Nurse-to-Nurse
Horizontal Violence:

Recognizing it and Preventing it

By Janice E. Hurley
Characteristics of Nurse-to-Nurse Horizontal Violence

- “Criticism, sabotage, undermining, infighting, scapegoating, and bickering” (Duffy, 1995, p. 9)
- “Intimidation, humiliation, excessive criticism, exclusion, innuendo, denial of access to opportunity, disinterest, discouragement, and the withholding of information;” (as quoted in McKenna, Smith, Poole, & Coverdale, 2003, p. 91)
- “Learning opportunities blocked, felt neglected, were given too much responsibility without appropriate support… rude[ness]” (McKenna et al., p. 93)
- “Raising of eyebrows… abrupt responses… not being available… withholding information about practice or about patients… sabotage… in-fighting… failure to respect privacy… broken confidences” (Dunbar, 2005, p. 1)
- “Dismissing, belittling, undermining, humorous ‘put downs’… gossiping… sarcastic comments… nitpicking… minimizing another’s concerns… slurs and jokes based on race, ethnicity, religion, gender, or sexual orientation… withholding support… limiting right to free speech and right to have an opinion… “better than” attitude… chronic understaffing” (Hastie, 2002, pp. 2-3)

The power of horizontal violence in nursing is now being countered by awareness, education, and on-the-job zero tolerance for abuse. “We’ve always cared for others. Now let’s care for each other” (Leiper, 2005, p. 45).

Causes of Horizontal Violence

Oppression as a norm
Historically, nursing recruited young women who valued patient care, service, and self sacrifice. Coupled with the developmental level common to nurses entering the profession, they were

Sarah, a new graduate, recently finished orientation and started evenings with an RN back from vacation. The RN jokingly asks Sarah, “Are you one of those college nurses? Here’s what we say, ‘Hire a baccalaureate grad while they still know everything!”

Beth, an experienced RN, has worked in a specialty area, Psychiatric Nursing, for one year. When Beth is off duty, a peer refers to Beth as “a little crazy herself.” The charge nurse has been seen to chuckle and say, “I know what you mean.”

Gretchen, a returning RN, works per-diem, four weekend shifts a month. Bill, another nurse on the unit, refuses to answer Gretchen’s questions about patient care. When asked about patient precautions in the cardex, Bill replied, “I don’t know what it means. If it’s there, I put it in my documentation.”

Reflecting on these nurse-to-nurse interactions, a new graduate might overlook what appears to be displaced humor and personal idiosyncrasy. Yet Sarah, Beth, and Gretchen have all been victims of horizontal violence, a phenomenon in nursing that now has a name. To promote excellence in patient care and survive in a chaotic health-care environment, students and newly graduated nurses need information about horizontal violence: its characteristics, causes, consequences, and cures.
perceived as “less than” in maturity, critical thinking ability, skill capability, and power base in a medical model health care system composed primarily of (older) male physicians. These nurses, lacking power, autonomy, and self esteem, took on the behaviors of the marginalized, looking to the powerful for approval and demeaning their own (Ferrell, 2001).

Task orientation Nurses are valued by their ability to complete assigned tasks in a timely manner, promoting “Caring as an Economic Activity” (Hurley, 1999, p. 11). Nurses who spend too long on a task or on a patient without facing the consequences – a missed meal, a reprimand – work against nursing’s culture and reap displeasure from peers. Yet these peers are needed as the source of “how-to” in the workplace, in the “real world,” so maintenance of the status quo is reinforced (Ferrell, 2001).

Negative role socialization Randle (2002b) reports that student nurses completed their educational program with “below average self-esteem,” (p. 143) having suffered from taking on the nursing role. A lowered self esteem affects role autonomy and competence (Fredriksson & Eriksson, 2003). To survive in a high-stress position, vulnerable nurses are pressured to adopt interpersonal rules, learning how to respond submissively to those who have power over them and too often respond negatively to their subordinates (Randle, 2003a).

Administrative retreat Nurse managers, implicated in horizontal violence through “acts of omission,” (Ferrell, 2001, p. 30) avoid or are unable to deal with horizontal violence and its ramifications. The prevalent attitude remains: nurses are employees first and individuals with rights second. Many nurses are acculturated to “turn the other cheek,” believing that negative staff interactions are to be expected and tolerated.

Educational shortcomings Students lack formal instruction in dealing with conflict, asserting their rights, and accessing resources to assist with the development of their professionalism (Chaboyer, Najman, & Dunn, 2001).

Consequences of Horizontal Violence Griffin (2005) reports that “Sixty percent of new-to-practice nurses leave their first professional position within six months because . . . of lateral [horizontal] violence . . . Twenty percent of [these] new-to-practice nurses . . . leave the profession forever . . . [involving a $30,000 to $50,000 loss every time a nurse leaves a facility)” (p. 3).

Horizontal violence can have the following consequences:
- Reduction of self confidence, self esteem
- Fear, anxiety, sadness, depression, frustration, nervousness
- Mistrust
- Fatigue, headaches, weight loss, angina
- Symptoms resembling Post-Traumatic Stress Disorder (PTSD)
- Compromised patient safety
- Dishilubition with nursing — intention to leave the profession (McKenna et al, 2001, p. 95).

Other outcomes include:
- Disintegration of a caring, supportive, kind, and empathic identity

Hastie (2002) suggests the role of horizontal violence in:
- Sleep disorders
- Low morale – apathy – disconnectedness
- Irritability
- Burnout
- Hypertension
- Eating disorders
- Impaired interpersonal relationships
- Removal of self from the workplace – sick leave, absenteeism
- Resignations (pp. 3-4).

Nurses are valuable patient resources who must reject toxic environments that affect them personally and professionally, impact their rights, and their ability to care. Interestingly, five nurses in one study who spoke out against horizontal violence reported positive outcomes from “standing up for myself,” “feeling stronger in myself,” (McKenna et al., 2003, p. 95) and benefiting from support. Self care, being seen and heard, and becoming empowered are critical approaches to impact horizontal violence.

Cures for Horizontal Violence Modular RN to BS nursing students and faculty (Module I, Group 31) at Roberts Wesleyan College (RWC) in Rochester, NY informally surveyed their peers regarding horizontal violence. Of 33 RN responses, 91% had experienced horizontal violence; 94% had seen horizontal violence taking place; and 76% believed that the level of horizontal violence in nursing was moderate to severe.

Yet there is hope. Horizontal violence is being discussed; its impact on patient care is being recognized; nurses are receiving support; and nurses are standing up for themselves.
care is now recognized; nurses increasingly assert their rights; and administrators are enforcing safe environments (Fischman, 2002). Methods of dealing with horizontal violence include:

- Feedback from an RWC survey supports education – college courses, “inservices, seminars” (Vonfrolio, 2005, p. 60) – as a path to impede horizontal violence.

- “Rules for relationships,” (Chaboyer et al., 2001, p. 530) posted at worksites promote supportive relationships, professional role socialization, and team building (Dunbar, 2005; Farrell, 1997).

- That individuals in conflict learn assertive responses and “fight fair” (“Fighting Fair,” n.d.).

- Dealing with any horizontal violence promptly. Consequences follow written policy (Hastie, 2002).

- Agreement by staff to refuse to engage in abuse, affirm their rights, and access necessary resources (Hastie 2002).

- Adherence to OSHA regulations regarding violence in the workplace (New York State Nurses Association [NYSNA], n.d.).

- That data gathering, confronting, verbal and written grievances, and legal action are employed without reprisal (Leiper, 2005).

- Nurse Managers committing to role model and enforce a change in unit culture that includes adequate mentoring and holding fast to nursing’s vision and values (Dunbar, 2005).

Professionalism begins with the individual. How will professional nurses and nursing students choose to look at, relate to, and value their peers to promote collegiality, accountability, and trust? Nurses have long looked to others, the environment, and society as major factors restricting nurse autonomy and credibility. Addressing horizontal violence is a significant step in nurses joining together, taking control of our profession, and positioning ourselves for responsive patient care.

“We’ve always cared for others. Now let’s care for each other.”
- Leiper (2005)

References


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