as an umbrella in which to address the entirety of the phenomena rather than the underpinning to the issues at hand. Examination of self and surroundings is always called for, being aware of how one reacts and considers others helps to understand the entire process and should be encouraged in all nurses. The process Croft and Cash have proposed is encompassing and worthy of consideration as an integrative process to view multiple theories, however it will not be part of the theoretical underpinning of this study.

Lateral violence is a complex and long-standing phenomenon. A singular viewpoint will not explain the reasons it has occurred or why it continues; nor will it result in a resolution. Portions of each theoretical framework hold truth in describing why lateral violence occurs, each is an incomplete truth and vision. There is more to be discovered about the foundations and correlates of lateral violence. This will occur as the

body of knowledge expands. A weaving together of conceptual frameworks will result in the most effective and truthful bases to explain lateral violence, define terms, research the phenomenon, and search for resolution. The theoretical bases for this study are Freire's Oppressed Group Theory as applied to nursing by Roberts in 1983 and Conti-O'Hare's Nurse as Wounded Healer (2002; Christie & Jones, 2013).

Methodology Literature

Thirty-six research articles on lateral violence in nursing and healthcare were critiqued in the literature review. Only three studies were qualitative in nature (Khalil, 2009; MacKusick & Minick, 2010; Simons & Mawn, 2010); one of these reported the qualitative results from a survey study (Simons & Mawn, 2010). One study was a mixed method (QUANT/qual) study (Berry et al., 2016). Five studies were comprehensive literature reviews (Alderson et al., 2015; Hutchinson & Jackson, 2013; Pfeifer & Vessey, 2017; Spector et al., 2014; Wilson, 2016). Two studies provided a quantitative analysis of data reported by an agency: Malone (2016) provided analysis of ISMP survey results and Groenewold et al. (2017) provided analysis of OSHA data. Thirteen studies were cross-sectional studies (Chang & Cho, 2016; Cheung & Yip, 2017; Evans, 2017; Fountain, 2017; Kutney-Lee et al., 2016; Mazurenko et al., 2015; Olsen et al., 2017; Pandey et al., 2017; Pellico et al., 2009; Rodwell et al., 2014; Sauer & McCoy, 2017; Viotti et al., 2018; Yildirim, 2009). Of the remaining quantitative studies one was a time-lagged, two-wave study (Laschinger et al., 2016); one was a longitudinal study (Trépanier, Fernet, & Austin, 2015); three were descriptive-correlational studies (An & Kang, 2016; Armmer & Ball, 2015; Maio et al., 2016); three were descriptive studies (Johnson & Rea, 2009; Vessey et al., 2009; Vogelpohl et al., 2013); and four were survey studies (Dotson et al.,

2014; Rosenstein & O'Daniel, 2008; Ward-Smith et al., 2018; Wright & Khatri, 2015). A total of 27 quantitative research articles were included in the literature review.

Three studies in the literature search used a qualitative methodology and one was a mixed-methods (QUANT/qual) study. The five reviews of literature also revealed a distinct lack of qualitative methodology in researching the phenomenon of lateral violence and its effects on nurses, nursing profession, and the public. Hutchinson and Jackson (2013) found just nine of the 30 studies in their review used qualitative methods. Spector et al. (2014) did not differentiate studies according to methodology, however noted that all but two of the 136 articles reviewed used survey methods. Alderson et al. (2016) did not report methodology as a part of their survey information. Wilson (2016) reported that all studies reviewed were of a quantitative methodology due to the nature of data sought on suicide prevalence. Pfeifer and Vessey (2017) noted that three of the 11 studies reviewed used qualitative methods.

Thirteen articles contained information about nurses' intent to leave either position or the nursing profession. Five of these 13 articles focused only on the factor of lateral violence/bullying and the intent to leave (Johnson & Rea, 2009; Dotson et al., 2014; Armmer & Ball, 2015; Mazurenko et al., 2015; Berry et al., 2016). No study focused on why nurses choose to stay in the profession despite experiencing lateral violence.

While lateral violence has increasingly become the focus of study in nursing over the past three decades (Embree, Bruner & White, 2013; Roberts, 2015) there is virtually no research into why nurses, particularly new nurses, decide to remain in the profession. Four studies (Berry et al., 2016; Dotson et al., 2014; Pellico et al., 2009; Simons &

Mawn, 2010) in the anecdotal remarks, mention some potential reasons for why nurses remain in the profession, including finances, scheduling, altruism, and value congruence. No study was located which focused on why new nurses may decide to remain in their positions or the nursing profession despite being victims of lateral violence or bullying behaviors

This descriptive phenomenological study of new nurses who have experienced lateral violence and have decided to remain in nursing will add to the nursing body of knowledge. The use of a qualitative method will add to the body of knowledge through sharing the lived experiences of the new nurses and will add to the more comprehensive understanding of the phenomenon. The focus on new nurses, a group identified as frequent targets for lateral violence, and their experience with lateral violence and decision to remain in nursing is one which has not been explored. This study will add to the nursing body of knowledge through the use of a methodology which is not used frequently and focus which has been unexplored.

Research Design Literature

Choosing a research design entails carefully considering what is to be studied and what is hoped to be learned about the topic. Quantitative research approaches a topic or phenomenon with logical positivism, gaining meaning through objective interpretation of data, rules of logic, and an historical methodology (Marczyk, DeMatteo, & Festinger, 2005). The quantitative research design focuses on what can be observed based on empirical inquiry (Laverty, 2003).

Moran (2000) described phenomenology as concentrating and discovering the relationship between objective reality and objectivity. Phenomenology examines a

phenomenon in the ordinary or everyday world by sharing in the individual's viewpoint of the reality of a lived experience. The individual is viewed as the valid source of knowledge.

Moustakas (1994) discussed the important principles of phenomenological research and inquiry, intentionality, noema and noesis, epoche, phenomenological reduction, and imaginative variation and synthesis. Noema is described as that which is experienced itself (the phenomenon), noesis is how it is experienced (meaning). Moustakas, based on the teachings of Husserl, explained the terms as a means to emphasize knowledge and understanding developing from the meaning of the experience rather than the physical realm. Examining the meaning of a phenomenon allows the truth of the experience to be revealed. Epoche is the setting aside of one's own prejudices, judgements, and becoming open to research and interview with an open mind which is able to be receptive and unbiased to the experiences shared (Moustakas, 1994). Balaban (2002) described epoche, using Husserl's teachings, as the ability to set aside and abstain from the objects and thoughts which might influence the researcher in order to concentrate on meaning.

Phenomenological reduction involves the procedures of bracketing and horizontalization. Bracketing is described as the researcher's suspension of their own reality, assumptions, and beliefs through an honest examination of self. This concept allows the systematic procedure to allow the lived experiences and interpretations of their meaning to come through from the participant (Moustakas, 1994). Knowing comes through expression of those who have experienced the phenomenon. Schmitt (1968) called bracketing a transcendental experience because the reality of the world transforms

into phenomena by examining and re-examining the experiences in order to describe within the context of the meaning. Tufford and Newman (2010) described bracketing as a way to mitigate the possible ill effects of researcher bias, unacknowledged preconceptions, and is used to increase the rigor of the study.

Imaginative variation refers to the many possible meanings within the phenomenon itself (Moustakas, 1994). The researcher must approach the data from multiple perspectives and viewpoints, allowing the themes and meanings to develop. Without taking alternate viewpoints, the researcher is limiting the data and potential meanings to be discovered. Imaginative variation helps the researcher find the essence of the experience or the phenomenon.

Synthesis of the noema and noesis occurs when the researcher uses reflective and reflexive construct, to integrate the meaning and essence of the phenomenon (Moustakas, 1994). Husserl (2012) described the essence of a phenomenon as the phenomenon itself. Husserl is noted to have stated that everyone sees essences throughout their day, for essence is in all we see and do. Each experience, phenomenon, or essence is judged, experienced, and is the basis for how the world is seen and experienced from that moment forward. These judgements are often subconscious and unexplored, however, becoming aware of the judgements and experiences allows for growth. The truth is seen in how the phenomenon has meaning to those who have experienced it.

The truth is that everyone sees ideas and essences, and sees them, so to speak, continuously. People operate with them in their thinking and also make judgments about them. It is only from their theoretical standpoint that people interpret these ideas and essences to make sense of them within their realm of reality.

Conclusions

It can be concluded that lateral violence in nursing is a worldwide concern and occurs in a variety of care settings (An & Kang, 2016; Chang & Cho, 2016; Cheung & Yip, 2017; Hutchinson & Jackson, 2013; Khalil, 2009; Maio et al., 2016; Olsen et al., 2017; Pandey et al., 2017, Rodwell et al., 2014 Yildirim, 2009). While any nurse can be a victim of lateral violence, nurses new to the profession, or new to an area or specialty, are frequently targeted (Berry et al., 2016; Chang & Cho, 2016; Laschinger et al., 2016; Pellico et al., 2009; Simons & Mawn, 2010; Vogelpohl et al., 2013). Exposure to lateral violence, either as victim or witness, is related to many physical and psychological concerns, as well as profession and industry detriments (Alderson et al., 2015; Malone, 2016; Rosenstein & O'Daniel, 2008; Sauer & McCoy, 2017; Trépanier et al., 2015; Viotti et al., 2018; Wilson, 2016; Wright & Khatri, 2015; Yildirim, 2009). There have been many studies into what the effects of lateral violence are, including why nurses intend to, or do, leave their positions or the nursing profession (Dotson et al., 104; Johnson & Rea, 2009; MacKusick & Minick, 2010; Rodwell & Demir, 2012b) and who are targeted as victims. Research tells us that approximately 30-40% of new nurses will leave the profession within the first three years of professional practice with most citing lateral violence as the main reason for leaving (Berry et al., 2016; Chang & Cho, 2016; Laschinger et al., 2016).

The data collection tools used to research lateral violence are varied; however, no single tool provides an expansive view of the phenomenon. Research is impeded by the lack of common nomenclature. Research into lateral violence is often impeded by the very nature of the phenomenon making potential research participants reluctant to share

their experiences due to fear or shame. The use of qualitative research methods to explore the lived experience of lateral violence is lacking, making the view of the phenomenon incomplete. Many studies into lateral violence in nursing were conducted outside of the United States, which makes transferability and generalizability difficult for American healthcare. The United States is made up of many cultures, ethnicities, and geographical and regional differences. These unique characteristics of the United States and its nursing workforce also makes transferability and generalizability difficult. A lack of nation-wide research into lateral violence is lacking.

Nursing and nurses are vital to the well-being of the populous as nurses are involved with every aspect of healthcare, from hands-on care to policy decisions. The lack of focus on nurses new to the profession and what will help them remain in the profession is concerning. The nursing shortage was somewhat mitigated when the economy declined, making many older nurses put off retirement (Grant, 2016; NCSBN, 2016). The attrition of new nurses in the first three years of professional practice coupled with the looming retirement of up to 1/3 of the experienced nurses (AACN, 2017, 2019a' 2019b; ANA, 2015b, 2017c, 2019; Grant, 2016; Laschinger et al., 2016; NCSBN, 2016) makes the study of ways to retain new nurses vital. Gaining insights into why new nurses decide to remain in the profession despite experiencing lateral violence may give missing details in which to combat this blight on the profession. It is to the benefit of the populous to retain nurses, especially new nurses, in the profession they have been called to. Any methods used to mitigate the negative effects of lateral violence or to prevent it from occurring will not be effective if all the information about the phenomenon is not known.

Chapter Summary

Thirty-six research articles related to lateral violence were critiqued in the literature review. Only three studies were qualitative in nature (Khalil, 2009; MacKusick & Minick, 2010; Simons & Mawn, 2010); one of these reported the qualitative results from a survey study (Simons & Mawn). One study was a mixed method (QUANT/qual) study (Berry et al., 2016). Five studies were comprehensive literature reviews (Alderson et al., 2015; Hutchinson & Jackson, 2013; Pfeifer & Vessey, 2017; Spector et al., 2014; Wilson, 2016). Two studies provided a quantitative analysis of data reported by an agency: Malone (2016) provided analysis of ISMP survey results and Groenewold (2018) provided analysis of OSHA data. Thirteen studies were cross-sectional studies (Chang & Cho, 2016; Cheung & Yip, 2017; Evans, 2017; Fountain, 2017; Kutney-Lee et al., 2016; Mazurenko et al., 2015; Olsen et al., 2017; Pandey et al., 2017; Pellico et al., 2009; Rodwell et al., 2014; Sauer & McCoy, 2017; Viotti et al., 2018; Yildirim, 2009). Of the remaining quantitative studies one was a time-lagged, two-wave study (Laschinger et al., 2016); one was a longitudinal study (Trépanier, Fernet, & Austin, 2015); three were descriptive-correlational studies (An & Kang, 2016; Armmer & Ball, 2015; Maio et al., 2016); three were descriptive studies (Johnson & Rea, 2009; Vessey et al., 2009; Vogelpohl et al., 2013); and four were survey studies (Dotson et al., 2014; Rosenstein & O'Daniel, 2008; Ward-Smith et al., 2018; Wright & Khatri, 2015). A total of 27 quantitative research articles were included in the literature review.

Research has revealed the international and pervasive nature of lateral violence in the nursing profession (Bambi et al., 2014; Wright & Khatri, 2015). The effects of lateral violence in nursing are numerous: development of a toxic environment; decreased work

effectiveness, work performance, and engagement; decreased patient safety, patient outcomes, and patient safety; negative physical and psychological impacts, including PTSD (Post-Traumatic Stress Disorder), anxiety, and even suicide (Office of National Statistics, 2017, 2018) nurses deciding to leave their positions or even the nursing profession (Trépanier, Fernet, & Austin, 2015) and the negative impact on new nurses who often choose to leave the nursing profession within the first three years of professional practice (Armmer & Ball, 2015; Robert Wood Johnson Foundation [RWJF], 2016). International and American studies have been included.

A review of the research revealed that while there is a good understanding of the effects of lateral violence, including psychological and physical health concerns, decreased patient outcomes, and leaving the profession; it additionally revealed the lack of understanding of why nurses choose to remain in the profession despite experiencing lateral violence. Anecdotal commentary was noted in four studies on why nurses might choose to remain in the profession; however, no study focused on this issue. The literature review also revealed that there is a distinct lack of qualitative research into the issue of lateral violence in nursing. These factors show the need for qualitative research into why nurses remain in the profession.

Those nurses new to the profession, especially within the first two years of beginning nursing practice, often leave their first positions or the nursing profession altogether due to lateral violence personally experienced or witnessed. The need for professional nurses continues to grow. The shortage of nurses is negatively affected by nurses choosing to leave the profession due to lateral violence in the workplace. Understanding the effects of lateral violence on nurses and nursing is vital, however it is

not the full answer to addressing this phenomenon. Understanding more about why new nurses choose to remain in the nursing profession may help improve retention of these nurses and may help mitigate the growing nursing shortage.

There is a distinct lack of qualitative research into lateral violence in nursing. Three of the 32 studies were qualitative in nature. One study reported qualitative findings of a survey study of new nurses. Research focused solely on the unique characteristics of new nurses and lateral violence are lacking. Commentary on why nurses might remain in their nursing position or the nursing profession were located in four studies (Berry et al., 2016; Dotson et al., 2014; Pellico et al., 2009; Simons & Mawn, 2010). A nurse commented in Berry et al. that she was only remaining in her position until her house closed. In Dotson et al., it was reported that nurses were more likely to remain in their nursing positions if their sense of altruism was fulfilled. Two part-time nurses commented in Pellico et al. (2009) that they remained in the nursing profession because it offered financial and scheduling flexibility not found in other professions. One new nurse commented she would only leave her current position if patient care were compromised (Simons & Mawn, 2010). No study focused on why experienced or new nurses remained in the nursing profession.

Research into why new nurses decide to remain in the nursing profession despite experiencing lateral violence has not been a focus of research. The qualitative method of research has been lacking in the study of the phenomenon of lateral violence. This study aims to begin qualitative inquiry to address this lack of research. While no single study will provide a thorough view of the phenomenon, this study will hopefully encourage further study so that a fuller view of new nurses and lateral violence may be achieved.

Chapter 2 has provided a review of the literature associated with lateral violence in nursing. A lack of research into why new nurses decide to remain in the nursing profession was noted; however, a substantial amount of research revealed a good understanding of the effects of lateral violence. Understanding the effects of lateral violence is needed, as is understanding what makes nurses leave the profession. Understanding why nurses remain in the profession may help develop new policies and procedures which will encourage those who are victims of lateral violence to be supported and aided to remain in the profession. This, in turn, will help decrease the nursing shortage.

Chapter 3 will discuss the methods used for this study to learn more about new nurses experiencing lateral violence and deciding to remain in the nursing profession. The chapter will detail research methodology and design appropriateness. Population sample, informed consent, and confidentiality will be reviewed. A discussion of instrumentation and results of the field test will be presented. The issues of credibility and transferability will be discussed. The data collection and data analysis processes, following the Modified Stevick-Colaizzi-Keen Method, will be presented.

Chapter 3

Research Methodology

Descriptive phenomenological research aims to accurately and comprehensively describe a particular or specific phenomenon (Reiners, 2012; van Manen, 1990). This study aimed to accurately and comprehensively describe the lived experiences of new registered nurses with lateral violence and their decision to remain in the nursing profession. Chapter 3 details how this was accomplished.

Research Method and Design Appropriateness

Phenomenology is a qualitative research design which is inductive in nature and the aim to gain deeper understanding of the individuals experiencing the phenomenon and founded on the basis that truth is found within the lived experience (LeVasseur, 2003; van Manen, 1990). Husserl (2012) is considered the founder of phenomenology and its philosophical underpinnings. Husserl believed that this method of study allowed the lived experience and perceptions of individuals to come forefront, providing a richness of understanding not possible with purely quantitative methods (Guba & Lincoln, 1994; Mason, 2018; Reiners, 2012). Husserl developed a descriptive manner of conducting phenomenological research based on what was termed "intentionality". Within the descriptive form of phenomenological research is the concept that opinions, pre-conceived thoughts, and bias are suspended by the researcher, making the researcher the tool of this research method (Guba & Lincoln, 1994; Malterud, Siersma, & Guassorak, 2016; van Manen, 1990).

Heidegger was a student of Husserl's who developed the interpretative method of phenomenological research. Heidegger used a philosophy of "being in the world"

compared to “knowing the world” as the basis for this methodology. Interpretive phenomenology seeks meaning in everyday events. Heidegger believed that it was not possible to suspend the researcher’s knowledge and that this personal knowledge of the topic under research was an important aspect of the research itself (Denzin & Lincoln, 2011; Reiners, 2012; van Manen, 1990).

The methods used to collect data, in and of themselves, are not intrinsically associated with a specific type of research. Lincoln and Guba (1985) noted the purpose of methods, such as interviewing and statistical analysis, and the way these methods are used, are what make a method qualitative or quantitative in nature. Lincoln and Guba went on to conclude that considering the inherent strengths of the tools should be the focus, not simply classifying the tools into qualitative or quantitative research methodologies. Qualitative research is inductive, subjective, and focused on content, while quantitative research is deductive, objective, and emphasizes generalization and replication (Guba & Lincoln, 1985). One of the tools used in research is interviewing. The inherent strengths of qualitative interviewing are that the tools allow themes to emerge (induction), uses the interpretation and perception of those who have experienced a phenomenon as the focus (subjective), and is able to collect details and depth of insight on a wide range of factors associated with a topic/phenomenon (context) (Castillo-Montoya, 2016; Fowler, 2008; Guba & Lincoln, 1985; Rubin & Rubin, 2004). Considering a design and method as a tool allows all potential aspects of research potentially to be used to mine the information sought and considered.

There are key differences between interpretive and descriptive phenomenological methodologies; each is useful to bring forth new information. Interpretive

phenomenology seeks to find the meaning of the event or events; clarifying or explaining the phenomenon. Descriptive phenomenology seeks to describe the lived experience of the person or persons regarding a specific phenomenon and provide new information about that phenomenon (Skea & Cert, 2016).

The use of interviews occurs in both descriptive and interpretive phenomenology. The use of face-to-face interviews allows the researcher to explore the phenomenon through the eyes and voice of the participant. The interview process allows the researcher to immerse his/herself into the lived experiences of participants while bringing forth themes which provide a richness of data not found in quantitative research methods (van Manen, 1990). Conducting interviews in a natural, or non-clinical, setting is a unique characteristic of qualitative research (Sandelowski, 1995).

There are several designs within the realm of qualitative research; grounded theory, biography or life history, ethnography, case studies, and phenomenology (Cohen & Crabtree, 2006; Gelling, 2015, Reiners, 2012). Grounded theory was not selected for this study since this method seeks to establish or define/refine theory. This study sought to gain understanding of a phenomenon, not a theory. Biography or life history was not selected since this method is focused on a single individual through examination and inquiry into their personal experiences and history. This study sought to understand multiple individuals' experiences (Glaser, & Strauss, 2017). Ethnography is often used in the field of social sciences, particularly in anthropology and in some branches of sociology. Ethnography studies people, cultures, ethnic groups, spiritual cultures and seeks to describe the culture as a whole through daily/prolonged interaction with the group in question (Anzul, Ely, Freidman, Garner, & McCormack-Steinmetz, 2003; Watts,

2008). Ethnography is not an appropriate method for this study, which was focused on the lived experiences of individuals within the phenomenon of lateral violence in nursing, Case study was not selected for this study since this method does not describe the lived experience of a phenomenon, rather it is based on a thorough study of a single individual, group, or event. The use of case study as a method would not reveal the information sought to be understood in this study, the lived experiences of new nurses with lateral violence and their decision to remain in the nursing profession (Houghton, Casey, Shaw, & Murphy, 2013).

Phenomenology attempts to gain insights and understanding of the essence of the lived experience of an individual (Flood, 2010). Phenomenology also seeks to understand the many ways people experience the phenomenon within their own realm of being. This method provides a means to give meaning to a phenomenon through the eyes of those who have lived it. An individual's lived reality within the world they exist is embraced and explored to gain greater insights and understanding of the phenomenon in question. This study was a descriptive phenomenological study which will explore the lived experiences of new nurses, within two years of beginning professional practice, with lateral violence and their decision to remain in nursing.

The phenomenon of lateral violence in nursing is one about lived experiences and how the individual interprets and understands that experience. This study sought to find the essence of the phenomenon through the lived experience, capturing the characteristics and themes in the data (Neubauer, Witkop, & Varpio, 2019). This information is not quantifiable. While there are studies into lateral violence in nursing which are quantitative in nature, such studies sought to determine the incidence rates, rates of

attrition, or other quantifiable data. This information is vital in the study of lateral violence; however, it was not the focus of this study.

The essence of nursing is seen as both art and science; human experiences which are unique to each individual and the science on which care is based. The use of qualitative methods to describe and interpret the "art" of nursing, which has been described as those unique individual experiences and multiple realities within the experience itself, is an appropriate and effective means to achieve this goal. Qualitative research focuses on the human experience and is the most appropriate method to examine these issues within the nursing profession.

Research Question

What are the lived experiences of new registered nurses, within two years of beginning professional practice, with lateral violence, and their decision to remain in the nursing profession?

Population and Sample

A purposeful sample was obtained from the population of new nurses who have experienced lateral violence and have chosen to remain in nursing living in central and southern Arizona. Inclusion criteria included new nurses, defined as those who have graduated from a pre-licensure baccalaureate nursing program within 36 months and had begun their professional nursing practice within 24 months, those who lived within the geographical area defined, and those within the age range of 21-65 years. Those who had worked previously as an LPN (Licensed Practical Nurse), lived outside the geographical area, had either graduated greater than 36 months previous to the study or had begun professional nursing practice longer than 24 months previous to the study, and those who

graduated from other than pre-licensure baccalaureate degree programs were excluded. Those outside of the 21-65-year age range were excluded. Participants were recruited through a blast email by the Arizona Nurses Association (AzNA) to members of the Emerging Nurse Professionals Chapter data base for the Phoenix Metropolitan and surrounding area. Purposive sampling is a non-randomized sampling strategy which uses the researcher's knowledge and understanding of the phenomenon (Gentles, Charles, Ploeg, & McKibbon, 2015; Moser & Korstjens, 2018; Polit & Beck, 2017; Vasileiou, Barnett, Thorpe, & Young, 2018).

The sample size for phenomenological studies is small due to the very nature of the methodology (Creswell, 1998; Denzin & Lincoln, 1994, 2007, 2011; Groenewald, 2004; Sandelowski, 1995). Qualitative research is concerned with gathering meaning and understanding of the phenomenon; focusing on the how and why of the phenomenon being researched (Vasileiou et al., 2018; Wertz et al., 2011). Phenomenological data are inductive and emergent in the process of collecting data: developing a data richness in order to understand. This makes a pre-determined sample size impossible to state.

Robinson (2014) contended that sample size is both influenced and determined by theoretical and practical aspects of conducting research. Hycner (1999) stated that the phenomenon dictates the number and type of participants. According to Moser and Korstjens (2018), a sample size of fewer than 10 participant interviews is required in phenomenological studies. Munhall (2012) recommended two to 10 participants and Creswell (1998) and Creswell and Miller (2000) have recommended a sample size of up to 10 participants.

The determination of sample size is dependent upon what has been called data saturation, which is also referred to as information power (Malterud et al., 2016). Malterud et al. contended that the term data saturation is imprecise and not an appropriate term in qualitative research where the aim should be on understanding the phenomenon and gaining new information concerning that phenomenon. Information power, as described by Malterud et al., is gaining new information about the phenomenon and this should be the focus of sample size. This gaining of new information is similar to the theory of data saturation which entails collecting data until no new information is emerging. Data saturation was reached with an actual sample size of nine participant interviews.

Informed Consent and Confidentiality

The Belmont Report was created by the U.S. federal government to protect human subjects of research by ensuring ethical standards through the three principles of respect for person, beneficence, and justice (Burkhardt & Nathanial, 2013; Marczyk, DeMatteo, & Festinger, 2005). The principles of the Belmont Report were respected and upheld in this study through the means of informed consent. Informed consent and confidentiality are vital to the successful conduction of research. When participants are not made aware of what the research entails, what potential benefits there are, and how their personal information will be kept confidential, poor quality data and non-participation chances are greatly increased. Informed consent's purpose is to protect participants through the statements of their rights, including the right to withdraw from participation without any repercussions and ending participation at any time during the research; potential risks and benefits; and purpose of the study (Olsen et al., 2017). Informed consent also assists in

ensuring confidentiality of participants' identities and information both during the collection and publishing of data (Corti, Day, & Backhouse, 2000; Walker, 2007).

Written permission to use the Emerging Nurse Professionals Chapter of Arizona Nurses Association email was obtained. The blast email recruiting volunteer participants was sent by the Arizona Nurses Association to members of the Emerging Nurse Professionals Chapter who lived in central and southern Arizona. The email contained the researcher's contact information allowing potential participants to make known their interest in voluntary participation. A follow-up email containing the same materials was sent out three weeks after the first. An in-person interview was then be arranged at a time and place mutually agreed upon by both participant and researcher. Informed consent documents (Appendix G) were emailed to the participant to review prior to any data collection. A review of how data were and will be kept secure and confidential, the voluntary nature of participation, right to withdraw at any time without repercussions or consequences, and how to contact the researcher was provided to the participants by the researcher. Participants were encouraged to ask questions before, during, and after the interview and throughout the study.

Once the participant had the opportunity to review the document and have any questions or concerns addressed, they were asked to sign the document which was witnessed and signed by the researcher. The participant was assigned a random alpha-numeric identifier. This identifier was provided to the participant so that if further communication was needed, their information would be readily identified. Field notes, recordings of semi-structured interviews, general demographic information, verbatim

transcriptions of interviews, and data analyses were identified and related to each other only using the identifier randomly assigned to each participant.

A study room at the local library was used to conduct the interviews in order to provide privacy and a neutral location. The use of the local library was needed for participants who lived in the further locations within the defined geographical area. These locations offered a quiet and private environment. The privacy and comfort of the participant was vital not only to ensure confidentiality, but to enhance the sharing of lived experiences which might have been uncomfortable and stressful to the participant. No participant appeared to be distressed or stated they were stressed during the interviews. Counseling service information for Crisis Response Network (CRN) was provided to each participant for the appropriate CRN locations for Northern Arizona, Central Arizona, and Southern Arizona locations (Appendix I). No participant displayed severe distress, thus no interviews needed to be stopped. All participants were provided with information and encouraged to seek immediate care from the Crisis Response Network, the local Emergency Room, or their own healthcare provider should untoward feelings arise after interview was concluded. No participants reported the need to use any of these measures. Information from any interviews stopped would have been destroyed and not included in the study.

Phenomenological research and the use of interviews requires participant and researcher to spend time together exploring the lived experience of the phenomenon. This may present ethical concerns (Ponterotto, 2010; Sanjari, Bahramnezhad, Khoshnava Fomani, Shoghi, & Ali Cheraghi, 2014). Establishing and maintaining a professional relationship is required for the successful phenomenological study.

Data were stored within the researcher's home office using two security measures. A locked cabinet was used for storage of recordings and all written materials; written informed consents were stored separately from data to maintain confidentiality and privacy of participants. Computerized information was stored on the researcher's personal password protected computer within a password protected and encrypted file. The list of participant identifiers was stored in a separate locked cabinet. All information was secured when not in direct use by the researcher. Only the researcher had access to the locked cabinets and computer.

Instrumentation

The main instrument in phenomenological research is the researcher his/herself (Creswell, 2009; Rudestam & Newton, 2007; Sandelowski, 1995). The researcher is both the collector of information and the tool in which it is collected. The researcher must remain open to hearing, seeing, and feeling the experience as expressed by the participant sharing their lived experience of the phenomenon in order to avoid bias (Creswell, 2009; Sandelowski, 1995).

Bias is defined by Merriam-Webster (n.d.) as a "systematic error introduced into sampling or testing by selecting or encouraging one outcome or answer over others" (¶ 1). Pannucci and Edwin (2010) defined bias as a tendency which prevents the researcher from conducting unprejudiced considerations to all information presented. Polit and Beck (2017) defined bias as any influence which impact or distorts the results of the research. Bias can occur at any stage of research. Bias, then, can be defined as anything which will impact the planning, data collection, data analysis, and interpretation of results for a research study. The researcher must take steps to avoid bias.

Potential bias may be reduced through various procedures put into place. These procedures also become methods to demonstrate validity of the study and study results (Ahern, 1999; Bevan, 2014; Gearing, 2004). The concept and practice of bracketing allows the researcher to set aside preconceived ideas and judgements about the phenomenon to prevent or decrease researcher bias, and to allow the essence of the participant's experience to be examined, discussed, and described (Moustakas, 1994). This process allows the peeling away of any symbolic meanings so that what is left is the experience and meaning of the phenomenon as provided by the participant, thus allowing the subjective perception to be examined and analyzed without interference. Husserl used the term "epoche" to describe the suspension of preconceived ideas and judgements, a neutralization of one's own beliefs (Guba & Lincoln, 1994; Husserl, 2012; Mason, 2018; Reiners, 2012). The use of bracketing allows the participant to teach the researcher about the phenomenon (Chan, Fung, & Chien, 2013; Polit & Beck, 2017; Tufford & Newman, 2010). The researcher becomes the student as the participant is the expert concerning their lived experience of the phenomenon.

Bracketing facilitates the understanding of the reader of the research to assess the validity of the study and that the process was free of researcher bias or influence (Ahern, 1999; Porter, 1993). The essence of bracketing must be practiced throughout the research. The researcher must remain ever vigilant to allow the participant's experience and meaning to come forth rather than the researcher's personal experience or assumptions (Ahern, 1999, Fischer, 2009; Tufford & Newman, 2010).

A researcher must be able to actively reflect on their motives, behaviors, and interpretations to appropriately bracket. Reflexivity is the capacity of the researcher to

honestly assess and examine their own biases, assumptions, experiences, and understanding of the phenomenon which may interfere with the research process (Ahern, 1999; Clancy, 2013; Johnson, 2019; Porter, 1993; Tufford & Newman, 2010). The researcher's ability to reflect and be honest in their assessment of self is vital to the successful completion of the qualitative research process (Clancy, 2013; Tufford & Newman, 2010). Ahern (1999) purported that reflexivity and bracketing were two parts of the same action within research, indicating that the researcher must be reflexive in order to bracket.

Semi-structured interviews were conducted using an interview guide (Appendix E). The interview took place at a time mutually agreed upon by researcher and participant at a study room at the local public library. The reflective bracketing process allowed the researcher to remain open to the participant, and be cognizant of body language, voice intonations, and how questions were asked (Englander, 2012). Interviewing was practiced with a volunteer prior to undertaking the semi-structured interviews with participants to enhance proficiency. After the first three interviews, the researcher conducted an additional practice semi-structured interview with an experienced researcher. The volunteers provided feedback on the process and the experience helped enhance the ability to conduct a successful interview, including taking field notes, voice recordings, transcription of interview, and coding. Experienced researchers were consulted, and peer-reviewed articles reviewed to enhance and improve the interviewing techniques to reveal the lived experience of each participant more fully (Polit & Beck, 2008).

Each participant interview was voice recorded and transcribed verbatim. Participants were asked to review the transcript to ensure accuracy and allowed

participants to share any other information they recalled or did not share during the interview. This member-checking enhanced the validity of the data gathered (Creswell & Miller, 2010; Polit & Beck, 2017).

The interview process is one of establishing a trusting professional relationship. Putting the participant at ease, beginning with general, non-threatening questions, and allowing the participant time to respond are key to conducting a successful interview (Creswell, 1998; Creswell & Miller, 2010; Englander, 2012; Polit & Beck, 2008, 2017; Rudestam & Newton, 2007; Shank, 2006). Demonstrating how the interview guide (instrument) aligns to both the research question and the descriptive phenomenological research process is vital (Table 2). The interview questions supported the epistemological position of the phenomenological research method. All knowledge obtained during the research process must be accurate and reflective of the participants' way of viewing and interpreting the phenomenon (Ravitch & Carl, 2016).

Table 2

Alignment of Instrument to Research Question

Interview Question	**Type of Questions**	**Alignment Rationale**
Tell me about your experiences with lateral violence as a new nurse	Key Question	Confirming of purpose, allows participant to explore the lived experience within their own realm of understanding
Can you give me an example of your experience with lateral violence	Follow-Up, Exploratory	Encourages depth of thought and allows reflection on lived experience and the meaning it holds for them personally
Tell me more about dealing with lateral violence in the workplace	Follow-Up, Exploratory	Encourages depth of thought and allows

		reflection on lived experience of what has occurred and how they have dealt with the experience
Tell me more about your experiences with lateral violence and your decision to remain in the nursing profession	Key Question	Explores the core question of study, open-ended question allows participant to share their personal meaning of the experience, encourages reflection on what may have been an unconscious decision to remain in the nursing profession
Is there any other information or insights you would like to add to this interview	Closing Question	Easy to answer, non-threatening, provides opportunity for closure
Do you have any questions	Closing Question	Easy to answer, non-threatening, provides opportunity for closure

Field Test

The interview guide was reviewed by three doctorally prepared registered nurses with expertise in the area of lateral violence. One reviewer holds both a PhD in Nursing and a DNP (Doctor of Nursing Practice) and is a director of a pre-licensure baccalaureate nursing program. Another reviewer holds a DNP, is a guest lecturer for a pre-licensure baccalaureate nursing program on the topic of new graduates transitioning to professional practice, has written several articles on lateral violence, and conducted research into the issue of lateral violence in nursing. The final reviewer is the founder of an institute aimed at researching ways to increase caring in nursing, holds a PhD in educational psychology and counseling, and is a Fellow of the American Academy of Nursing. None of the reviewers recommended changes to the interview guide, though suggestions to remain open to the process and to keep a list of ways to ask open-ended questions were received.

Credibility and Transferability

Qualitative research is based on subjective and interpretive data, which may lead to findings being questioned. The credibility of a qualitative study is comparable to internal validity in quantitative research and is defined as the believability and trustworthiness of the findings (Center for Innovation in Research and Teaching [CIRT], 2019; Kirk & Miller, 1986; Kvale, 1989; Laverty, 2003; Noble & Smith, 2015). Credibility is not dependent upon the quantity of data obtained, rather the richness and depth of that information. Only the participants themselves can determine if the findings are presented accurately and are reflective of their lived experience of the phenomenon.

Verbatim transcripts of interviews were reviewed by the participants for additions or corrections. This allowed the participants to judge the accuracy of data and provide further insights they may have not shared earlier. Findings were shared with the participants for further confirmation of accuracy.

Quantitative research considers generalizability of the research findings while qualitative research considers the transferability of research findings. Transferability is defined as the degree the research findings are applied to other settings (Kuper, Lingard, & Levinson, 2008, Thomas & Magilvy, 2011). Transferability of findings is not an aim in qualitative research as it cannot be pre-determined, rather the researcher must collect and analyze the rich data and increase the body of knowledge. Lincoln and Guba (1985) stated it was the responsibility of the researcher to present or establish a database for others to judge the level of transferability. Kuper et al. stated that the researcher should discuss how the findings resound with the established body of knowledge.

Lincoln and Guba (1985) recommended the technique of thick description to establish transferability. This technique has been most commonly associated with ethnographic studies, however it can be applied to all phenomenological methodologies. Thick description is defined as providing, literally, a thick or robust description detailing the researcher's experience during the data collection phase, making connections to the cultural and social mores and contexts occurring at the time of data collection (Hesse-Biber, 2017). The description of one-on-one interviews should include where and when the interview took place so that the very scene can be visualized and constructed by the reader of the interview experience. Kuper et al. (2008) recommended that transferability may also be established and enhanced through a detailed discussion of how the findings contribute to the advancement of theoretical understanding of the phenomenon. This will allow a more thorough understanding of the findings and addition to the body of knowledge; enhancing the reader's ability to determine transferability and overall quality of the study.

The concept and practice of bracketing, or phenomenological reduction, allowed the researcher to set aside preconceived ideas and judgements about the phenomenon to prevent or decrease researcher bias, and to allow the essence of the participant's experience to be examined, discussed, and described (Moustakas, 1994). The researcher must accept the phenomenon as lived and described by the participant. This process allows the peeling away of any symbolic meanings so what is left is the experience and meaning of the phenomenon as provided by the participant; allowing the subjective perception to be examined and analyzed without interference. Husserl used the term "epoche" to describe the suspension of preconceived ideas and judgements, a

neutralization of one's own beliefs (Guba & Lincoln, 1994; Husserl, 2012; Mason, 2018; Reiners, 2012). While bias cannot be fully neutralized, taking the steps of bracketing or phenomenological reduction allows the researcher to be cognizant of potential biases or preconceived ideas concerning the phenomenon. Verbatim transcription and member-checking will help to further reduce bias by confirming accuracy and providing the participant an additional opportunity for input on the interview.

Credibility, transferability and trustworthiness were established through presentation of a thick description of the context of the interviews to include place and time, as well as the participants' demographic data. According to Johnson (2019) and Alex and Hammarstrom (2008), transparency is achieved by clearly stating the researcher's qualifications. The researcher's qualifications, including staff nurse experience, were disclosed to the participants prior to interviews to decrease the assumption of a power differential (Johnson, 2019). A discussion of how the findings contribute to the body of nursing knowledge and enhance the theoretical understanding of the phenomenon of lateral violence in nursing were provided. This information will allow the reader to determine if the findings are transferable in the context of their own situation (Hesse-Biber, 2015). Dependability was demonstrated through member-checking and establishing and sharing a comprehensive audit trail.

Data Collection

Once University of Phoenix (UoP) institutional review board (IRB) approval was been obtained, a blast email to recruit participants was sent by the Arizona Nurses Association to members of the Emerging Nurse Professionals Chapter. Permission from the Arizona Nurses Association was obtained (Appendix H). A screening of respondents

to the email was conducted to ensure that inclusion criteria was met. Potential participants were contacted to answer questions and set up face-to-face interviews once screening had been completed. Data saturation was reached at nine interviews.

Semi-structured interviews were conducted at an agreed upon time and place. Informed consent was obtained and signed, and demographic information was collected prior to the audio recorded interview. Each participant had their rights reviewed, including the ability to withdraw from the research at any time, up to, and including submission of findings. Questions were answered prior, during, and after the interview process to ensure that participants feel comfortable and able to share about their lived experience openly. Field notes were used to denote such things as body language, voice intonation, and environment during the interview. All interviews were audio-recorded and transcribed verbatim within 48 hours of the interview. A reflective journal was maintained and used prior to transcription of each audio recording. The reflective journal included thoughts, insights, or feelings from the interview. This journal accounted for bracketing and aided in the removal of bias and any preconceived notions regarding the interview. Additionally, this aided in an audit trail in the analysis and description phases of the study (Denzin & Lincoln, 2013). Participants were asked to review the transcripts to check for accuracy, or to provide forgotten or further information or clarification.

While no participant showed signs of distress, information for the Crisis Response Network (CRN), Inc. (Appendix I) was provided. Participants were encouraged to call or visit CRN, local emergency room, or their personal healthcare team as appropriate if untoward feelings or distress were noted. No participant reported the need to contact CRN when followed up occurred.

Data analysis was ongoing until data saturation, or information power, was achieved when there are no further themes coming forth in the interviews. Interviews scheduled at a time after information power was achieved were canceled via a phone call to the potential participant(s). If a participant decided to withdraw from the study all data, including field notes, audio recordings, and forms, will be destroyed. No information obtained from the withdrawn participant would be used in the study. No participant chose to withdraw.

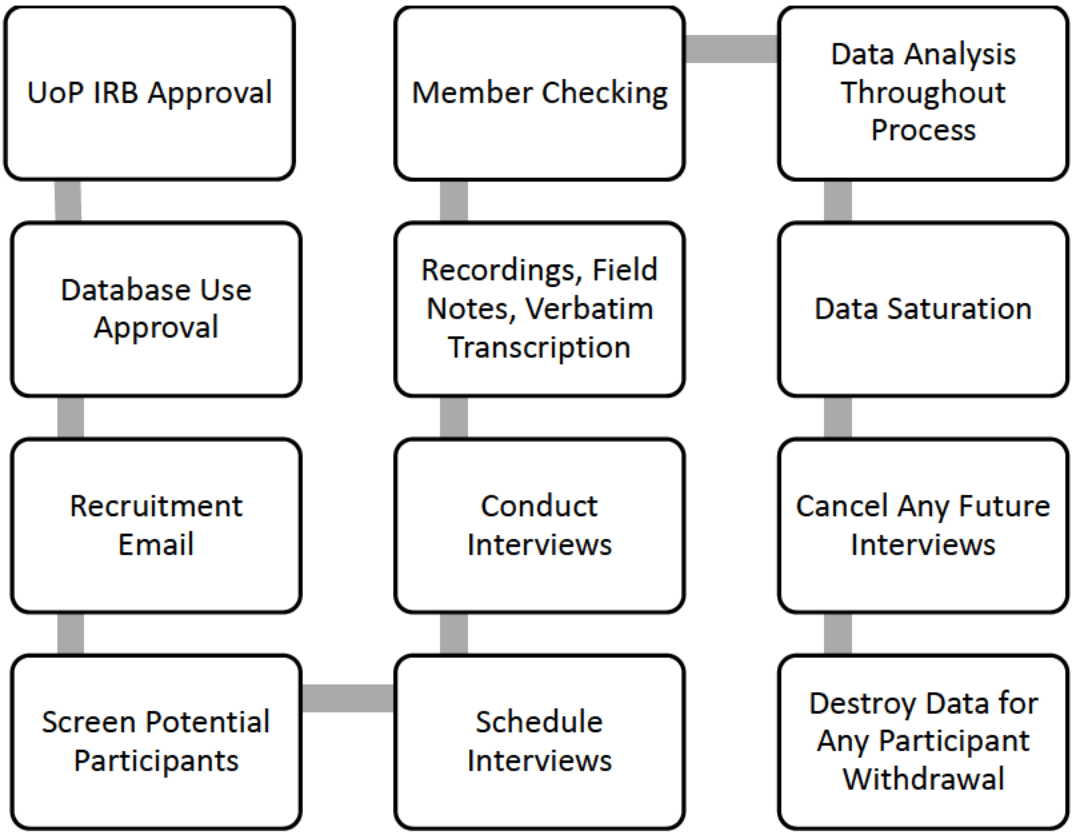

Figure 1. Data collection process followed

Data Analysis

The task set forth to the researcher in phenomenological studies is to transform the data to the lived experience, taking those lived experiences shared in words through data analysis, and finally trying to find meaning and understanding of those very

experiences via the discovery of themes. Finally, the researcher must be able to share these discoveries in a comprehensible and logical manner, so others may learn from the experiences of others (Smith, 1999; Sanjari et al., 2014; Speziale & Carpenter, 2011). All of this must be accomplished in an unbiased manner, without prejudice so that the words of those who have lived this phenomenon may shine through and reveal the essence of the experience. The Modified Stevick-Colaizzi-Keen Method was chosen to analyze the data of this study (Figure 2).

Qualitative research requires a simultaneous and continuous analysis of data during data collection which begins when the first data are collected. Analysis of qualitative data is time-consuming as it requires each interview to be transcribed verbatim, validated with each participant, and then reading and re-reading transcripts, field notes, and observations to identify repetition of ideas, words, and feelings expressed. This immersion in the data allows the researcher to identify themes, engage with the data reflectively, and bring forth the themes found within the words and experiences of the participants.

The use of horizontalization is the process of listing each statement or phrase within the verbatim transcript which represents a new and separate data point regarding the phenomenon. The extraction of significant statements and themes was completed. Each participant statement must initially be treated as of equal value. Repetitive or over-lapping statements were eliminated which left only the themes, or horizons, which brought meaning to the phenomenon. Theme clusters were identified as the core themes of the phenomenon. Each verbatim transcript was subjected to the process of theme cluster identification to verify that data were expressed. Upon the completion of

aggregating into theme clusters, a rich, exhaustive description of the phenomenon was developed and validated with the participants.

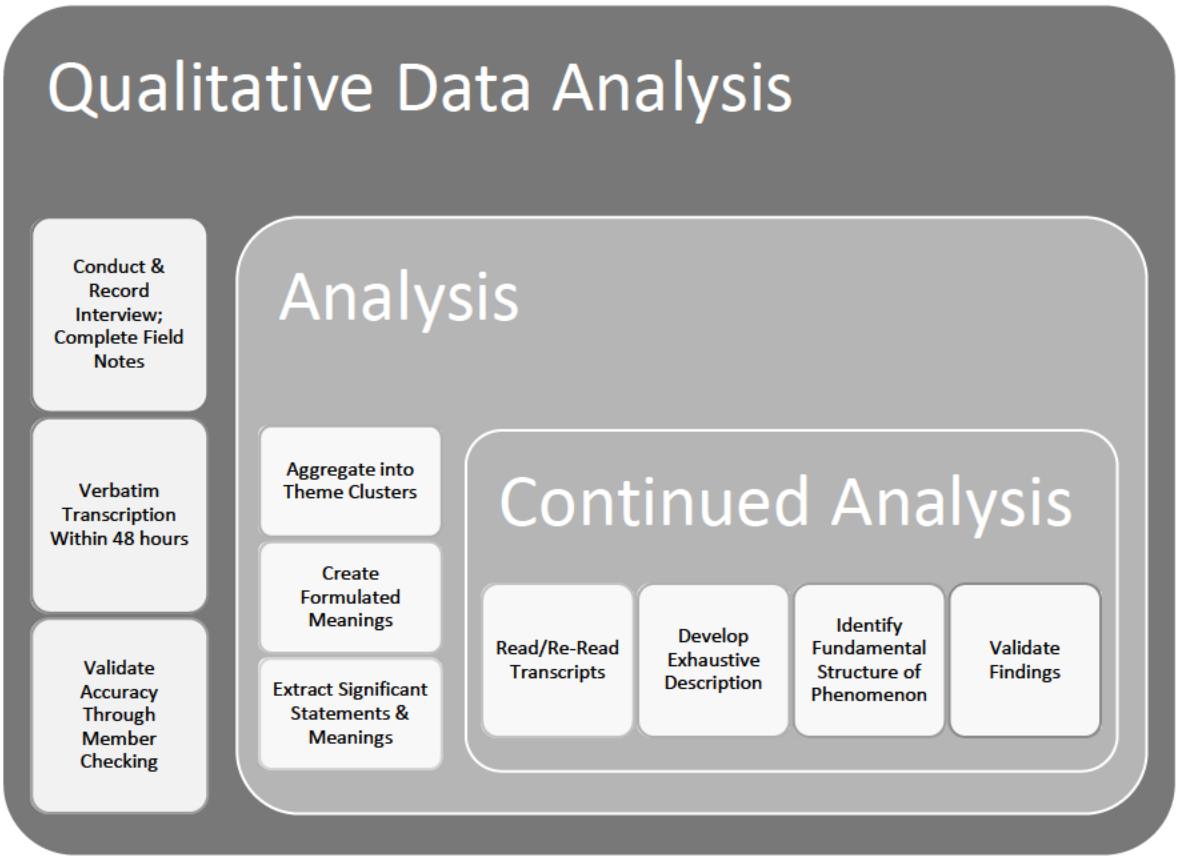

Figure 2. Modified Stevick-Colaizzi-Keen Method

Consistent with the Modified Stevick-Colaizzi-Keen Method (Figure 2), each interview was audio recorded and field notes made during the interview. Verbatim transcriptions, which was completed within 48 hours of the interview, was validated with the participants for accuracy. After each interview, theme clusters were identified, aggregation of formulated meanings, and extraction of significant statements and meanings was accomplished. It was vital to read and re-read transcripts to become immersed in the data. This immersion allowed the researcher to compare the themes emerging from the different interviews to identify commonalities. Without this immersion, themes and meanings might have been missed and more subtle data ignored.

Data analysis is a continuous process and was continued throughout the research process. An exhaustive description of the data was completed. The essence and fundamental structure of the phenomenon of lateral violence and new nurses' decisions to remain in nursing was revealed only through continual analysis and the exhaustive description processes. Findings must be validated. This was accomplished through member checking and having a doctorally prepared experienced researcher review the findings.

Summary

Chapter 3 has presented a discussion of the chosen research method of descriptive phenomenology, the appropriateness of this method for the study's focus, research question, and has defined the steps taken to conduct this study into the lived experiences of new nurses with lateral violence and their decision to remain in the nursing profession. The population was defined. Steps to maintain confidentiality were detailed. The field test was accomplished through review by three doctorally prepared nurses with experience with lateral violence. The use of the Modified Stevick-Colaizzi Keen Method for data analysis was defined. The steps within data collection and data analysis to maintain credibility and transferability, and measures to prevent researcher bias were detailed.

Lateral violence in nursing has been a long-standing concern. Research has increased into the effects, prevalence, and influence of various factors in mitigating the damage lateral violence can and does impact the nurse, the profession, the patient, and the healthcare industry. The increase in research into lateral violence in nursing also reveals that there is a definite need for common nomenclature and data collection methods. Research is limited by the multiple definitions of terms, lack of understanding

of the phenomenon of lateral violence, and the inability to transfer or generalize findings to other populations.

Chapter 4 details the research process and presents the lived experiences of new nurses with lateral violence and have decided to remain in the nursing profession. The data collection process involving interviews and verbatim transcription are presented. The demographic information associated with the participants is discussed. Data analysis and the resulting themes extracted from the data are detailed. The research process, including results, is summarized.

Chapter 4

Analysis and Results

The objective of this descriptive qualitative research was to explore the lived experiences of new nurses with lateral violence and their decision to remain in the nursing profession. There is a large body of research indicating the reasons why new nurses leave the nursing profession, however, only anecdotal data were located to discuss why nurses choose to stay despite their experiences with lateral violence/bullying. While no single study can provide the answers sought, adding to the body of knowledge and increasing awareness of the reasons nurses choose to remain in the nursing profession may stimulate further research and, potentially, programs to encourage more nurses to remain. Chapter 4 will describe the research process, including data collection, analysis of data, and study results. Verbatim responses from each participant provided during the one-on-one interviews support the themes which emerged from the analysis of data.

Research Question

The broad research question asked of each nurse participant was, "What is your lived experience with lateral violence and your decision to remain in the nursing profession?" Phenomenological research methods allow the discussion between researcher and participant to develop throughout the interview. It also allows the participant to lead the discussion and share information which is the most pertinent to their own lived experience with the phenomenon. The totality of the participants' experiences helped to reveal key themes and provided a rich understanding of the personal experiences each nurse had with lateral violence and their decision to remain in the nursing profession.

Probe questions allowed the researcher to elicit a deeper understanding of each participant's experiences. The probe questions were: Tell me about your experiences with lateral violence as a new nurse. Can you give me an example or examples of your experience with lateral violence? Tell me more about dealing with lateral violence in the workplace. Tell me more about your experiences with lateral violence and your decision to remain in the nursing profession.

The final two questions allowed the participant to share or elaborate on any other pertinent personal experiences or on those insights or issues they felt were most important and to ask questions previously unanswered. These questions were: Is there any other information or insights you would like to add to this interview? Do you have any questions?

Data Collection

In qualitative research data collection transforms and evolves during the process of the research. The objective of data collection is to obtain a rich description of the phenomena through the eyes of the participant, thus making the participant the expert on the topic. The researcher is present to facilitate the conveyance of those experiences for further analysis. Each participant was selected due to their personal experience with lateral violence and their decision to remain in the nursing profession. One-on-one interviewing is the main collection data method of this qualitative research; careful observation and note-taking are also essential means of collecting data. The combination of listening, observing, and documenting provided the most complete picture being provided by each participant regarding their experiences.

The participants were recruited via a blast email from the Arizona Nurses Association Emerging Nurse Professionals Chapter in Maricopa, Pima, Pinal, or Yavapai counties. A total of 606 emails were sent resulting in 27 replies; 15 of which met criteria; 12 returned the researcher's request for a one-on-one meeting. One participant withdrew from the study after the interview and transcription process and this data was deleted from the study. Data saturation was obtained at nine interviews, the remaining two potential participants were thanked for their interest and were not interviewed.

Each potential participant was assigned an alpha-numeric identifier to protect confidentiality of data. The identifiers were used on audio recordings, field notes, and transcripts as the only identification. The participants were provided with their personal identifier so that if they wished to withdraw from the study, they would be able to provide this information to the researcher for identification of data.

All participants were emailed a copy of the Demographic Data Collection Guide (Appendix D) and Informed Consent (Appendix G) forms prior to the interview which allowed for careful reading and consideration of the information without the pressure of the researcher being present during their reading. The information was reviewed by the participant and researcher prior to the start of each interview. The participants were informed of the purpose of this study, reminded that participation was voluntary, and that they could withdraw from the study at any time during or after the interview without consequence. Each participant was provided the information for Crisis Response Network (CRN) (Appendix I) and were informed that they were able to stop the interview at any time due to untoward feelings which might arise during the interview process and without consequence to them. This was done because discussing stressful events may

trigger adverse feelings similar to those experienced during the event. Each participant was also encouraged to seek assistance from CRN, the emergency room, or their own personal counselor or physician should untoward emotions develop after the interview was completed. The informed consent was then signed by the participant and witnessed by the researcher prior to beginning the interview. A copy of the signed consent was given to each participant. The participants were asked if they had any questions or concerns prior to commencement of the interview and were encouraged to ask questions during and after the interview.

Demographics

Demographic data regarding gender, age, marital status, ethnicity, employment status, place of employment, previous college experience, and highest non-nursing degree obtained were collected prior to the start of the interview (Table 3). All participants were female between the ages of 21- 60 years (Figure 3). Five of the participants worked in the hospital setting; two on medical/surgical units, one in surgery/pre-post op, one in the emergency room, and one in labor and delivery. Two participants worked in long term care, one worked in public health, and one in another setting but still in nursing. Eight worked full-time, the remaining one worked part-time. Eight had attended another college before entering the nursing program. Six of the nine participants had previous obtained a college degree in a non-nursing related field: two associate degrees, two Bachelor of Science, one Bachelor of Fine Arts, and one Master of Science. The study participants all had recently graduated from a pre-licensure baccalaureate nursing program; eight of the nine persons interviewed had obtained their BSN (Bachelor of

Science in Nursing) and one had obtained their Bachelor of Arts (BA) in Nursing. All participants resided in central and southern Arizona.

Table 3

Summary of Demographic Data (n=9)

Code	**P1**	**P2**	**P3**	**P4**	**P5**	**P6**	**P7**	**P8**	**P9**
Age	55-60	41-45	36-40	41-45	31-35	36-40	46-50	20-25	31-35
Marital Status	D	D	S	S	SO	M	M	M	M
Ethnicity	Multi	C	C	AA	AA	H	Multi	NA	Asian
Highest Non-Nursing degree	AS	AA	BS	NA	NA	MS	BFA	NA	BS
RN Obtained	10/2018	05/2018	12/2017	05/2019	05/2019	12/2018	05/2019	10/2018	10/2018
Professional RN Practice Begun	12/2018	08/2018	02/2018	09/2019	11/2019	06/2019	05/2019	01/2019	12/2018

Figure 3. Comparison of Participant Area of Professional Practice

Interviews

Prior to the commencement of the interview, participants were informed of the audio recording and notations to be made during the interview process; each consented.

Interviews were one-on-one, semi-structured, and used open-ended questions to allow the participant to share what they felt was the most important aspects of their lived experience. Open-ended probe questions allowed the researcher to ask the participant to clarify or expand on statements to gain a more thorough understanding of the lived experience being conveyed. Participants were encouraged to fully share their experiences and to not edit their thoughts. Participants were reassured that they were the ones in charge of what was shared, and the researcher was there to learn from their truth and experiences. Each participant was interviewed in a neutral location (local library study room) to ensure privacy and comfort. Interviews were conducted between December 2019 and March 2020 and lasted from 38 minutes to 71 minutes. Emotions expressed as smiles, frowns, downcast eyes, tears, and laughter were observed and notated. At the end of each interview participants were asked if they had any further insights or experiences they would like to share and then were asked if they had questions or concerns. Audio recordings were transcribed verbatim within 48 hours of the interview by the researcher. One participant was re-interviewed to clarify data. Transcripts were emailed to the participants for validation and for addition of any further data. Two participants added data to the transcript. One participant contacted the researcher to share further information they recalled after the interview. Transcripts were validated as accurate by all participants. Data collection and data analysis were conducted continually and simultaneously. Data saturation was achieved after nine interviews.

Data Analysis

Data analysis was accomplished continually and simultaneously throughout the data collection process. Data analysis began prior to the commencement of each

interview when the researcher conducted self-reflection, also known as bracketing, to become aware of preconceptions, potential biases or prejudices, and preconceived assumptions regarding the phenomenon, participants, and results. A reflective journal was maintained throughout the data collection and analyses. This allowed the researcher to interview and analyze data with fresh eyes. All data was manually analyzed.

Consistent with the Modified Stevick-Colaizzi-Keen Method, each interview was recorded, field notations made, and verbatim transcription completed within 48 hours. Transcripts were member-checked, or validated, by the participants. Field notes and transcripts were both compared and read repeatedly at various times and dates to examine the data from different perspectives and to achieve a level of familiarity with, and clarity of, the data.

After transcription of each interview, statements and segments of meaning were identified and color-coded. The color-coding helped to identify commonalities between transcripts. Immersion in the data through reading and re-reading of the transcripts was vital to ensure that subtle meanings or statements were not missed. Immersion also aided in the comparison and identification of commonalities between the interviews. Each statement or segment was initially given equal importance, a method known as horizontalization. The segments were then clustered into general themes. Meanings were formulated for the themes and aggregated. Significant statements and meanings were extracted. Thematic support for each general theme was supported by the recurring words and phrases from the verbatim transcripts. The significant segments and six core themes were synthesized into a rich and exhaustive description of the lived experiences of these new nurses with lateral violence and their decision to remain in the nursing profession.

This description revealed the fundamental foundation and structure of the phenomenon. Findings were validated by a doctorally prepared experienced researcher.

Results

The objective of this descriptive phenomenological study was to explore the lived experiences of new nurses with lateral violence and their decision to remain in the nursing profession. The responses from the nine participants were analyzed and six main themes emerged from the data. A core research question was used to guide the study. Further probe questions were asked to assist the researcher in further exploring the phenomenon and the full extent of the participants' lived experiences. The six themes emerged from the data through the immersion in the data by reading and re-reading the transcripts, listening to the audio-recordings of the interviews, and identification of commonalities in wording, segments, and meaning. The verbatim responses of each participants resulted in the identification of six main themes. The six core themes identified were 1) The patients, 2) Needed the experience, 3) I got counseling, 4) There was an end, 5) I cried and 6) Nothing changed.

Definitions for Themes

Defining of the themes helps others to understand the data and results more thoroughly. The definitions below describe and define each theme, which were derived from the verbatim responses each participant made during the one-on-one interviews.

The Patients

Nursing is predicated on the care of individuals, families, and communities. Each participant discussed how they felt that nurses should be focused upon the patients and the impact lateral violence has on their sense of safety, security, and upon the actual care

each patient receives. Participants expressed concern for the continuity of care and the functioning of the team in relationship to patients and patient outcomes.

Needed the Experience

Nurses entering their professional practice for the first time need practical working experience in order to further their careers and goals for future practice. Participants discussed the need for this experience as part of the reason they remained in their jobs and thus, in the nursing profession.

I got Counseling

The nurses needed coping mechanisms to deal with any difficult situation and dealing with the stress of a first job and suffering lateral violence often required the use of an outside resource. Participants discussed counseling and use of a therapist/counselor as a factor in their ability to remain on their jobs and in the nursing profession.

There was an End

When discussing what helped the new nurse to remain in the job or in the nursing profession, participants shared how knowing that there was an end to the current position and that they could search for a different position once the end was reached.

I Cried

This theme was identified when participants shared how they dealt with the events surrounding lateral violence on their units. There are many coping mechanisms which one can use to release emotions or frustration; most participants identified one such mechanism as crying in response to lateral violence.

Nothing Changed

The participants stated that while they did report the incidents of lateral violence, they felt that nothing was done in response to their reports and thus, nothing changed in the behaviors being perpetrated on them. This theme reveals the hopelessness many felt and how difficult it was to try to change the behaviors occurring on their unit.

Table 4

Participant Endorsement of Themes

Theme	P1	P2	P3	P4	P5	P6	P7	P8	P9	**Total**
The patients	X	X	X	X	X	X	X	X	X	**9**
Needed the experience	X	X	X	X	X	X	X	X	X	**9**
I got counseling	X	X	X	X	X	X	X		X	**8**
There was an end	X	X	X	X	X	X	X	X		**8**
I cried	X		X	X	X	X	X		X	**7**
Nothing changed	X	X	X	X	X	X	X			**7**

Theme 1: The Patients

The first theme emerged when each participant shared that they felt a responsibility towards *the patients* under their care, that they have come into nursing to help patients, and that they had concerns regarding the level of care and outcomes for the patients. Participants expressed how lateral violence impacted the nursing team, explaining that patient care, and thus patient outcomes, were fractured. Seven participants expressed concerns regarding medication errors and near misses related to the lateral violence occurring on their units.

> P1 stated, "If you have a dysfunctional team, patient care is what really suffers…it's the patients." She continued, "The patients need you, that's what drove me…...the patients. If just hurts the patients in the end. That is really who

suffers." Later in the interview she stated, "And then think of the patients – isn't what why we're supposed to be there in the first place?"

P2 stated, "I realized I DID make differences in people's lives…my experiences were there to help others." She further stated, "We have to be better about talking to our patients – and each other – so that our patients get better care and better outcomes…...we need to remember that compassion and empathy are not just for the patients, but for each other. We have to work as a team to help these patients. If we are a fractured team, we give fractured patient care." She added, "I mean it affects patients and how they do. If we aren't focused, you know, on patients……(shrugs) why are we there?"

P3 shared, "They're (patients) supposed to be first. It breaks down the morale, um, and it break down your surveys. It seems, um, like it's all about those scores. I've never seen it directly, um, cause an issue, um, with patient care, but it breaks down trust and breaks the healing process. How the hell, um, can someone heal with nurses are tearing, um, ripping, each other apart?" She further emphatically stated, "I CHOOSE to be there for the patients."

P4 stated, "I got into nursing to take care of people. I mean, isn't that why we're supposed to be here? I just couldn't think about ever leaving the patients."

P9 shared why she stayed, "The patients. How do you abandon those who you vowed to care for? I cared too much to leave them without someone caring to help them." She further stated, "Patient care suffers when nurses are at each other. Our energies need to be on the patients, especially ones getting ready to have a baby! Nobody wants to give birth with a bunch of people fighting around them!"

Theme 2: Needed the Experience

The theme of *needed the experience* emerged as each participant expressed their need for their first professional nursing experience. The ability of new graduate nurses to obtain their initial RN position in a hospital setting in the study area can take up to one year. Each participant shared how important it was to find and remain in the first job not only to obtain needed experience, also not to appear to job hop or because their facility required a minimum time on a unit prior to transferring. One participant explained that the specialty she chose was difficult to get into, so she remained in the position in order to remain in her chosen area and achieve a needed certification.

> P3 stated, "This was a steppingstone. I needed to stay there a while to get experience. I needed six months on that unit before I could transfer, um, and I knew I could do just about anything for six months. I needed, um, really needed this job. I needed experience, um, needed it to move on."
>
> P5 stated, "I had to get experience in order to do something different, something better."
>
> P7 stated, "I had to stay for six months before I could get the hell out of there. I ran the first chance I could get. I needed the experience before going elsewhere. I started out on a Med/Surg tele unit, I moved to Med/Surg ortho the first opening they had. I'm soooooo much happier, so much. I wanted to be at that hospital, I knew that I had to put in my time on tele before moving. I had high hopes for tele and wanted that experience."
>
> P8 shared, "I got on with a hospital first thing out of school and I hated it, but I needed to stay there for that experience and not to look like a flake. I moved to

long term care and I'm so much happier, not just about the lateral violence, the name-calling, the picking on each other stuff, I'm happier because I love using what I know and can do to help these older people. The people I work with now are amazing. They wouldn't have hired me without some hospital experience since they needed someone for their more acute wing, so what I went through wasn't a waste.

P9 stated, "I put in nine months with this position at another hospital in their L&D unit. I needed that certification from them so I could move on, I wasn't going to waste the chance to do what I have always wanted to do. I needed to have experience before another hospital would touch me. L&D is hard to get into already, much less someone who jumps around jobs."

Theme 3: I got Counseling

I got counseling was a prominent theme endorsed by eight of the participants. The term PTSD (Post-Traumatic Stress Disorder) was used by participants to describe the symptoms they were experiencing as a result of lateral violence. The ability to deal with the distress associated with their experiences took most participants to seek counseling. Each of the participants who spoke of counseling stated that no one in their facility had recommended counseling and none were informed of the EAP (Employee Assistance Program) available to them within their facilities. One participant shared that even if she had been aware of the EAP program she would have sought counseling from an outside source due to fear of reprisals and perceived lack of confidentiality. Four participants shared about suicidal ideation and without the counseling and support of their friends and family, they would not "be here".

P2 discussed that the decision to seek counseling as "the best decisions", sharing, "Well, you know, a lot of things really – being a nurse, working with my counselor, and life coach. Having that person from the outside asking the right question to get you thinking and get you moving – helps too, in broadening perspectives." She further stated, "Thank God I did (counseling). I think we have to build a network of support as nurses – and not just other nurses. We need those."

P3 shard, "I've worked with a therapist about these feelings and what, um, I went through there. I swear it's like PTSD. My brother was in Afghanistan, he's got PTSD over shit he saw and did over there. I think, um, I can't compare to what he went through, but damn, um, the feelings sure are, or were, really similar. He's the one who recommended I see someone. I didn't, um, think I needed it……at first…. but, um to humor him, I went. I am sure as hell glad I did. I didn't realize the depth this had affected me. One week I see the counselor and the next I attend a group meeting. It really helps. I'd, um, recommend it to anyone. As nurses we see and do so much shit, add the crap from others, and, um, well, you can start feeling toxic. Hell, some environments are really toxic in nursing." When asked if anyone else besides her brother suggested counseling, she stated, "My friend ******* did But, no, nobody even reminded me we had an EAP."

P4 shared, "I ended up seeing a counselor. She told me, oh hell, that I showed signs of PTSD. Who the hell gets PTSD doing a supposedly caring job? Obviously, nurses do! If I hadn't had counseling, I'm not sure I could have made it."

P6 stated, “I hate to admit this, but I felt suicidal. The more I got bullied, the worse I felt. My therapist saved me….. She’s using techniques used with PTSD sufferers. To think on it, that is so weird to me.”

P7 shared, “Our daughter was seeing a counselor and we were in a family session when something I said made the therapist suggest I should get individual counseling. I’m so glad I did, you know.” She later shared, “My therapist, and I sure as hell agree, that what I experienced, you know, what I went through, was, well, like war – PTSD type feelings. I was even suicidal for a short time. Without the family and my therapist, I might not be here to tell you about this.”

Theme 4: There was an End

There was an end was expressed by eight participants who shared that having an end in sight helped them deal with the phenomenon of lateral violence. Participants shared that they could deal with any situation if they knew how long it would last, two participants likened it to the difficulties in pregnancy and labor with a resulting positive end. Participants expressed the end envisioned was an end to the lateral violence and to move forward to a better situation.

P1 shared, “I could see that there was an end and I knew there was…well…an end point. This was not permanent, Better things would come…and I believed that. For me, the end point was being able to leave with some experience.” She further shared, “I knew it would end and I could leave. I guess we can get through anything if we know it will end – sort of like being in labor with a baby – it hurts like hell during it all and then the end point is that baby. I am able to use my

knowledge and skills…this is the end point I had hoped for. This is the 'baby' at the end of labor. I am happy."

P6 stated, "Knowing it would end helped a lot. Having that finish line in sight made it bearable."

P7 shared, "He (husband) kept telling me that things would get better once I could transfer – and he was right. He kept telling that there was an end in sight. If there isn't any stopping point, well, that would mean it was hopeless, you know. Hell, knowing it was going to end helped me get through that last month."

P8 stated, "I saw an end to all this; I know it would end. Having that end point was vital. I think I can do anything, put up with anything, knowing it was going to end in the not so distant future. I'm pregnant now and it really is sorta like that – there is a prize at the end."

Theme 5: I Cried

Seven participants shared that *they cried* to deal with the stress associated with the phenomenon of lateral violence. Two participants expressed that this crying was out of frustration and was a release of their emotions. The statements share some of the depth of emotion felt by the participants.

P1 stated, "I cried every single day I worked. I would go into the bathroom to cry, or even patient rooms…...You just go into the bathroom and cry……and move on."

P3 shared, "Oh God, I didn't want her to see me cry after that first time! I started to have tears in my eyes and all of sudden she is chewing my ass about being a 'snowflake' and 'not cut out for being a nurse'!.....It wasn't like I cried every shift

I worked, but I cried more often than you think one would at work…..I think I cried out of frustration. Damn, it was frustrating. I tried not to cry in front of the others, cuz, um, that would have made it worse, I think. I wanted help to learn more."

P6 stated, "To deal with this all? I cried a whole heckuva lot. I never cried at work…...I wouldn't give **** that satisfaction…...I cried at home, or on the way home."

P7 stated, "You know what? I cried almost every single day! I was heartbroken. Why are they so mean to new people?"

Theme 6: Nothing Changed

Seven of the nine participants shared how, despite having reported the incidents of lateral violence, *nothing changed*. Participants shared that they gave up going up the chain of command after nothing changed in the work environment despite making management and administration aware of the lateral violence they were experiencing. Two shared that they felt they were not heard and thus, had no voice. One participant expressed her view that the reason behaviors towards her did not change was because management didn't enforce consequences to the behavior.

P2 stated, "I even asked for a different preceptor, complained about it to management. But nothing was done, nothing changed, you know…... And then I did go to my direct supervisor and the supervisor over her, and even the CEO (Chief Executive Officer), nothing, NOTHING changed. Why does it have to be that way?" She later stated, "So, I went to management with a patient complaint to back me up, and nothing changed. NOTHING."

P3 shared "Nothing ever happened. Which was didn't set well with me. I don't know what all policies were – I went up my change of command like I was taught was proper to do, um….. Nothing happened. Nothing changed. I didn't take it up any further. I guess I could have gone to the CNO (Chief Nursing Officer) after, um, everyone didn't response, um, well, um…… I just gave up. I, um, felt like I wasn't heard, like, um, I didn't have a voice. I felt like nothing would get done. Nothing changes."

P5 stated, "I told my manager. I told my charge nurse. I told the director of that service. Nothing changed. I filled out incident reports. I swear they shredded them!" She went on to state, "Nothing ever changed. It felt like they were saying it was okay to be treated this way. ****** never changed. Why should she if management is going to do nothing about it?"

P7 shared, "You know, you're told to take it up the ladder of command. I call BS! Nothing ever changes. You know, you just get labeled a 'snowflake' or a 'troublemaker' so they can keep doing this BS. Nothing was ever done to make it better, you know."

Summary

The purpose of this descriptive qualitative research was to explore the lived experiences of new nurses with lateral violence and their decision to remain in the nursing profession. One core research question guided the study with support of six probe questions to explore the extent and meaning of the phenomenon of lateral violence. Data were analyzed using the Modified Stevick-Colaizzi-Keen Method of phenomenological data analysis. The data analysis revealed six core themes. The six themes were: 1) The

patients, 2) Needed the experience, 3) I got counseling, 4) There was an end, 5) I cried, and 6) Nothing changed. Chapter 4 has provided a detailed explanation of data collection and the analysis of data accomplished to reveal the study findings. Chapter 4 also addressed the participant population and demographics, sampling and recruitment procedures, and coding of data. The findings were supported by the words of the participants to reveal the meaning of the lived experience with lateral violence and the decision to remain in the nursing profession. Two tables and one figure were included to further highlight data. Table 3 summarized the demographics, Figure 3 provided a comparison of the participant ages, and Table 4 provided participant endorsement of the emergent core themes.

Chapter 5 includes a discussion of the findings including comparison to published sources. The theoretical perspectives used to guide the study, implications for nursing, nursing education, nursing practice, and nursing leadership are discussed. Recommendations for future research and limitations of the study are also included. Chapter 5 concludes with a summary of the study and researcher reflection.

Chapter 5

Conclusions and Recommendations

The purpose of this descriptive phenomenological study was to explore the lived experiences of newly graduated nurses with lateral violence and their decision to remain in the nursing profession. Lateral violence, also termed incivility or bullying amongst many other terms, has been a growing concern in the nursing profession (Embree, Bruner & White, 2013; Roberts, 2015). However, there is virtually no research into why nurses, particularly new nurses, decide to remain in the profession. Four studies (Berry et al., 2016; Dotson et al., 2014; Pellico et al., 2009; Simons & Mawn, 2010) in the anecdotal remarks, report some potential reasons for why nurses remain in the profession, including finances, scheduling, altruism, and value congruence. Lateral violence may include overt and covert actions by others which lead to a variety of symptoms, including depression, anxiety, and the decision to leave the position or the profession. Nearly 1/3 of newly graduated RNs leave the nursing profession within three years of beginning professional practice (Berry, Gillespie, Gates, & Schafer, 2012; Bureau of Labor Statistics [BLS], 2018b, 2019; Chipps, Stelmaschuk, Albert, Bernhard, & Holloman, 2013; Robert Woods Johnson Foundation [RWJF], 2013; Roberts, 2015). Results from extensive research on lateral violence have been reported regarding mitigating factors to the violence, resulting consequences of the violence, and why nurses leave their profession. This study has aimed to add to the body of knowledge regarding lateral violence and encourage further study on why nurses, particularly new nurses, choose to remain in order to help find ways to improve the nursing profession and retain the valued professionals within it.

Chapter 4 presented the findings and the six core themes which emerged from the data collected through interviews. The Modified Stevick-Colaizzi Keen Method was used to conduct the data analysis. Based upon the results of that data analysis, the themes which emerged were: The patients, Needed the experience, I got counseling, There was an end, I cried, and Nothing changed.

Conclusions regarding the results, as they align with the current body of literature, are included in Chapter 5. Recommendations for the nursing profession, nursing education, nursing leadership, and future research are presented. The limitations of this study are also included. The chapter concludes with the researcher's reflection and a summary of the research.

Research Question

What are the lived experiences of new registered nurses, within two years of beginning professional practice, with lateral violence, and their decision to remain in the nursing profession?

Discussion of Findings

The study findings are based on the central, or core, research question. The Modified Stevick-Colaizzi Keen Method of data analysis was used to code and identify the six themes (Table 5). These themes emerged through the identification of common words and word segments stated by the participants during interviews. These themes helped reveal the lived experience of the participants with lateral violence and their decision to remain in the nursing profession.

The Patient

This core theme was endorsed by all the participants. Each participant stated that they felt that the patients were the only objective nurses should have when at work. Each discussed that they entered nursing due to the concern for patient outcomes or they had experienced a caring nurse and wanted to emulate that in their own professional practice. Examples of potential or actual medication errors, concern for patient outcomes and safety were shared. Participants also shared their concern for the function of the nursing team and the impact lateral violence had on both patient trust and the healing environment. The theme is supported in previous literature.

The concerns voiced by participants of this study regarding patient safety, medication errors, and an erosion in patient trust are supported in previous literature. Hutchinson and Jackson (2013) conducted a mixed-methods systematic review of literature to investigate the relationship between "hostile clinician behaviors" and patient care. Nineteen survey studies, two mixed methods studies, and nine qualitative studies were reviewed. Four studies identified that patient trust was harmed by lateral violence amongst caregivers occurring in front of the patients or family members. Sofield and Salmon (2003) reported that 13% of nurses directly linked medication errors to lateral violence, and 41% reported a diminished work productivity in response to lateral violence. Wright and Khatri (2015) reported that those nurses who had experienced workplace bullying had significantly more anxiety and fear, and an increased rate of medication errors.

The concern voiced regarding a fracturing of the nursing team's ability to deliver effective care is supported by a survey study by Rosenstein and O'Daniel (2008). The

authors reported that 75% of respondents linked lateral violence behaviors with medical errors and increased patient mortality. Lateral violence was linked by 71% of respondents to decreased overall patient care, and 87% reported reduced team collaboration and communication.

Further supporting the concerns voiced regarding patient outcomes and care team fracturing is a descriptive, cross-sectional correlational study by Fountain (2017). The reported results showed that RNs not exposed to lateral violence behaviors had higher levels of patient and work engagement. RNs who were exposed to moderate levels of lateral violence behaviors reported higher levels of negative outcomes related to the lateral violence, including more frequent call-ins, resignation, physical and mental distress, and diminished patient and work engagement.

Simon and Mawn (2010) conducted a survey study of 187 newly licensed registered nurses. In the anecdotal comments, one participant stated that she would only leave nursing if patient care was compromised. Most of the respondents reported a lasting effect from the lateral violence they experienced, including decreased ability to relate to other nurses and to their patients.

Needed the Experience

Each participant commented on the need for experience as an RN as a main reason for remaining in their current position, despite the lateral violence occurring. Participants shared that they had difficulty obtaining their initial nursing position, making this first job more important. One participant spoke of her specialty area of Labor and Delivery and the difficulty entering the specialty for new graduates. She was entered into

a program for certification in the area and felt that she needed to remain until this certification was obtained in order to be able to remain in her chosen specialty.

No quantitative or qualitative studies were located which reported the finding of needing experience as a reason for new nurses to choose to remain in their current nursing position or the nursing profession. However, Simon and Mawn (2010) noted that the initial employment period was an especially vulnerable time for those just entering the profession. Most nurses reported that the lateral violence they experienced in their initial employment caused them to seriously consider leaving, or to have left, the nursing profession.

Participant concerns voiced regarding the importance of their first job and the difficulty in locating that first job is supported by the Arizona Nurses Association (AzNA) (2018) which reported that in the state of Arizona obtaining a first job as an RN has resulted in many nurses waiting up to a year or more to enter hospital-based practice. Extended waiting times may be experienced by those RNs seeking to enter a specialty field such as intensive care, surgery, or labor and delivery.

I Got Counseling

Eight of the participants reported that they received counseling as a means to deal with the lateral violence they experienced. Six of the eight participants compared their feelings as similar to PTSD (Post Traumatic Stress Disorder), several being officially diagnosed with PTSD. Four participants discussed feeling suicidal due to the behaviors perpetrated on them. Each of the eight participants described counseling as "life-saving" and recommended that counseling be more readily encouraged for all nurses experiencing lateral violence. No qualitative or quantitative studies were located which identified the

theme of receiving counseling as a means for new nurses to deal with lateral violence and to remain in the nursing profession.

However, multiple studies discuss the psychological impact of lateral violence on mental health, resulting in depression, anxiety, PTSD-like symptoms, and an increased incidence of suicide (Davidson, Mendis, Stuck, DeMichele, & Zisook, 2018; Quine, 2001; Thew, 2018; Trépanier, Fernet, & Austin, 2015; Wallace & Gipson, 2017). Statistics from the United Kingdom from 2011 to 2015 reported that nurses were 23% more likely to commit suicide than the general populous (Office of National Statistics, 2017, 2018). Davidson, Accardi, Sanchez, and Zisook (2020) discussed the issue of suicide in nursing and ways to address this issue. The authors stated that nurses are at a higher risk of suicide than the general populous due to nurses sacrificing their own needs for those of others, namely, their patients. The American Foundation for Suicide Prevention (AFSP) (2020) has stated that there is no single cause for suicide, but that suicide does occur when the stressors experienced by the person exceed the ability of the person to cope.

A Canadian longitudinal study conducted by Trépanier, Fernet, and Austin (2015) reported that the satisfaction of basic psychological needs, despite experiencing lateral violence, led to enhanced nurse workplace engagement, satisfaction, and decreased intent to leave. While the study did not specifically mention counseling, it can be extrapolated that counseling may help the nurse meet his/her basic psychological needs which can result in enhanced ability to remain in their nursing position or the nursing profession.

There was an End

Eight participants endorsed this theme stating that knowing there would be an end to the situation they were in helped them remain in their nursing position. The participants stated that seeing an "end point" or knowing that they were wanted on another unit allowed them to work through the lateral violence to achieve the goal of remaining in nursing. Statements regarding required time on the unit before being able to transfer, or the need to stay to achieve a goal such as certification were expressed. One nurse stated that while she felt she had to stay for other reasons, those reasons outweighed not having a job, so she remained until a new position was secured. No studies were located which identified the theme of seeing an end as a means for new nurses to cope with lateral violence and to remain in their position and the nursing profession.

Pellico, Brewer, and Kovner (2009) conducted a secondary analysis of a national study of NLRN (Newly Licensed Registered Nurses) and identified the theme of "change is on the horizon". The authors reported that many participants found the first year of professional practice to be difficult and emotional and had hope for the future. It was further reported that participants also noted that after that initial period the difficulties subsided. Sanner-Stiehr and Ward-Smith (2014) conducted a case study of a new nurse entering the nursing profession in the ICU (Intensive Care Unit). One conclusion brought forth by the authors was that nurses may remain in their position if the benefit outweighs the risk of leaving. Additionally, the authors stated that some employees may remain with hopes that the lateral violence perpetrated against them might change.

I Cried

Seven participants stated they cried in response to the lateral violence they experienced. Another participant stated that while she did not cry, she often felt like it. The terms “frustration”, “relief” and “release” were used to describe why they cried. The participants stated they cried at work, though they would try to hide this from the perpetrator of the lateral violence because they feared repercussions or an escalation of the behaviors. Other comments were that they cried in patient rooms, bathrooms, or on the way home. One participant described crying on the bus going home from work, another participant spoke of crying on her way home, and another crying in the shower. No studies, either qualitative or quantitative, were located which found that crying helped new nurses deal with lateral violence and thus remain in their nursing position and the nursing profession.

In the Pellico et al.’s (2009) study anecdotal evidence was presented that some nurses cried in response to verbal abuse. The crying was presented as a response to stressors and not as a means to deal with verbal abuse by other healthcare professionals. Multiple studies have shown the benefit in crying as a response to stress. Gračanin, Bylsma, and Vingerhoets (2014) reported that emotional tears are predominantly linked to mood enhancement, stress relief, and self-soothing. The authors also found emotional tears were cathartic to the individual, further relieving stress. Vingerhoets, van de Ven, and van der Velden (2016) reported that the social impact of visible tears may be both positive and negative. People may view the person crying as helpless, but also needing support. The person crying may also be seen as friendlier, and the observer may feel a greater connection to the individual who is tearful. Authors found that crying may offer

both physical and psychological support for the individual. The University of Pennsylvania's Penn Medicine (2016) reported that there are many benefits to crying, including improvement of mood and vision, protection of eyes, cleaning of the nasal passages, and strengthening personal relationships with others. Dr. Timothy Legg, as reported by Burgess (2017), found that crying is the body's way to relieve stress hormones and offers a reduction in stress by releasing oxytocin and endorphins.

Nothing Changed

Seven participants stated that despite reporting of the lateral violence behaviors to management, nothing changed. Participants reported feelings of "having no voice", "frustration", "Why does it have to be like this?", and "We really have to do better" in response to receiving little to no support from supervisors. While no studies were located which identified this theme in response to new nurses experiencing lateral violence and choosing to remain in the nursing profession, research has identified the role management/administration have in the response to lateral violence.

Stanley, Martin, Nemeth, Michel, and Welton (2007) reported the critical role of management/administration in establishing and enforcing a supportive culture and appropriate tone on the nursing units. The authors identified the unit manager as the key member of the management team in establishing such a culture. The authors further noted that unit manager lack of awareness of the problem of lateral violence, non-support of those reporting lateral violence behaviors, and failure to enforce already established policies is a key factor in the proliferation of lateral violence on the nursing units. The inclusion of all staff members and managerial support for this inclusion allows change to occur and be more likely to succeed in the long-term. Coursey, Rodriguez, Dieckmann,

and Austin (2013) reported that there is a lack of implementation and enforcement of effective lateral violence policies by management/administration. They further reported that positive administrative involvement and working relationships with staff members is vital to successful implementation of such policies. The authors identified effective management and administrative persons as key to preventing and resolving lateral violence in the nursing and healthcare workplace. Rice, Edwards, and Bork (2013) reported that just over 35% of the new nurses surveyed identified that management/administration were not supportive of those who were experiencing lateral violence. These findings were reported as part of a study to look at intent to leave positions or the profession by new nurses.

The core theme of *The Patient* was supported by previous literature (Hutchinson & Jackson, 2013; Salmon, 2003; Wright & Khatri, 2015). The nurses interviewed for this study were mindful of the negative impact lateral violence has on patient care, including higher risk of medication errors and the damage to interdisciplinary teamwork. The core themes of *I Got Counseling* and *Nothing Changed* were supported by literature (Davidson et al., 2020; Stanley et al., 2007), however, these themes have not been previously found as they related to new nurses' experience with lateral violence and their decision to remain in the nursing profession. This study brought forward the concerns of new nurses experiencing lateral violence and the vital role of nursing leadership in the development of a healthy work environment. This study also reinforced the negative impact of lateral violence as participants discussed suicidal ideation and PTSD symptoms. The core themes of *Needed the Experience*, *There was an End*, and *I Cried* were not previously noted in literature. However, the theme of *I Cried* is supported by literature as a means to

relieve stress (Gračanin et al., 2014; Vingerhoets et al., 2016). The literature search identified four studies (Berry et al., 2016; Dotson et al., 2014; Pellico et al., 2009; Simons & Mawn, 2010) which reported anecdotal evidence of why nurses have chosen to remain in the nursing profession ranging from financial to scheduling ease. No study focused on why nurses had decided to remain in the nursing profession. This study has added to the nursing body of knowledge through the emergence of themes previously not presented in literature in regard to new nurses' experience with lateral violence and their decision to remain in the nursing profession.

Limitations

Limitations impacting this study were identified. One is the assumption that most nurses who had experienced lateral violence would want to speak truthfully and confidentially about their experiences. A blast email was sent by the Arizona Nurses Association Emerging Nurse Professionals Chapter in Central and Southern Arizona with only a few respondents. A reminder email was then sent out. The emails were sent out during the Thanksgiving to Christmas holiday season which may have led to the emails being ignored or forgotten. The issue of lateral violence may bring untoward emotional responses while speaking of the events, making some reluctant to discuss their experiences.

Another limitation of the study was that the population was not reflective of the nursing population as a whole. All of the participants were female. No males came forth to participate in the study. The lived experiences of males with the phenomenon of lateral violence is needed to obtain a more complete understanding of why new nurses choose to remain in the nursing profession. The inclusion of males and a demographic mix which is

more representative of the nursing profession would improve transferability and increase the understanding of the phenomenon. The study took place in central and southern Arizona. The unique cultural and ethnic background of the area could affect the results of the study. The inclusion of only those new nurses who have graduated from a pre-licensure baccalaureate nursing program may affect the results as they may not be reflective of all new nurses.

Recommendations for Leaders and Practitioners

Research should be able to add to the body of knowledge and advance professional practice. The purpose of this study was to explore and understand the lived experiences of new nurses with lateral violence and their decision to remain in the nursing profession. Freire's Oppressed Group Theory (OGT) and Conti-O'Hare's Nurse as Wounded Healer (NWH) acted as the theoretical frameworks for this research. OGT provided the background to why such behaviors occur, the hierarchical structure and nature of the nursing profession. NWH provided the structure to help understand the participants' experiences. NWH also provided further understanding of the ability of these new nurses to work through their experience to remain in the nursing profession. There are several recommendations for nursing which have resulted from this study. Recommendations for the nursing profession, including nursing education and nursing leadership are presented.

The promotion of a healthy work environment for all involved is an essential practice for practitioners and for the safety and well-being of the patients. The promotion of this healthy work environment is the responsibility of all involved from student,

educator, nurse, and administration. A healthy work environment must be established in the classrooms, clinical rotations, and the work setting.

Education

A healthy work environment (American Nurses Association [ANA], 2020; Evans, 2017) begins with an effective preparation for students to assume the role of professional nurse. Each participant in this study reported either no or little preparation in response to the phenomenon of lateral violence. A dedicated and purposeful teaching module, including role-playing scenarios, needs to be included in the curriculum. This module will assist students to be more prepared and able to anticipate the variety of behaviors associated with lateral violence. This will have the added bonus of educating the next generation of nurses on the importance of civil and professional working relationships and leading to either a decrease or an elimination of lateral violence in the nursing workforce.

In the clinical setting, debriefings for each day should include discussion of positive and negative experiences. This should include a focus on the collaborative approach to nursing care of patients. If students should suffer negative professional interactions, including lateral violence behaviors, the ability to report this behavior and have it addressed through both the educational institution and the clinical facility.

Leadership

The recognition of lateral violence is an important step in developing and maintaining a healthy work environment. The lack of recognition of behaviors, especially overt behaviors, must be part of preparing nurses to take on preceptor, managerial, and administrative roles. New nurses need a dedicated and purposeful preceptorship to help

them make the transition from student to novice independent practitioner. Trained preceptors are required to make the preceptorship meaningful and supportive. Training should include not only lateral violence recognition and intervention, but also the skills needed to help a new nurse to grow and develop needed critical thinking skills. Such education on the expectations of the role of preceptor should be required on a minimum of yearly basis. Only preceptors who are screened and trained should be assigned new nurses, assignment should not be based on number of years in practice. Training will allow for the early identification of, and interventions for, those new nurses who are at risk to be victimized.

Well-defined, zero-tolerance policies should be both implemented and enforced by all management and administrative personnel. Participants stated that they reported lateral violence behaviors to their supervisors, including to higher levels of management, and nothing changed regarding their experiences. A supportive response begins with a confidential reporting process being developed by administration with input from online staff. Participants stated that they feared reporting the behaviors for fear of retaliation. One participant specifically stated that she refused to report the behaviors perpetrated on her because her name would be shared with others. A well-defined process of investigation of complaints of lateral violence must be developed and followed. Having a person outside of the unit and unit politics may help produce an unbiased conclusion. Specific consequences of lateral violence need to be detailed. The reporting process, investigation protocols, and consequences need to be included in the initial orientation and reviewed on an at least yearly basis.

Support for those who have experienced lateral violence is needed. Having management and administration who are responsive and supportive for those reporting lateral violence is essential. Most facilities have an Employee Assistance Program (EAP) (Attridge, Cahill, Granberry, & Herlihy, 2013; Taranowski & Mahieu, 2013). Many of the participants reported not being aware of their facility's EAP. Educating staff on the presence of the EAP and reviewing the program during staff meetings would improve awareness of the program and possibly increase usage. One participant voiced concerns that receiving counseling through the EAP would not be confidential. Offering counseling, either sponsored by facility EAPs or through independent mental health professionals, is encouraged for victims of lateral violence. Counseling can enhance retention of these nurses and improve the work and patient engagement each feels (AFSP, 2020).

Table 5

Alignment of Recommendations with Core Themes

Recommendation	Associated Core Theme(s)
Promote healthy work environments at all levels	• All
Dedicated and purposeful teaching module on lateral violence during educational preparation to include role-playing	• All
Clinical site debriefings to include lateral violence response	• All
Dedicated and purposeful preceptorship upon entering profession • Screened and trained preceptors • Only screened and trained preceptors will be assigned a new nurse • Promote early identification of, and intervention for, those new nurses at high risk	• The patients • Needed the experience • I got counseling • I cried • Nothing changed

Improve recognition of lateral violence: • Train all staff, managers, and administrators on overt and covert lateral violence behaviors	• The patients • Nothing changed
Well-defined, zero-tolerance policies implemented and enforced • Confidential reporting process developed and defined • Well-defined consequences for lateral violence behaviors • Well-defined and unbiased investigation of lateral violence reports • Educate staff and supervisors at orientation and on an at least yearly basis	• The patients • There was an end • I cried • Nothing changed
EAP awareness and Counseling • Educate all personnel at orientation and during unit meetings of the purpose and availability of the program • Offer counseling through EAP or independent mental health professionals for those who have suffered lateral violence	• The patients • I got counseling • There was an end • I cried • Nothing changed

Recommendations for Future Research

This study was the first study, quantitative or qualitative, identified in the literature which concentrated on new nurses remaining in the nursing profession despite experiencing lateral violence Additional research examining these reasons is needed to gain a full understanding of this phenomenon. Further qualitative research of nurses from other educational backgrounds, geographic locations, and the inclusion of males would bring about further understanding of the essence of this phenomenon. The reasons for new nurses to remain in their nursing positions and the nursing profession can also be assessed using quantitative methods. Such research would help establish baseline numbers about what reasons are the most prominent within the new nurse population.

This research would also help the nursing profession to focus educational programs to promote retention of new nurses. All research must encourage the inclusion of males in the studies and new nurses from both baccalaureate and associate degree programs.

Further exploration of the theme *I got counseling* is encouraged. This theme revealed the many psychological effects of the phenomenon. Several participants expressed that they experienced PTSD or PTSD-like symptoms related to their experiences with lateral violence. This association between PTSD and the phenomenon of lateral violence requires further investigation. While many facilities offer some type of employee assistance program (EAP), the usage of such a program and encouragement to seek counseling were not fully explored in this study. Several participants stated that they were not encouraged to seek counseling through the EAP or independent mental health professionals by the nurses they worked with. Exploration of the use of counseling by new nurses who have experienced lateral violence in the role of retention in the nursing position or profession should be included with future research into programs to respond to, and eliminate, lateral violence. Qualitative research methods examining the lived experience of nurses would bring forth the essence of this phenomenon. Quantitative research into the actual usage and knowledge of EAPs would give a baseline from which other studies could be determined.

The phenomenon of nurse suicide is poorly researched in the United States. Quantitative studies to determine actual rates of nurse suicide and mitigating factors would establish the baseline numbers and factors associated with the phenomenon. Qualitative research examining the lived experiences of nurses who have had suicidal ideation or suicidal attempts would add to the understanding of the phenomenon. Both

quantitative and qualitative research into the phenomenon of nurse suicide is needed to fully comprehend this complex issue.

Summary

The decision of new nurses to remain in nursing despite experiencing lateral violence was explored using one-on-one interviews with nine participants who voluntarily shared their experiences and insights. The interviews explored the lived experiences of each new nurse with lateral violence and the decision to remain in the nursing position. The common experiences and themes derived from the words of the participants were 1) The patient, 2) Needed the experience, 3) I got counseling, 4) There was an end, 5) I cried, and 6) Nothing changed. These six themes reveal the lived experiences of new nurses experiencing lateral violence and their decision to remain in the nursing profession.

After a review of the literature this was the first qualitative study to explore the experiences of new nurses with lateral violence and their decision to remain in the nursing profession. No single study can fully explore lateral violence and the decision of new nurses to remain in nursing, however, this study adds to the growing body of knowledge concerning lateral violence and presents a unique focus of the phenomenon. In-depth exploration of ways to improve the nursing profession will lead to improved retention of nursing professionals, improve interdisciplinary teamwork, improve patient care, and enhance patient outcomes.

Researcher Reflection

Achieving my PhD has been a 10-year journey filled with many ups and downs. This research has been a passion of mine since I was first asked what I thought my

research would be for my dissertation. It is a proud moment, filled with gratitude and humility seeing it all come to fruition.

The assumption by some that phenomenological research is "easy" was certainly not my experience. This qualitative method is time-consuming and far more detailed than I could have ever imagined prior to the start of research. The term "data immersion" has taken on new meaning to me. The idea of living and breathing the data would be a far better description of phenomenological research. If I were to estimate the time for an actual interview, transcription, and data analysis of that one interview, I would estimate it to be no less than 10-15 hours. I think I began to recite themes and word segments of the interviews in my sleep. They truly consumed my being as I lived and breathed the data. My own assumption that writing Chapters 1-3 would mark the "nearly complete" stage of my research was also dismantled. However, literature searches and reviews are their own type of time-consuming entities.

During this journey I have learned many things and realized aspects of my personality which I had not previously noticed. Coming to terms with, and acknowledging, my own biases related to this topic was eye-opening. Despite immersing myself in this topic for over 10 years, I had to set aside what I "knew" and learn about the phenomenon from those I was interviewing. They are truly the experts on the topic. No amount of reading can prepare you for hearing the experiences of those nurses who have truly experienced it. It humbled me, and also made me angry that my fellow nurses would be treated in such a manner by other nurses. I had to set aside this anger in order to truly listen and to observe. This skill in listening and observing has improved my inter-

personal relationships as well as my professional ones. I also learned that I could persevere through anything to achieve a goal.

The expert guidance of my committee chair has allowed me to grow as a researcher in qualitative methodologies. I have found a passion for interviewing people and looking for the meaning of their experiences. These meanings, first hidden and then revealed, in their words and actions, can be brought forth to allow a depth of knowledge not previously considered.

The insights into research itself will be shared with my students and used to help them develop and hone qualitative research skills. I will be sharing my findings with my colleagues at the university I teach. I also plan to further disseminate what I have learned through educational presentations and publications. I have already been in discussion with colleagues, both in education and those who work as either direct care nurses or management/administration, on ways to identify, intervene, and resolve lateral violence. I have spoken to several groups about the issue of lateral violence and plan to continue to do so. It is my hope that we will soon end this blight on the caring profession of nursing.

This experience has been a long and arduous one. However, it is one I cherish and embrace. Earlier in my career if someone had asked me if I wanted to pursue a doctoral degree, I would have said no. I now see the benefit of advancing education to this level. It has only made me realize how little I actually do know and encourages me to continue to "dig deeper" and understand aspects of my profession with a new perspective.

I will forever remain thankful to those who were brave and came forward to share their experiences, you are truly my heroes! I hope to make a difference to my nursing students as they enter professional practice, and to help influence changes in the

profession I cherish. Our superpower is in our caring for others and ourselves. We can and should do and be better!

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Appendix A

Overt and Covert Lateral Violence Behaviors

Overt Behaviors	***Covert Behaviors***
Verbal criticism	Sabotage*
Name-calling	Withholding information*
Intimidation	Excluding others
Blaming	Unfair assignments
Ethnic jokes or slurs	Undermining*
Finding fault	Downplaying accomplishment
Threatening	Betraying trust*
Physical threats or violence	Backstabbing*
Scapegoating (blaming everything on one person) *	Non-verbal innuendo (e.g., raising eyebrows) *
Infighting*	Failure to respect privacy *
Verbal affront (e.g. snide remarks) *	Gossiping
Passive-Aggressive behavior	Refusing to help
Complaining about another without addressing the person	Refusing to work with someone or only wanting to work with certain people
Cliques	Isolation
Shouting	Fabrication

*Griffin 10 most frequent forms of lateral violence behaviors

(Bartholomew, 2014; Freshwater, 2000; Griffin, 2004; Griffin & Clark, 2014; Meires, 2018; Stanley, Martin, Nemeth, Michel, & Welton, 2007; 2008; Schwarz & Leibold, 2015)

Appendix B

Additional Lateral Violence Associated Terms and Definitions

Term	***Author***	***Definition***
Bias	In Merriam-Webster Dictionary, n.d.	a "systematic error introduced into sampling or testing by selecting or encouraging one outcome or answer over others" (¶ 1)
Bullying	Boyle & Willis, 2016	a person's perception of repeated negative acts such as harassment, intimidation, exclusion, isolation, hostility, character assignation and constant criticism
Encultured or Enculturation	In Merriam-Webster Dictionary, n.d.	the process by which an individual learns the traditional content of a culture and assimilates its practices and values
Hazing	Brown & Middaugh, 2009	Involves inclusionary behaviors, sometimes referred to as "sink or swim" or "thrown to the wolves", involves groups or teams. Members of the teams are basically tortured – embarrassed, harassed, and may suffer physical and emotional harm, intent is to see if the new member is worthy to become part of the group or team
Horizontal Violence or Horizontal Hostility	Bartholomew, 2014	"a consistent pattern of behavior designed to control, diminish, or devalue a peer (or group) that creates a risk to health and/or safety" (p. 4)
Incivility	Schwarz & Leibold, 2015	rude behavior that is disruptive to the well-being of the individual that is the target of the behavior
Mobbing	Yamada, Duffy & Berry, 2018	antagonistic behaviors, with unethical communication, directed systematically at one individual by one or more individuals in the workplace
NCLEX-RN Exam	Arizona State Board of Nursing, 2018	National Council Licensure Examination is a standardized exam used to determine whether a graduate of an accredited nursing program is prepared for entry-level nursing practice
Nurses Eating Their Young	Meissner, 1986	term coined by author, a nursing professor, to encourage nurses to stop "ripping apart" inexperienced colleagues and students; term continues in use today
Nurse-on-Nurse Violence	American Nurses Association, 2015b	repeated, unwanted harmful actions intended to humiliate, offend, and cause distress in the recipient

Physical Abuse	Boyle & Willis, 2016	a person's perception of an unwelcome or uninvited action that involves physical contact with a person with the intent of causing physiological, emotional and bodily harm
Registered Nurse, RN	Grand Canyon University, 2018	a graduate from an accredited school of nursing, has passed the NCLEX-RN exam administered by the National Council of State Boards of Nursing (NCSBN), and has met all the other licensing requirements mandated by their state's board of nursing
Relational Aggression	Dellasega et al., 2014	a type of aggression in which harm is caused by damaging someone's relationships or social status
Sabotage	Ling, Marshall, Xu, & Lin, 2014	Willful act to undermine a person's ability to perform or carry out their professional duties; deliberately destroy, damage, or obstruct (something), especially for a perceived advantage
Sexual Abuse	Boyle & Willis, 2016	a person's perception of sexual propositioning or unwelcome sexual attention. This can include behaviors such as humiliating, offensive jokes, stories, remarks or voyeurism with sexual overtones, suggestive looks or physical gestures, exposed genitalia, gifts of a sexual connotation or requests for inappropriate physical examinations, pressure for dates
Sexual Harassment	Boyle & Willis, 2016	a person's perception of an unwelcome or uninvited action that involves physical contact with a person with the intent of causing physiological, emotional and bodily harm
Social Bullying	Goldberg, Beitz, Wieland, & Levine, 2013	rumors and embarrassment to get others to purposely leave a person out of a designated group of people, a repeated pattern of destructive behavior
Threat	Boyle & Willis, 2016	a person's perception of an intention to inflict personal pain, harm, damage, disadvantage, or psychological harm
Verbal Abuse	Boyle & Willis, 2016	a person's perception of being professional and personally attacked devalued or humiliated via the spoken word
Workplace Bullying	Massachusetts Nurses Association, 2017	unjustifiable actions of an individual or group toward a person or group over an extended period

Workplace Engagement	Fountain, 2017	refers to a positive mental state of well-being defined as vigor, dedication, and absorption in one's work
Workplace Violence	Occupational Safety and Health Administration, 2015)	"violent acts, including physical assaults and threats of assault, directed toward persons at work or on duty" (¶ 1).

Appendix C

List of Abbreviations Used

AACN	American Association of College of Nursing
ADN	Associate Degree in Nursing
AHRQ	Agency for Healthcare Research and Quality
AMSN	Academy of Medical-Surgical Nurses
ANA	American Nurses Association
ANCC	American Nurses Credentialing Center
AS	Associate in Science
AA	Associate in Arts
AzNA	Arizona Nurses Association
BA	Bachelor of Arts
BFA	Bachelor of Fine Arts
BS	Bachelor of Science
BSN	Bachelor of Science in Nursing
CDC	Centers for Disease Control and Prevention
CIRT	Center for Innovation in Research and Teaching
CRN	Crisis Response Network
CSS	College of Saint Scholastica
DNP	Doctor of Nursing Practice
GCU	Grand Canyon University
ICHRN	International Centre for Human Resources in Nursing
ICN	International Council of Nurses
IOM	Institute of Medicine
ISMP	Institute of Safe Medication Practices
JBI	Joanna Briggs Institute
JC	Joint Commission
LPN/LVN	Licensed Practical/Licensed Vocational Nurse
LV	Lateral Violence
LVNS	Lateral Violence in Nursing Survey
MS	Master of Science
MSN	Master of Science in Nursing
NAQ, NAQ-R, SNAQ	Negative Acts Questionnaire, Negative Acts Questionnaire Revised, Short Negative Acts Questionnaire
NCLEX-RN	National Council Licensure Examination – Registered Nurse
NCSBN	National Council of State Boards of Nursing
NCSL	National Conference of State Legislators
NWH	Nurse as Wounded Healer
NWS	Nurse Workplace Behavior Scale
OSHA	Occupational Safety and Health Administration
PSS	Perceived Stress Scale
RA	Relational Aggression
RAAS	Relational Aggression Assessment Survey

RCN	Royal College of Nursing
RN	Registered Nurse
RWJF	Robert Wood Johnson Foundation
SDT	Self-Determination Theory
SHRM	Society for Human Resource Management
STTI	Sigma Theta Tau International Honor Society of Nursing
WBI	Workplace Bullying Institute

Appendix D

Demographic Data Collection Guide

Participant Identifier: _____

Gender:

(a) Female _____

(b) Male _____

(c) Transgender _____

(d) Other _____

Age Range in Years:

(a) 20-25 _____

(b) 26-30 _____

(c) 31-35 _____

(d) 36-40 _____

(e) 41-45 _____

(f) 46-50 _____

(g) 51-55 _____

(h) 56 -60 _____

(i) Over 60 _____

Marital Status:

(a) Single _____

(b) Married _____

(c) Divorced/Separated _____

(d) Widowed _____

(e) Significant Other _____

(f) Other _____

Race/Ethnicity:

(a) African American (AA) _____

(b) Asian (A)_____

(c) Caucasian (C)_____

(d) Hispanic (H)_____

(e) Native American/Native Alaskan/ Native Hawaiian (NA/NA/NH) _____

(f) Multiple Ethnicities (M)_____

(g) Other (O) _____

Graduation/College Experience:

What month/year did you graduated from your pre-licensure baccalaureate nursing program: _____/201___

Had you previously attended college:

(a) Yes _____

(b) No _____

Highest non-nursing degree held:

(a) None _____

(b) Technical degree or certificate _____

(c) Associates degree _____

(d) Bachelor's degree _____

(e) Master's degree _____

(f) Doctoral degree _____

Professional Practice:

(a) What month/year did you obtain your RN license: _____/201___

(b) What month/year did you start professionally practicing as an RN: _____/201___

Employment Status:

(a) Working 36-40 hours per week (full-time) _____

(b) Working less than 36 hours per week (part-time) _____

(c) Not working currently _____

Place of Employment:

(a) Hospital (H)_____

(i) Emergency Department _____

(ii) Medical-Surgical _____

(iii) Labor & Delivery/Nursery/Post-Partum _____

(iv) Intensive Care _____

(v) Surgery/Pre-Op/Post-Op _____

(vi) Other _____

(b) Home Health (HH) _____

(c) Public Health (PH) _____

(d) Long Term Care (LTC)_____

(e) Other _____

Thank you for sharing your demographic information. Your demographic information will be compiled with those of the other participants and may help reveal trends within defined groups.

Your participant identifier is _____.

Please use this identifier should you need to contact me for any reason.

Appendix E

Interview Question Guide

Participant Identifier: _____

Date: _____ **Place**: _____

Time Session Began: _____ **Time Session Ended**: _____

You have indicated that you have experienced lateral violence in your nursing workplace since becoming a registered nurse. I am hoping to understand more about your lived experience with lateral violence in the nursing workplace.

Research Question:

What are the lived experiences of new registered nurses, within two years of beginning professional practice, with lateral violence, and their decision to remain in the nursing profession?

Probe Questions:

1. Tell me about your experiences with lateral violence as a new nurse.
2. Can you give me an example of your experience with lateral violence?
3. Tell me more about dealing with lateral violence in the workplace.
4. Tell me more about your experiences with lateral violence and your decision to remain in the nursing profession.
5. Is there any other information or insights you would like to add to this interview?
6. Do you have any questions?

I want to thank you for your time and for participating in the interview. I appreciate your willingness to share your experiences and insights with me. All your responses will be kept confidential, your name will not appear in the analysis of the data. Your responses have been recorded and will be transcribed verbatim by myself. Themes from your interview and the interview of others will be identified after review of the responses has been analyzed. This information will be shared through publication of findings with nurses and other healthcare professionals who may be experiencing similar incidents as you have shared in hopes of raising awareness of the issues and helping to improve the nursing workplace for all nurses and our patients.

Appendix F

Informed Consent

Greetings,

My name is Lorraine Hover and I am a student at the University of Phoenix working on a Doctor of Philosophy in Nursing. I am conducting a research study entitled Lived Experiences of New Nurses with Lateral Violence and Their Decision to Remain in Nursing Profession.

The purpose of the study is to understand the lived experiences of new registered nurses who have graduated from a pre-licensure Bachelor of Science in Nursing (BSN) of Bachelor of Arts in Nursing (BA) program, who are within two years of starting professional practice, who have experienced lateral violence, and have decided to remain in the nursing profession.

Through the sharing of your experience and insights, this study may add information to how to help retain new nurses in the profession and may help to mitigate some of the issues related to the nursing shortage.

Your participation will involve:

1. A one-on-one interview with the researcher with an approximate time commitment of 1 hour.
2. Review of your interview may require an additional time commitment of approximately 1 hour.
3. Interviews will be audio recorded and the researcher will make field notes during the interview.
4. Participation may be ended at any time without consequence by following the instructions below.
5. The sample size, or number of persons interviewed, is projected at 10-15 individuals.

You can decide to be a part of this study or not. Once you start, you can withdraw from the study at any time without any repercussions. The results of the research study may be published but your identity will remain protected and your name will not be made known to any outside parties.

In this research, there is a risk of emotional distress due to the topic. However, measures will be taken to minimize this risk. You may end the interview at any time should you desire to do so.

Although there may be no direct benefit to you, a possible benefit from your being part of this study is adding to the nursing body of knowledge. There is much research into why nurses leave the profession, what the consequences are of lateral violence, but there is little research into why nurses who have experienced lateral violence choose to remain in the nursing profession.

If you have any questions about the research study, please call me at [redacted] or email me at [redacted]. For questions about your rights as a study participant, or any concerns or complaints, please contact the University of Phoenix Institutional Review Board at IRB@phoenix.edu.

As a participant in this study, you should understand the following:

1. You may decide not to be part of this study or you may want to withdraw from the study at any time. If you want to withdraw, please call the researcher at [redacted] or email your request to [redacted].
2. Your identity will be protected.
3. Lorraine Hover, the researcher, has fully explained the nature of the research study and has answered all of your questions and concerns.
4. Interviews will be conducted and recorded. Before interviews are recorded, you must give permission for the researcher, Lorraine Hover, to record them. The information from these recorded interviews will be transcribed by the researcher. Data will be coded to assure that your identity is protected.
5. Data will be kept secure by the following means: The participant will be assigned a random alpha-numeric identifier. This identifier will be provided to the participant so that if further communication is needed their information may be readily identified. Field notes, recordings of semi-structured interviews, general demographic information, verbatim transcriptions of interviews; and data analyses will be identified and related to each other only using the identifier randomly assigned to each participant.
6. Data will be stored within the researcher's home office using two security measures. A locked cabinet will be used for storage of recordings and all written materials. Computerized information will be stored on the researcher's personal password protected computer within a password protected and encrypted file. The list of participant identifiers will be stored in a separate locked cabinet. All information will be secured when not in direct use by the researcher. Only the researcher will have access to the locked cabinets and computer.
7. The data will be kept for three (3) years, and then destroyed by shredding of hard copy data and erasure and data scrubbing of all electronic data.
8. The results of this study may be published.

By signing this form, you agree that you understand the nature of the study, the possible risks and benefits to you as a participant, and how your identity will be protected. When you sign this form, this means that you are 18 years old or older and that you give your permission to volunteer as a participant in the study that is described here.

(☐) I accept the above terms. (☐) I do not accept the above terms. (CHECK ONE)

Signature of the research participant _____Date _____

Signature of the researcher _____Date _____

Appendix H

Blast Email

Hello Fellow Nurse,

My name is Lorraine Hover and I am a doctoral student at the University of Phoenix pursing my PhD in Nursing. I am working on my Doctoral Dissertation, conducting a research study entitled Lived Experiences of New Nurses with Lateral Violence and Their Decision to Remain in the Nursing Profession. The purpose of the study is to explore the lived experiences and perceptions of those male or female nurses who have experienced lateral violence/bullying in their work setting and have decided to remain in the nursing profession.

Participation criteria include:

- Graduated from a pre-licensure baccalaureate nursing program within the past 36 months
- Have started professional nursing practice within the past 24 months
- Have not worked previously as an LPN/LVN
- Have experienced lateral violence/bullying since becoming a nurse
- Have decided to remain in the nursing profession
- Live in or around the Phoenix Metropolitan area, including Maricopa, Pima, Pinal, or Yavapai counties

If you are interested in being a participant in this study, the time commitment involves a face-to-face interview of approximately 60 minutes which will take place at a time and place agreed upon between you and me using a private room at a local library. A follow-up opportunity to review interview transcripts for accuracy will be provided which may take up to an additional 60 minutes of your time to complete. The projected sample size is 10 to 15 nurses.

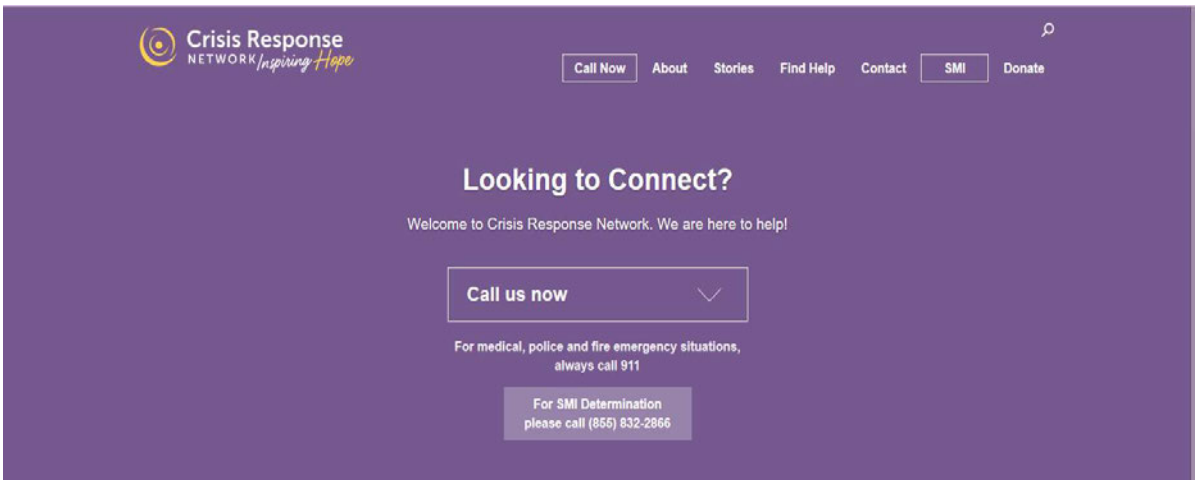
Participation is fully voluntary. There is the potential risk of emotional distress due to the nature of the topic. However, all care will be taken to minimize the distress and interviews will be stopped if you begin to feel too upset to continue. There may be no direct benefit to you, however the information gained will add to the nursing body of knowledge concerning lateral violence in nursing and may help in improving retention of new nurses in the profession.

If you are interested in participating, please contact me either on my cell number [redacted] or my email [redacted].

Thank you for your interest and I look forward to hearing from you.

Kindly,
Lorraine Hover, RN, MSN, BA
Doctoral Candidate, University of Phoenix

Appendix I
Crisis Response Network Information



Northern Arizona

Crisis Line: **(877) 756-4090**
TTY/TDD: **711**
SMI Determination: **(855) 832-2866**

Central Arizona

1275 W. Washington Street, Suite 108, Tempe, AZ 85281 **View Map**
Administrative office: **(602) 427-4600**
Crisis Line: **(602) 222-9444** or **(800) 631-1314** TTY **(602) 274-3360** or **(800) 327-9254**
Warm Line: **(602) 347-1100**
SMI Determination: **(602) 845-3594** or **(855) 832-2866**

Southern Arizona

5656 E. Grant Road, Suite 300, Tucson AZ 85712-2200 **View Map**
Administrative office: **(520) 727-3005**
SMI Determination: **(855) 832-2866**