Intraprofessional Conflict among Registered Nurses in Hospital Nursing: A Phenomenological Study of Horizontal Violence and Bullying

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Intraprofessional Conflict among Registered Nurses in Hospital Nursing:  
A Phenomenological Study of Horizontal Violence and Bullying

by

Joyce A. Goff

A Dissertation Presented to the  
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Dedication

This research is dedicated to all the registered nurses (RN), who work in hospital nursing. I hear you and understand your dilemma, and I thank you for your long hours and hard work when caring for others. Most of all, the research is dedicated to the registered nurses who were brave enough to share their story with me.
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Abstract

By the year 2025, the nursing workforce shortage will exceed 500,000 registered nurses (RN). Hospitals will primarily experience this loss. The retention of RNs is a critical issue for hospitals, and studies about RNs leaving jobs in hospital nursing are essential to addressing the workforce shortage. Limited data exists about why RNs leave hospital nursing, other than job dissatisfaction. There is limited current data on whether horizontal violence, bullying, and intraprofessional conflict between RNs influence such decisions. This qualitative phenomenological study explored RNs’ experiences of horizontal violence, bullying, and intraprofessional conflict in hospital nursing. Findings suggest behaviors such as alienation, intimidation, sabotage, lack of intellectual respect, and failed professionalism contribute to horizontal violence and intraprofessional conflict among RNs in the hospital workplace. These findings may help develop strategies to educate healthcare teams and hospital administrative staff, and lobby for universal anti-horizontal violence and anti-bullying policies in hospitals. The findings highlight the need for conflict management training for RNs and healthcare workers, to facilitate intraprofessional communication and collaboration, and the need for further research. Keywords: registered nurse, hospital, horizontal violence, bullying, intraprofessional conflict.
Chapter 1: Introduction

In the United States, the nursing workforce shortage may exceed 500,000 registered nurses (RN) by the year 2025 (AACN, 2010; Juraschek, Zhang, Ranganathan, & Lin, 2012). The nationwide demand for RNs may grow by 612,000 full-time equivalent (FTE) RNs from 2,897,000 FTEs in 2012 to 3,509,000 FTEs in 2025, a 21% increase (U.S. Department of Health and Human Services, 2014). According to data from the American Health Care Association (2013), “10,000 registered nurses’ positions were vacant at the end of 2012, a 21.0 percent increase from 2010” (p. 1). The increase in RN vacancies may be due to the national shortage in nurses (AHCA, 2013). The supply of RNs is decreasing while the demand is increasing (AACN, 2010).

According to the U.S. Department of Health and Human Services (2010), hospitals are the most common employment setting for RNs, increasing from 57.4% in 2004 to 62.2% of employed RNs in 2008. Needleman, Buerhaus, Mattke, Stewart, and Zelevinsky (2011) analyzed the records of 198,000 hospital patients and 177,000, eight-hour nursing shifts across 43 patient-care units, and found that the shortage in nurse staffing is related to higher patient mortality rates. Thus, the nursing shortage is literally a life or death matter.

This phenomenological study is focused on RNs because of their roles, responsibilities, and statuses in the hospital organization and hierarchy. In hospitals, RNs provide direct patient care, manage and direct complex nursing care, and supervise the routine duties of the healthcare staff. RNs are vital to hospital operations, but are leaving at an alarming rate. I used a purposeful sampling of six RNs who worked in hospital
nursing and left a job at some point in their career due to conflict related to horizontal violence and bullying. The participants were from central and south Texas.

A study conducted by Budin, Brewer, Chao & Kovner (2013) found that RNs early in their nursing career are vulnerable, and become victims of verbal abuse from their colleagues. Approximately 17.5% of newly-licensed RNs leave their first nursing job within the first year and 33.5% leave within two years (Kovner, Brewer, Fatehi, & Jun, 2014). The most common form of disruptive behavior experienced by RNs, in the hospital workplace, is verbal abuse, which can be destructive. Other behaviors that can be destructive in the hospital include work place aggression (Farrell, Bobrowski, & Bobrowski, 2006), disruptive behaviors (The Joint Commission, 2008), incivility (Andersson & Pearson, 1999; Hutton, 2006), bullying (Quine, 2001), harassment, and horizontal or lateral violence (Center for American Nurses, 2008; Vessey, DeMarco, & DiFazio, 2010) as cited in (Budin, et al., 2013).

**Statement of the Problem**

There are many reasons for the shortage of RNs in hospital nursing. According to Hayes, Bonner, and Pryor (2010), attrition of hospital RNs relates to lack of job satisfaction. Job satisfaction is a multifaceted concept that includes intrapersonal, interpersonal, and extra-personal aspects (Hayes et al., 2010). In the hospital workplace, working relationships between nursing colleagues and the medical staff are essential to teamwork, job satisfaction, and patient outcomes (Hayes et al., 2010). Workplace conflict involving violence such as physical assault, emotional or verbal abuse, or threatening, harassing, or coercive behavior that causes physical or emotional harm towards nurses is a concern (Vessey, et al., 2011). The National Institute for Occupational Safety and
Health (1996) defined workplace violence as any physical assault, threatening behavior, or verbal abuse occurring in the workplace; violence includes overt and covert behaviors ranging from aggressiveness to verbal harassment and murder. In hospital nursing, horizontal violence and negative behavior among peers (i.e. intraprofessional conflict) are major predictors of job satisfaction and attrition of hospital RNs (Budin, et al., 2013).

Dating back to the mid-1960s, the phrase nurses eat their young explains the dynamics of relationships between nurses in the workplace (Hippeli, 2009). Violent behavior in the workplace often leads to conflict and job dissatisfaction. In this study, I investigate the experience of horizontal violence, bullying, and intraprofessional conflict of RNs’ who at some point in their professional careers decided to leave their job in hospital nursing. Wilmot and Hocker (2011) claimed that “health care environments present the probability of damaging conflicts” (p. 5). Poor intraprofessional relationships, together with workplace (interprofessional) conflict, cause job dissatisfaction, and some nurses to leave the profession while others continue working, and remain chronically unhappy (Duddle, & Boughton, 2007).

Workplace violence in hospitals comes in many forms, including verbal abuse. This form of abuse may leave no visible scars, but emotional damage can affect productivity, increase medication errors, absenteeism, and decrease morale and overall satisfaction within the nursing profession (Araujo & Sofield, 2011). In a self-reporting, online survey used to determine the level of violence experienced by nursing students in their clinical assignments, 100% experienced some type of workplace violence and the perpetrators were most often other staff members (Hinchberger, 2009). Patients, relatives
of patients, other nurses, and members of other professional groups may perpetrate workplace violence (Jackson, Clare, & Mannix, 2002).

The American Nurses Association (ANA) (2011) health and safety survey surveyed more than 4,600 nurses, and found that 11% had been physically assaulted in the previous 12 months; approximately 50% had been threatened or verbally abused. When there is conflict within the health care team, patients suffer (Baldwin & Daugherty, 2008). Serious intraprofessional conflict results in high numbers of medical errors (Baldwin & Daugherty, 2008). A survey of 970 female nurses from 47 nursing units found the main perpetrators of violence towards nurses were patients, followed by physicians and patients’ families (Park, Cho, & Hong, 2014). In the operating room, physicians were the most frequent perpetrators of all types of violence, except bullying, towards RNs (Park et al., 2014). Nurse colleagues committed the most bullying in all nursing units (Park et al., 2014).

In this study, the primary research question was: What are the lived experiences of RNs who left a nursing job because of horizontal violence, bullying, and intraprofessional conflict in hospital workplace? The study was guided by the following secondary research questions:

1. What actions or behaviors do RNs describe as experiences of horizontal violence (i.e., acts of violence perpetrated by a RN against another RN) and bullying in the hospital workplace?
2. What is the impact of HV (RN on RN) and bullying on nurses in the hospital workplace?
3. How do incidents of horizontal violence and bullying contribute to intraprofessional conflict?

4. How do nurses perceive the connection between horizontal violence, bullying, and the RN’s decision to leave hospital nursing?

**Purpose Statement**

The purpose of this transcendental phenomenological study was to explore the lived experiences of RNs who left a job in hospital nursing, at some point in their career, because of horizontal violence and bullying that result in intraprofessional. The study participants included six RNs, from central and south Texas, who work in private, public and a hospital operated by the federal government. Conflict and bullying in the hospital workplace jeopardize teamwork, productivity, and quality of care for patients. The phenomenon of workplace bullying leads to negative psychological and psychosomatic outcomes, effects individual behavior, and causes severe side-effects on the professional environment (Einarsen, Hoel, & Notelaers, 2009; Johnson & Rea, 2009; Rayner, 1997). Persistent bullying, harassment, and horizontal violence can have detrimental effects on job satisfaction, workforce retention, the psychological and physical health of nurses, and quality of patient care (Vessey et al., 2011). I used a purposeful sampling to identify RNs who worked in hospital nursing and left a job at some point in their career, due to conflict related to horizontal violence and bullying.

**Significance**

The findings from this study contribute to the literature on horizontal violence, bullying, and intraprofessional conflict as reasons why RNs leave hospital nursing. The findings reveal various forms of horizontal violence and bullying that contribute to
intraprofessional conflict, which may encourage researchers to include horizontal violence and bullying in the hospital workplace as factors influencing job dissatisfaction and attrition. Horizontal violence and bullying are destructive behaviors with direct and indirect consequences. Findings from this study may be instrumental in developing strategies for interventions to identify and manage RN against RN violence, and provide a foundation for developing educational tools, conflict management training programs, and lobbying for universal anti-horizontal violence and bullying polices in hospitals. RNs and health care workers must recognize horizontal violence and bullying behavior in its many forms. This study may aid in the development of conflict management and resolution training for RNs and health care teams. Addressing the issue of horizontal violence and bullying in hospital nursing is important because health care providers, including physicians, recognize that the growing shortage of RNs in hospitals will decrease the quality of care and safety of patients (Vessey et al., 2011).

**Definitions of Terms**

*Registered nurse.* is an individual who completed the educational requirements and became licensed to practice professional nursing (Schorr & Kennedy, 1999).

*Hospitals.* are health care institutions with organized medical and professional staff and inpatient facilities that provide medical, nursing, and health-related services 24-hours per day, 7 days per week to the public (WHO, 2014). Modern hospitals are more organizationally complex, more geographically dispersed, provide more services along the continuum of care, and accept some financial risk for the provision of care (Shalowitz, 2013).
Violence. is “the intentional use of physical force or power, threatened or actual, against oneself, another person or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation” (WHO, 2002, p. 13).

Workplace violence. is violence that occurs within the work environment (Magnavita, 2014). Workplace violence is an act of aggression that ranges from offensive or threatening language to homicide.

Horizontal violence. is intergroup conflict manifested in overt and covert non-physical hostility such as sabotage, infighting, scapegoating, and criticism (Dellasega, 2009). Horizontal violence is hostile and aggressive behaviour of an individual or group towards another individual or members of a larger group (Duffy, 1995).

Bullying. refers to “repeated efforts to cause another person physical or emotional harm or injury” (Dellasega, 2009, p. 54). “Bullying can reflect an actual or perceived imbalance of power or conflict, but it can also occur between peers and even friends” (Dellasega, 2009, p. 54).

Conflict. is a complex behavior that can occur at intrapersonal, interpersonal, intra-group or intergroup levels. Intrapersonal conflicts occur within the person, and interpersonal conflicts occur between people (Patton, 2014). Intra-group conflict happens within one group of people and intergroup conflict occurs between two or more groups of people (Forte, 1997: Patton, 2014).

Intraprofessional conflict. refers to discord between and among members of the same profession, such as RNs (Duddle & Boughton, 2007).
Theories

Five theories are utilized to analyze group behavior as it relates to horizontal violence, bullying, and intraprofessional conflict among RNs in the hospital workplace. The first is needs theory, the theory of human motivation, developed by Abraham Maslow (1943). Maslow conceptualized human needs as a pyramid with five levels ranging from physiologic needs at the base to safety, belonging, esteem, and self-actualization (Groff-Paris & Terhaar, 2010). People are naturally motivated by psychological growth and self-development and work to achieve unmet needs at the lower levels before attending to those at the higher levels (Groff-Paris & Terhaar, 2010). When people satisfy lower-level needs, the next higher-level needs become the focus until satisfied. The highest level of needs, self-actualization, is that of “becoming all that one is capable of becoming in terms of talents, skills and abilities” (Groff-Paris & Terhaar, 2010, p. 6). When nurses do not feel that their basic practice environment needs are met, they are less motivated and less likely to progress to the higher-level of performance (Groff-Paris, & Terhaar, 2010). Conflict is rooted in unmet needs; when basic needs are met, individuals are better able to manage and resolve conflict (Burton, 1990). For this study, I used needs theory to analyze the consequences of unmet psychological and professional needs on RNs’ self-development in hospitals.

The second theory is critical social theory (CST), which seeks human “emancipation from slavery,” acts as a “liberating … influence,” and works “to create a world which satisfies the needs and powers” of human beings (Horkheimer, 1972, p. 246). Browne (2000) explained that “as a theoretical and philosophical orientation to science, critical social theory (CST) is increasingly used in nursing inquiry, theory, and
practice to address oppressive sociopolitical conditions influencing health and health care” (p. 43). Nursing scholars utilize CST to analyze and critique the socio-political context of nursing practice, and to develop frameworks for emancipatory nursing action (Browne, 2000). In this study, CST provided the framework for researching horizontal violence and bullying among RNs in the hospital workplace. This behavior may be the result of oppression in the nursing profession (Cody, 1998). According to CST, economics and power influence the lives of individuals and groups (Ekstrom & Sigurdsson, 2002). A researcher using CST “strives to interpret the condition of a group of sufferers, make plain to them the cause of their suffering, and by sketching a course of relief, demonstrate that their situation is not immutable” (Bohman, 2005, p. 600). I use CST to examine how RNs are viewed by society, their role in society, the fact that most nurses are women, and the similarities between nurses and those who are oppressed.

The third theory is oppression theory (Freire, 1968). Freire (1968) characterized oppression as assimilation, marginalization, self-hatred, low self-esteem, submissive behavior, and horizontal violence. Through the lens of oppression theory, Freire (1968) identified the dynamics of group behaviors linked to increased horizontal violence and bullying. In this model, the dominant group interacts with a subordinate group, resulting in the subordinate group taking on oppressed characteristics. RNs are an oppressed group within the hospital workplace (Rodwell, Demir, & Flower, 2013). Roberts (1983) described horizontal violence and bullying for nurses as outcomes of structural or social contexts of the work environments based on Freire’s Pedagogy of the Oppressed (1972) and observations of nurses in the workplace who exhibited oppressed group behaviors.
The fourth theory is *feminist theory*. Women make up much of the nursing workforce. Feminist theory raised the issue about the ways women are viewed in the home, society, and workplace. Friedan (2001) paved the way for modern-day feminist movements and advances made by women in society. The longest journey begins with the first step. According to Friedan (2001), women moved out of their homes, where they were enslaved by their husbands and children, into a workforce where the behavior continued. Feminist theories compare the differences between men and women as viewed by society and in the workplace to better understand human behavior in the social environment by focusing on women in contemporary society (Lay & Daley, 2007). Feminist theory focuses on how gender differences affects human behavior in the context of historical, political, social, and cultural concerns, as well as gender-based oppression (Lay & Daley, 2007). Gender inequality is the argument that women are oppressed within the family and undervalued in employment (Hooyman, 2002). Gender inequalities may lead to horizontal violence, bullying, and intraprofessional conflict in hospital nursing.

The fifth theory is *intergroup threat theory*. Intergroup threats may cause negative out-group attitudes (Riek, Mania, Gaertner, McDonald, & Lamoreaux, 2010). Threats are major causes of conflict and barriers to conflict resolution (Stephen & Mealy, 2011). Intergroup threat theory suggests that professional rivalry may be the antecedent to intraprofessional conflict such as horizontal violence and bullying (Stephen & Mealy, 2011). This theory provides the framework for the analysis of intra-group biases of RNs from different education levels. The three levels of RNs are those who received a diploma, associate degree, and bachelor of science, each having the same basic training and licenses. Hospitals administer the diploma program (AACN, 1995). The associate
degree is a 3-year program at a community college, and the bachelor of science (BSN) degree is a 4-year program at a college or university (AACN, 1995). Graduates of all three programs must be licensed by the state where they practice (AACN, 1995). Through intergroup threat theory, I explored how distinct levels of nursing education (diploma, associate, BSN) influenced the behaviors of RNs and may relate to horizontal violence, bullying, and intraprofessional conflict in the hospital workplace.

Chapter Summary

The projected shortage of RNs in hospital nursing is related to job dissatisfaction in the workplace, which can be caused by horizontal violence and bullying (Budin, Brewer, Chao, & Kovner, 2013). Physical or non-physical violence can occur in any environment, but RN on RN horizontal violence and bullying should not occur in the hospital workplace. Janzekovich (2016) cited that “Vonfrolio (2005) suggests that nurses are emotionally, spiritually and physically drained after administering patient care and have nothing left in reserve to maintain their peer relationships” (p. 88). Rowell (2005) argued that adults carry lifelong unresolved issues that may result in horizontal violence towards others. Horizontal violence and bullying disrupt patient care and are difficult for nurses to manage.

Nursing is an occupation traditionally dominated by females, but recently many males become RNs. Male nurse experiences of horizontal violence and bullying in the hospital workplace are no different than those of female nurses. In this study, I used five theories to view horizontal violence and bullying from different perspectives. Human needs theory affirms that all human beings have needs that are personal and professional.
CST and feminist theory facilitate social change. Nurses are an oppressed group, and horizontal violence and bullying are the effects of this oppression. Nurses compete for professional recognition and status in the hospital workplace. Intergroup threat theory applies to one group's actions, beliefs, or characteristics that challenge the goal attainment or well-being of another group (Riek et al., 2010). Additional research is needed to explore what is causing the shortage of RNs in hospital nursing. The purpose of this transcendental phenomenological study was to research horizontal violence and bullying between RNs in the hospital workplace. The purpose of this transcendental phenomenological study is to explore the lived experiences of RNs who left a job in hospital nursing, at some point in their career, because of horizontal violence and bullying that result in intraprofessional conflict. In Chapter 2, the literature review, will focus on the background and history of the nursing profession, and the evolvement of horizontal violence and bullying in the workplace.
Chapter 2: Literature Review

The shortage of RNs in hospitals is a global problem. Hospitals cannot function effectively or efficiently without RNs, a crucial part of health care delivery. By the year 2025, the RN shortage in the U.S. may exceed 500,000 (AACN, 2010). Several factors contribute to the shortage of RNs in hospital nursing, including horizontal violence and bullying, which may result in client complaints, increased medical errors, job dissatisfaction, and leaving a job or the nursing profession. The prevalence of horizontal violence and bullying in hospital nursing is unknown to some degree, due to a lack of reporting (Vessel et al., 2011). Global epidemiologic data of horizontal violence and bullying is incomplete due to difficulty tracking events, definitional inconsistencies, and measurement problems, including the “lack of systematic and coordinated data collection procedures and scant research (NACNEP, 2007, p. 18)” (Vessey et al., 2011). Horizontal violence and bullying are common pernicious problems that are persistent occupational hazards within the global nursing workforce (Vessey et al., 2011). As the nursing profession has evolved so has the dynamics of the workforce and the hospital workplace. The historical context and existing theories will describe the effects of horizontal violence in hospital nursing.

Nursing History

Nursing is a noble calling dating back to the 17th century. In the 18th century, Rabia Choraya became the head nurse in Braddock’s army (Smith, 2012). In the 19th century, hospitals recognized nursing as a profession (Smith, 2012). Male nurses originally dominated the field; they served in the military while female nurses provided care at home (Smith, 2012). These roles changed during the Civil War when women
cared for to the wounded because there were not enough men (Holder, 2004). The primary roles of these female caregivers were to gather food, offer first aid, and collect supplies (Holder, 2004). Over time, the field of nursing evolved because nursing is vital to human survival. After the Civil War, women who worked as nurses returned to caring for the poor (Smith, 2012). However, Clara Barton, Doretha Dix, and Mary Bickerdyke showed women that they had a place in nursing outside of the home, and were the first activists for women to become gainfully employed as professional nurses (Holder, 2004). Universities soon provided formal training of nurses. Linda Richards graduated from the New England Hospital for Women and Children in 1873, and is considered America’s first trained nurse (Smith, 2012).

According to Smith (2012), the nursing profession began to evolve in the 19th century due to the efforts of several female nursing revolutionists (Klainberg & Dirschel, 2010). The foremost leader of the nursing revolution was Florence Nightingale, the lady with the lamp, who changed the practice of nursing forever. Having a life of wealth and privilege, Florence Nightingale chose to care for sick and diseased individuals and enrolled in a 3-month nurse training program. After graduation, she formed the Establishment for Gentle Women During Illness organization. As the leader of the organization, she trained other nurses to care for the sick and injured during wartime. She worked in the Crimean War (1853-1856) after hearing about the unhealthy conditions of injured soldiers. She found sick and injured soldiers neglected and living in filthy conditions that caused infections, diseases, and death. She organized female volunteers and brought clean bedding, bandages, soap, and water to clean the wounds of soldiers dying from infections. Her actions led to a significant decrease in the death rate among
soldiers. As the pioneer of modern nursing, she set the standards for nursing practice (Schorr & Kennedy, 1999).

Mary Seacole (1805-1861), the daughter of a Jamaican nurse and a Scottish career soldier, used nursing skills learned from her mother during the cholera and yellow fever epidemic in Cuba and Panama. Like Florence Nightingale, she cared for wounded and fatigued soldiers in Balaclava where she established a hospital and respite. On the battlefield, she was known as Mother Seacole. Unlike Florence Nightingale, Seacole received little recognition for her contributions in the Crimean War, possibly due to her ethnicity (Carnegie, 1992).

Clara Barton (1812-1912) was a New England school teacher who volunteered as a nurse during the U.S. Civil War. She acquired needed supplies for the troops, often using her own financial resources. The soldiers referred to her as the little lone lady in black silk (Danahue, 1996). After the war, she devoted her efforts to locating missing soldiers and helped establish the first national cemetery for soldiers. Clara Barton created a new field of volunteer service when she established the American Red Cross in 1881, an organization to service the needs of people in distress (Barton, 1898). During this time, hospitals staff included nurses and women gained recognition in the U.S. military as nurse officers (Smith, 2012).

The Nursing Profession in the 20th Century

The 20th century brought significant changes to the nursing profession with the implementation of rules, regulations, and policies by the ANA (2010). The ANA is the only full-service professional organization representing the interests of the nation's 3.1 million RNs through its constituent member nurses’ associations and its organizational
affiliates. The ANA advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and lobbying Congress and regulatory agencies on health care issues affecting nurses and the public (ANA, 2010). The ANA is the most prestigious nursing organization due to their leadership in foundational aspects of the nursing (ANA, 2010).

Nursing education expanded during the 20th century. Hospital-based nursing training programs became formal schools of nursing, Yale University being the first, that offered several types of degrees (Smith, 2012).

**Shortage of Registered Nurses**

Since 1998, there continues to be a deficit of RNs due to a growing elderly population and an aging nursing population (Juraschek et al., 2012). According to MacKusick and Minick (2010), there is a wealth of data concerning RNs who choose to stay in hospital nursing, but few studies focused on the experiences of RNs who leave hospital nursing.

The Bureau of Labor Statistics (2015) estimated that there will be a need for 525,000 replacements nurses in the workforce by 2022, bringing the total number of job openings for nurses’ due to growth and replacement to 1.05 million. Vogelpohl (2011) found that 60% of RNs in the U.S. leave their first position within six months due to horizontal violence and bullying. Nursing is predominantly a female profession, and 90-97%, of nurses have experience verbal abuse from physicians, which is historically a male-dominated profession (Juraschek et al., 2012). A state-by-state analysis predicted that the RN shortage will be most intense in the South and West (Juraschek et al., 2012). The U.S. General Accounting Office (2001) and other government agencies monitored
the shortage of RNs in the U.S. health care delivery systems. The U.S. Department of Health and Human Services (2000) reported that the nation’s supply of FTE RNs is 1.89 million, but the demand is two million, a shortage of 110,000 or 6%. According to the U.S. Department of Health and Human Services Centers for Disease Control and Prevention National Institute for Occupational Safety and Health (2002), “if the shortage of registered nurses is not addressed, and trends continue, the projected shortage will grow to 29% by 2020” (p. 2). These data support the conclusion that the shortage of RNs in hospitals, in the U.S. is a severe problem, and requires continuous research.

The shortage of RNs in hospital nursing will impact the general population, the aging population, and public health. According to the Administration on Aging (2014), the population of people 65 years of age and older will be 46.2 million by the year 2060, which will represent 14.5% of the U.S. population. Medical researchers at the Centers for Disease Control and Prevention (CDC) claimed that people 65 years of age and older are a population living longer with many medical and health care needs (CDC, 2013). These health care needs will strain health care systems and increase the need for RNs.

Factors Contributing to the RN Shortage

A survey conducted by the National Council of State Boards of Nursing and The Forum of State Nursing Workforce Centers found that 55% of the RN workforce is 50 years of age or older (Budden, Zhong, & Cimiotti, 2013). The Health Resources and Services Administration (2014) projected that more than one million RNs will reach retirement age by 2030. Age, job dissatisfaction, intrapersonal and interpersonal violence, horizontal violence, and bullying will also result in loss of nurses.
**Job dissatisfaction.** Job dissatisfaction of RNs may be caused by unrealistic workloads complicated by expectations of hospitals, salaries, benefits, demands of patients, and family members (Aiken, Clarke, Sloane, Sochalski, & Siber, 2002). According to Aiken et al. (2002), “job dissatisfaction among hospital nurses is four times greater than the average for all U.S. workers, and one in five hospital nurses report that they intend to leave their job within a year” (p. 1987). Hayes et al. (2010) found that it was difficult to define job satisfaction specifically related to nursing. Although “factors contributing to satisfaction in the workplace have been described, a concise and consistent definition is not apparent” (Shader, Broome, Broome, West, & Nash, 2001, p. 212). Shader et al. (2001) argued that “satisfaction with work is a multidimensional construct consisting of elements essential to personal fulfillment in one’s jobs” (p. 212).

Fung-kam (1998) described job satisfaction as the “affective reaction to a job that results from the comparison of perceived outcomes with those that are desired” (p. 355). Adams and Bond (2000) defined job satisfaction as “degree of positive affects towards a job or it components” (p. 538). Liu, Aungsuroch, and Yunibhand (2016) found the main attributes of job satisfaction to be: (a) fulfillment of desired needs within the work settings; (b) happiness or gratifying emotional responses towards working conditions; and (c) job value or equity. Antecedent conditions (e.g., demographic, emotional, work characteristics, environmental variables) influence these factors (Liu et al., 2016, p. 90).

The personal characteristics of an individual, such as attitudes and behaviors, influence job satisfaction (Hayes et al., 2010). According to Aiken et al. (2002), 40% of hospital nurses reported burnout levels that exceed the norms for healthcare workers. An estimated 30%-50% of newly licensed nurses change positions or leave the nursing
profession within the first three years of clinical practice (AACN, 2003; Aiken et al., 2002; Cipriano, 2006; Cowin & Hengstberger-Sims, 2006). Job satisfaction is the primary indicator of an individual remaining in a position and is a significant factor in nurse turnover (Brewer, Kovner, Greene, Tukov-Shuser, & Djukic, 2012). From a psychological perspective, “satisfaction in the nurse personal life has been linked to job satisfaction” (Demerouti, Bakker, Nachreiner, & Schaufeli, 2000, p. 456). Demerouti et al. (2000) found that “life satisfaction is the degree to which the experience of an individual’s life satisfies the individual’s wants and needs both physically and psychologically” (p. 456). Life satisfaction depends on how satisfied nurses are with life in general and how it relates to their physical and psychological needs being met (Demerouti et al., 2000). Job dissatisfaction often leads to conflict in the workplace, home, and family.

**Intrapersonal and interpersonal factors.** Hayes et al. (2010) labeled the factors contributing to nurse job satisfaction as intrapersonal and interpersonal factors. Intrapersonal factors are those the nurse brings to the job, such as age, education, and coping strategies (e.g., behavior disengagement, positive reframing) that influence job satisfaction (Hayes et al., 2010). Jack (2011) argued that silencing the self is an intrapersonal behavior based on a relational situation, such as women trying to avoid conflict to maintain relationships to ensure their psychological or physical safety.

Interpersonal factors are interactions between the nurse and others, such as colleagues and patients. Interpersonal factors include autonomy, providing patient care, professional relationships, leadership, and professional pride (Hayes et al., 2010). According to Hayes et al. (2010), intrapersonal factors that contribute to conflict in the
workplace occur within the individual. Wilmot and Hocker (2011) argued that intrapersonal perceptions are the foundation for conflicts, and interpersonal conflicts emerge when people communicate these perceptions. Communication is the common element in all interpersonal conflict (Wilmot & Hocker, 2011). Communication can be verbal or non-verbal, leading to miscommunication, misunderstanding, and conflict between RNs in the hospital workplace.

Intrapersonal and interpersonal factors can manifest in the dynamics of group behavior. Fisher’s (2000) approach to understanding intergroup conflicts is a social-psychological perspective; conflicts between people occur according to group identities. Fisher (2000) argued that intergroup conflicts arise from objective differences of interest coupled with antagonistic or controlling attitudes or behaviors. Of the many factors contributing to intergroup conflict, economics, power, value differences, and differences in needs-satisfaction are most significant (Duffy, 1995).

 Violence. Violence among humans is not a new phenomenon. North, Wallis, and Weingast (2009) argued that all societies experience violence. Violence can occur anywhere and does occur everywhere there are groups of people because it is part of societal behavior (North et al., 2009). The fact that “an individual can become violent, poses a central problem for any group” (North et al., 2009, p. 9). The CDC (2016) reported that “violence is a serious public health problem” (para. 1). Violence affects people in all stages of life, and survivors suffer physical, mental, and emotional health problems for the rest of their lives (CDC, 2016). Health care workers suffered two thirds of nonfatal workplace violence injuries since 2003 (CDC, 2013).
Workplace violence is one of the most complex and dangerous hazards for nurses in the hospital workplace (McPhaul & Lipscomb, 2004). The ANA’s (2014) health risk appraisal survey of 3,765 RNs and nursing students found that 21% reported being physically assaulted and over 50% verbally abused by peers over a 12-month period. The violence included overt and covert behavior: aggressiveness, verbal harassment, threatening gestures such as kicking, hitting, biting, punching, stabbing, sexual assault, shooting, and murder (Dellasega, 2009).

Nurses are 57% more likely to be assaulted than physicians (Harrell, 2011). The Emergency Nurses Association (2011) found that 43% of emergency department nurses reported verbal abuse from a patient or visitor in a seven-day calendar period in an average work week of 36.9 hours. The violence survey found that 11% of nurses reported both physical abuse and verbal abuse, 1% reported only physical abuse, and 62% of emergency room nurses who reported being victims of physical violence experienced more than one incident of physical violence from a patient or visitor in a seven-day period (ENA, 2011). Chapman, Perry, Styles and Combs (2009) reported that “violence towards nurses can lead to physical injury, negative effects on personal lives, debilitating emotional, social, physical and cognitive symptoms” (p. 1256).

**Horizontal violence and bullying.** Horizontal violence and bullying affect nurses. According to Vessey et al. (2011), global epidemiologic data on horizontal violence and bullying in the nursing workforce is incomplete. Horizontal violence and bullying are common and persistent occupational hazards within the global nursing workforce (Purpora, Blegen, & Stotts, 2012). The term horizontal violence includes aggression between nurses, including verbal or nonverbal behaviors (Dellasega, 2009).
The ten most common forms of horizontal violence experienced by nurses are “non-verbal innuendo, verbal affront, undermining activities, withholding information, sabotage, infighting, scapegoating, backstabbing, failure to respect privacy, and broken confidences” (Griffin, 2004, p. 257).

Thobaben (2007) defined horizontal violence as “hostile, aggressive, and harmful behavior by a nurse or group of nurses toward a coworker or group of nurses via attitudes, actions, words and/or behaviors” (p. 82). Stanley, Martin, Michel, Welton, and Nemeth (2007) described horizontal violence as any unwanted abuse or hostility within the workplace. Horizontal violence is a series of undermining incidents over time, not one isolated conflict in the workplace (Becher & Visovsky, 2012). Horizontal violence is “injurious behavior aimed by one worker toward another who is of equal status within a hierarchy that seeks to control the person by disregarding and diminishing their value as a human being” (Blanton, Lybecker, & Spring, 1998, p. 18). Blanton et al. (1998) stated that “horizontal violence includes, calling coworkers demeaning names, using words, tone of voice, or body language that humiliates or ridicules them, belittling their concerns, and pushing them or throwing things” (Purpora et al., 2012, p. 3).

Groups at the greatest risk for horizontal violence and bullying are the weakest members, such as the new nurse graduates, transfer nurses, or newly hired nurses (Vogelpohl, 2011). Baltimore (2006) reported that experienced nurses often eat their young through behaviors such as gossiping, criticizing, scapegoating, and withholding information. Sofield and Salmon (2003) indicated that verbal abuse in the workplace decreases morale, increases job dissatisfaction, and contributes to a hostile work
environment. Horizontal violence and bullying may contribute to the increasing nursing shortage (Sofield & Salmon, 2003).

Horizontal violence has a definite impact on nursing practice (Curtis, Bowen, & Reid, 2007; Dellasega, 2009; Dunn, 2003; Farrell, 1997; Hutchinson, Vickers, Wilkes, & Jackson, 2010). Horizontal violence is intergroup conflict that manifests in overt and covert behaviours of hostility (Duffy, 1995; Freire, 1972). Farrell (2001) argued that oppression of nurses by the medical hierarchy is a platform for horizontal violence among nurses. Horizontal violence and bullying directly relate to RNs’ intent to leave hospital organizations (Baltimore, 2006; Sofield & Salmon, 2003).

Bloom (2014) provided several meanings of horizontal violence. Bartholomew (2006) defined horizontal violence as a consistent hidden pattern of behavior designed to control, diminish, or devalue a peer. Purpora et al. (2012) described horizontal violence as “behavior that is directed by one peer toward another that harms, disrespects, and devalues the worth of the recipient while denying their basic human rights” (p. 3-4).

MacIntosh (2005) conducted a qualitative study of 21 people who experienced workplace violence, and found that most horizontal violence behaviors had psychosocial bases such as intimidation, lack of respect, and coercion. MacIntosh (2005) found that competent and committed employees experienced violence that caused extensive use of sick time and absenteeism. Simons and Mawn (2010) surveyed 184 newly licensed U.S. nurses, and identified four major themes of bullying and the impact of bullying behavior, including “structural bullying; nurses ‘eating their young’; being out of the clique; and leaving the job” (p. 307).
In hospital nursing, Leiper (2005) found that “nurse managers were the most common perpetrators of bullying in clinical areas” (p. 45). Bloom (2014) examined characteristics of horizontal violence experienced by RNs in two city hospitals, and found that an increase in workload stress, behavior practices tolerated in the work area, and the apathetic attitude of management were the most common factors leading to horizontal violence among nurses. Bloom (2014) showed that horizontal violence in hospitals can be controlled by management awareness and support, staff support, and educational programs. Hewett (2010) found that many nurses experience some form of horizontal violence behaviors in the hospital environment. Horizontal violence and bullying lead to poor morale, dissatisfaction, and dysfunctional peer relationships in the nursing workplace (Farrell, 2001; Jackson et al., 2002; Lewis, 2006). Jackson et al. (2002) argued that violence in nursing is a major impediment to recruitment and retention of nurses in the healthcare environment. According to Harcombe (1999), horizontal violence and bullying are behaviors associated with oppressed groups and occur in any arena where there are unequal power relations, and one group's self-expression and autonomy is controlled by forces with greater prestige, power, and status than themselves.

**Bullying.** Bullying is defined as a common form of non-physical workplace violence that occurs among all ranks of workers in a hospital environment including managers and the nursing staff (Hoel & Giga, 2006). The Taskforce on the Prevention of Workplace Bullying (2001), define bullying as an “offensive abusive, intimidating, malicious or insulting behavior, or abuse of power conducted by an individual or group against others, which makes the recipient feel upset, threatened, humiliated or vulnerable” (p. 1). In the hospital workplace, “bullying is associated with a perpetrator at
a higher level of authority gradient, for example, nursing supervisor to staff nurse”
(Center for American Nurses, 2007, p. 6).

Past research focused on horizontal violence and bullying of new nurse graduates, but senior nurses can also be victims of bullying. Strandmark and Hallberg (as cited in Longo, 2013) identified some reasons that contribute to bullying of senior/experienced nurses, such as competence, success, and a strong sense of personal strength, which may make them a target for bullying; adult bullies are often jealous of those with higher qualifications. Lewis (2006) reported that bullying in nursing is primarily intraprofessional or nurse-to-nurse. Bullies are demeaning, sarcastic, and critical; they isolate and disadvantage their targets (Lewis, 2006). Bullying remains a dangerous problem for nurses and for patients (Rosenstein & O’Daniel, 2008). Bullying is a behaviour that is endemic in the workplace, and an unacceptable and destructive phenomenon (Duffy, 1995). Glazer and Alexandre (as cited in Smith, 2011) linked bullying to the current nursing shortage. More than 20 years of research suggest that bullying exists in the nursing workplace. It is persistent, systematic, and ongoing, and contributes to the current nursing shortage (Smith, 2011).

Conflict is a complex phenomenon of human interaction that exists all around us (Weeks, 1994). Conflict is a visible sign of human energy, the evidence of human urgency, and the result of competitive striving for the same goals, rights, and resources (Augsburger, 1992, p.18). Wilmot and Hocker (2011) argue that conflict is a struggle between parties who have perceived incompatible goals, concerns over scarce resources, and interference in achieving goals. Cloke, Goldsmith, and Bennis (2011) reported that “conflict in the workplace arises from simple miscommunications, misunderstandings,
irrelevant differences, poor choices of language, ineffective management styles, unclear roles and responsibilities, false expectations and poor leadership” (p. xvii). Johansen (2012) reported that “workplace conflicts in the health care environment tend to be far more complicated because they often involve ongoing, complex relationships that are based in emotion” (p. 54).

In the hospital workplace, conflict emerges in many different forms, such as nurse on nurse, physician on nurse, or other members of the health care delivery team (Plummer, 2014). Plummer’s (2014) phenomenological study of 18 nurses in a south Florida hospital found that conflict occurred among nurses, doctors, patients, patients’ family members, representatives of insurance companies, administrators, and auxiliary staff. Plummer (2014) explored aspects of conflict in an organizational culture as it relates to the hospital environment. RNs are vital to the operations and organizational success of hospitals, because they are gatekeepers (Hegney, Eley, & Francis, 2013). In their role as gatekeepers, RNs monitor, manage, and supervise patient care. From an institutional perspective, RNs help patients navigate a complex healthcare system (Collyer, 2014). OSHA (2010) reported that two million U.S. workers experienced workplace violence and healthcare workers, particularly nurses, pharmacists, and therapists are targets of workplace violence (p. 1).

Almost, Doran, Hall, and Laschinger (2010) found that conflict among nurses negatively impacts retention of qualified staff and patient outcomes, and nursing shortages are due to workplace conflict. Horizontal violence and bullying are rooted in interpersonal and intrapersonal conflict. The theoretical frameworks that will be used to explore horizontal violence, bullying, and intraprofessional conflict among RNs in the
hospital workplace, will include human needs theory, critical social theory, oppression theory, feminist theory, and intergroup threat theory.

**Theoretical Framework**

This study builds on five theories to analyze the dynamics of group behavior as it relates to horizontal violence and bullying among RNs in hospital environments.

According to Moustakas (1994), conducting a theoretical assessment includes exploring the theories that provide a reason for the phenomenon. First, human needs theory is important to studying horizontal violence, bullying, and intraprofessional conflict, because it is the foundation of human behavior (Maslow, 1943). It offers insight into the sources of conflict and possible resolutions (Burton, 1990). In this study, human needs are either basic or professional; both are important in human behaviors. Conflicts and violence are caused by unmet human needs (Burton, 1990). Maslow (1943) defined the hierarchy of human needs as both biological and physiological. Burton (1990) moved beyond basic needs to include security, recognition, stimulation, distributive justice, meaning, rationality, and control (p. 64). According to Burton (1990), conflict may occur if real or perceived needs are unmet.

Rosenberg (2003) argued that violence is an expression of unmet human needs, suggesting that humans are motivated to satisfy needs. McClelland (2014) proposed that individuals acquire specific needs over time based on early life experiences. McClelland (2014) also argued that needs influence motivation and effectiveness in work performance and job satisfaction. Maslow’s (1943) theory of needs was the foundation for evaluating unmet needs of RNs in the hospital workplace. Critics argued that Maslow’s needs theory was not originally designed for work environments. As a clinical
psychologist, Maslow (1943) based his theory on observations of individuals in a clinical setting. One criticism is the order in which Maslow ranked needs. Neher (1991) questioned whether individuals who go hungry and are in fear for their lives might retain strong bonds to others, which suggests a different order of needs. Researchers failed to support that once a need is satisfied it no longer serves as a motivator, and that only one need is dominant at a time (Neher, 1991).

In applying Maslow’s hierarchy of needs to the workplace environment, Alderfer (1969) argued that basic human needs could be grouped in three categories: existence, relatedness, and growth. Existence corresponds to Maslow’s physiological and safety needs, relatedness corresponds to social needs, and growth refers to Maslow’s esteem and self-actualization (Alderfer, 1969). Judging from Maslow’s needs theory, RNs working in hospital environments may have unmet self-esteem and socialization needs. Likewise, when experiencing any form of violence in a hospital environment, RNs may feel that their personal dignity and integrity is threatened (ANA, 2000). These factors contribute to the theory of unmet needs and may lead to intra-group and intraprofessional conflict. The disruptive acts of horizontal violence affect RNs and other members of the health care team, and threatens the delivery of quality patient care (ANA, 2000). Such acts can have a direct and indirect effect on the hospital and the community.

The second theory is Critical Social Theory, developed by theorists from the Institute for Social Research at the Frankfurt School. The leader of CST in the 20th century was Jurgen Habermas (1971) who argued that the fundamental concept of CST is that no aspect of social phenomena can be understood unless it is related to the history and structure in which it is found. Habermas promoted CST as an imperative branch of
scientific enquiry that describes “distortions and constraints that impede free, equal and uncoerced participation in society” (Stevens, 1989 p. 58). Habermas (1971) and Freire (1972) suggested social conditions distort individuals’ self-perceptions, and that insights from critical social science enable people to see conditions for what they are and find ways to become free. CST is one way to promote praxis (i.e. reflection with action). Praxis is the precursor to liberation and empowerment (Freire, 1972). Reflection without action is meaningless and alienating (Fulton, 1997).

Researchers using Critical Social Theory strive to transform society by analyzing the social whole, including history, culture, and consciousness (Held, 1980). When studying horizontal violence between and among RNs, CST has the potential to inspire positive change. The goal of CST is emancipation (Bohman, 2005). Emancipation is the freedom for RNs to practice their profession and express themselves without fearing acts of violence or bullying from other RNs in the hospital workplace. CST seeks “human emancipation in circumstances of domination and oppression” (Bohman, 2005, p. 2). CST empowers human beings to move past the constraints placed on them by race, class, and gender (Creswell, 2007). Critics of CST claim it fails to answer two basic questions raised by earlier theorists, “(a) how can critical theory be connected to political practice, (i.e. who or what will be the agent of social change), and (b) how can a theory which arises within history provide a basis for universal critique” (Held, 1980, p. 25)?

The third theory that helped to shape this study is oppression theory, based on the model of oppression behavior identified by Freire (1968). In the literature, the Theory of Oppression has been found to significant play a role in horizontal violence for more than thirty years. It is a systematically applied injustice based on “coercively enforced
inequality or diminished choice” (Cudd, 2005, p. 22). In Freire’s model, oppression is “characterized by assimilation, marginalization, self-hatred, low self-esteem, submissive behavior and horizontal violence” (Bloom, 2014, p. 20). Researchers use the oppression model to understand probable causes of aggression between nurses (Rodwell et al., 2013). Cody (1998) associated oppression with critical theory in relation to “the practice of nursing, the role of the nurse in society, the fact that most nurses are women and the relations between nurses and those who are oppressed” (p. 41). Critics of oppression theory argue that men as a group are not oppressed because social systems and organization do not impose oppressive mistreatment on a broad scale (Frye, 1983).

Oppressive theory analyzes the organization culture of hospitals conducive to horizontal violence.

Roberts (1983) argued that oppression is the result of female RNs working in a patriarchal medical hierarchy that creates feelings of hopelessness and helplessness. Horizontal violence in nursing results from the oppressed state of the profession (Roberts, 1983). Roberts (1983) claimed that female RNs have little power within the hospital hierarchy, as they participate in a dominant-submissive relationship with more powerful members of the healthcare team, such as male physicians and management. RNs who cannot exert power upwardly lash out, exerting violence against their peers or someone with less power through intra-group conflict (Roberts, 1983). Intra-group conflict is the incompatibility of members of a group or subgroups regarding goals, functions, or activities of the group (Tajfel & Turner, 1986). Roberts (2002) reported that nurses are critical of each other rather than supportive in the healthcare environment, which often leads to conflict. The practice of medicine, which dominates health care delivery,
subsumed the art and science of nursing (Roberts, 2002). This form of suppression results in RNs seldom verbalizing contributions to patient care and the organization (Roberts, 2002). According to Roberts (2002), nurses often talk to each other about the pleasure of being a nurse, but rarely articulate their occupation in public.

The fourth theory is feminist theory. According to Florence Nightingale, every woman is a nurse, defining nursing as a calling for women (Malka, 2007). Most often associated with the rights of women, feminist theory offers a perspective for understanding human behavior in the social environment by focusing on women’s issues in contemporary society (Lay & Daley, 2007). Also, feminist theories focus on how gender differences affect human behavior. Critics of feminist theory, such as Flax (1999), argued that

Feminist theory views women’s oppression as a unique constellation of social problems and must be understood. Oppression is a part of the way the world is structured and is not due to pockets of bad attitudes or that oppression is embedded in the very socio-economic and political organization of our society.

The structure is the patriarchy, which has deep roots in the culture at large. (p. 10)

Feminist theory is based on the argument that “women have often been oppressed within the family and undervalued in employment” (Hooyman, 2002, para. 6).

Mary Wollstonecraft, a pioneer of feminist theory, argued that corrupt processes of socialization enslave women and stunt their intellect and purpose in life (Donovan, 2012). Gender inequality puts women at a disadvantage (Lorber, 2010). The disparity between males and females is an important aspect of the present study because according to the Bureau of Labor Statistics (2015), the nursing profession is 95% female. A feminist
theoretical approach to analyzing horizontal violence among and between RNs in the hospital environment must consider the fact that hospitals employ both female and male RNs.

Salary inequalities may also contribute to intraprofessional conflict. Male RNs have higher pay rates than female RNs for the same work in hospitals (Muench, Sindelar, Busch, & Buerhaus, 2015). Marxist feminists consider capitalist economic systems, such as hospitals, the main sources of female oppression (Brown, 2014). Brown (2014) explained that Marx (1844) argued “women’s position in society could be used as a measure of the development of society” (para. 6). For this study, feminist theory was utilized to view the dynamics of gender in a broader scope. Feminist theory deals not only with gender inequality, but also with structural and economic inequality, power and oppression, gender roles and stereotypes. Marxism, a theory of class and inequality can be considered. Marxism and feminism both provide accounts of social arrangements and disparity that are internally rational and systematically unjust (MacKinnon, 1989). Disparities based on gender rather than knowledge, skill, or ability contribute to intraprofessional conflict (Hurst, 2013).

The fifth theory is intergroup threat theory. Threats are a major cause of conflict and a barrier to conflict resolution (Stephen & Mealy, 2011). Tajfel and Turner (1986) argued that the psychological benefits of the group members, particularly those who identify with in-groups, influence intergroup aggression. These benefits include acceptance, belonging, social support, and system of roles, rules, norms, values, and beliefs to guide behavior (Tajfel & Turner, 1986). Intergroup threat theory provides the framework for the analysis of intra-group biases of RNs from the three different
education levels (diploma, associate degree, and BSN). Hospitals prefer to hire RNs with associate degrees and BSN degrees, which increases competition (AACN, 2001). Differences in education influence group behavior of RNs who compete for power, prestige, and status in the organizational structure (AACN, 2001).

Chapter Summary

Nursing literature includes many studies of horizontal violence and bullying. Past research demonstrated that many nurses experience horizontal violence and bullying in the workplace. Horizontal violence is deliberate behavior, such as verbally abusive communication, workplace sabotage, social isolation, and negative non-verbal gestures (e.g., eye-rolling, raised eyebrows). Such behaviors have negative psychological and physiological effects on nurses’ ability to perform, which puts patients at risk. Past literature identified multiple sources of this behavior in the workplace, but there is little to connect horizontal violence to the shortage of RNs in hospital nursing. Hospitals’ organizational culture may increase the risk of horizontal violence and bullying, resulting in intraprofessional conflict among nurses.

This study relied on foundational theories to understand horizontal violence, bullying, and intraprofessional conflict among RNs in the hospital workplace: human needs theory, CST, oppression theory, feminist theory, and intergroup threat theory. Of these theories, oppression theory is the prevailing framework researchers use to examine horizontal violence and bullying in the nursing workplace. The concept of oppressed group behaviors provided some understanding of horizontal violence and bullying in the nursing workplace. Oppression of nursing as a profession can have a ripple effect for individual nurses.
Researchers believe that oppression of nursing as a profession drives these behaviors of horizontal violence and bullying. This study explored horizontal violence and bullying that result in intraprofessional conflict as experienced by RNs who left jobs in hospital nursing.

In Chapter 3, I will discuss the research methodology chosen to investigate this phenomenon. For this study, a qualitative research approach was chosen because as the researcher, I am interested in exploring how people make sense of their world and the experiences they have in the world (Merriam, 2009). The transcendental phenomenological approach is used because it attempts to understand individuals’ lived experiences of horizontal violence, bullying in hospital nursing, resulting in intraprofessional conflict, and the behavioral, emotive, and social meanings that these experiences have for them (Moustakas, 1994).
Chapter 3: Research Methodology

This chapter will include a detailed description of the research methodology that was utilized in the study. The chapter is organized into several sections that provide a framework within which to describe the research plan. A statement of the purpose of the study is provided, followed by the research questions that guided data collection and analysis procedures. The role and responsibilities of the researcher and the research plan is outlined. The chapter ends with a discussion of data collection and analysis. This study explored the research question: What are the lived experiences of RNs who at some point in their nursing career, left a job because they experienced horizontal violence, bullying, and intraprofessional conflict in the hospital workplace?

Introduction

The purpose of this study is to explore the lived experiences of RNs who experienced horizontal violence and bullying, in the hospital workplace and at some point, in their career left a job or the nursing profession. When RNs leave jobs in hospital nursing, it contributes to the shortage of RNs in the hospital workforce. This study uses the transcendental phenomenological research methodology to capture the essences of the RNs experiences of horizontal violence and bullying, in their own words. The objective is to explore the lived experiences of RN victims of horizontal violence, bullying, and intraprofessional conflict. The interview responses provided data regarding the research question. I interviewed six RNs about their hospital nursing experience and incidents of horizontal violence, bullying, and intraprofessional conflict. Participants discussed hospital strategies to resolve conflicts between RNs.
The research questions for this study emerged from the literature review. The primary research question for this study was: What are the lived experiences of RNs who experience horizontal violence, bullying, and intraprofessional conflict in hospital nursing? The following secondary research questions guided interview question content:

SRQ 1. What actions or behaviors do RNs describe as experiences of horizontal violence (i.e., acts of violence perpetrated by a RN against another RN) and bullying in the hospital workplace?

SRQ 2. What is the impact of RN on RN violence, including bullying, in the hospital workplace?

SRQ 3. How do incidents of horizontal violence and bullying contribute to intraprofessional conflict?

SRQ 4. How do nurses perceive the connection between horizontal violence, bullying, and the RN’s decision to leave hospital nursing?

I chose qualitative phenomenology to study the phenomenon of horizontal violence, bullying, and intraprofessional conflict among RNs in hospital nursing.

**Research Design and Rationale**

This research study utilized a Qualitative research focuses on subjective meanings, definitions, metaphors, symbols, and descriptions of specific events of a phenomenon (Burns & Grove, 2009), and specifically, the transcendental phenomenological approach. The methodological framework and appropriateness of the chosen approach are discussed in subsequent paragraphs. Qualitative research focuses on subjective meanings, definitions, metaphors, symbols, and descriptions of specific events of a phenomenon (Burns & Grove, 2009). According to Creswell (2013), qualitative
research is an appropriate method to use when “a problem or issues needs to be explored” (p. 47). Chenail (2011) recommended qualitative research be as simple as possible because the complexity of research lies in the matter to be studied, especially in naturalistic and exploratory inquiries. According to Creswell (2009), “the selection of the research design is based on the nature of the research problem or issue being addressed, the researcher’s personal experiences and the audience for the study” (p. 3). In this qualitative study, I conducted interviews using a phenomenological approach. Creswell (1998) contended, “phenomenological data analysis progresses through the process of reduction, the analysis of specific statements and themes, and a search for all possible meanings” (p. 180). Welman and Kruger (1999) argued that “phenomenologists are concerned with understanding social and psychological phenomena from the perspectives of people involved” (p. 189).

Phenomenological studies focus on the meanings of human experiences in situations as they spontaneously occur during daily life (Lin, 2013). Edmund Husserl (1859-1938) is the father of the philosophical movement known as phenomenology, the attempt to describe experiences and the things themselves without metaphysical and theoretical speculations (Wrenn, 2016). Smith (2013) described phenomenology as the science of the essence of consciousness as articulated by the individual. Husserl founded phenomenological research by insisting that phenomenology is a science of consciousness rather than a science of empirical things (Beyer, 2015).

Moustakas (1994) argued that researchers should focus on the wholeness of experience and search for the essences of experience. The objective of phenomenology inquiry is not to examine what is visible and clearly defined, but to examine phenomena
that remain hidden, covered over, or somehow disguised (Heidegger, 1976). Van Manen (1990) contended the “purpose of phenomenology is to reduce individual experiences with a phenomenon to a description of the universal essence, a grasp of the very nature of the thing” (as cited in Creswell, 2013, p. 72). Van Manen (1990) asserted that the purposes for phenomenological inquiry include description, interpretation, and critical self-reflection into the world as a world; “central is the notion of intentionality and caring: the researcher inquiries about the essence of lived experience” (p. 72). The researcher is the primary instrument for data collection and data analysis. According to Creswell (1998), in phenomenological research, the “researchers search for essentials, invariant structure (or essence) or the central underlying meaning of the experience and emphasize the intentionality of consciousness where experiences contain both the outward appearance and inward consciousness based on memory, image and meaning” (p. 52). Van Manen (1990) asserted that “phenomenology formatively informs, reforms, transforms, performs, and pre-forms the relation between being and practice” (as cited in Sloan & Bowe, 2014, p. 1295).

Phenomenological inquiry explores the lived world of experiences, allowing readers to be “steadfastly oriented to the lived experience that makes it possible to ask the ‘what is it like’ question in the first place” (VanManen, 1990, p. 42). Moustakas (1994) suggested that phenomenological researchers must identify a topic and question that have both social meaning and personal significance. A phenomenological research method is suitable for this study, because it is pragmatic, interpretive, and grounded in lived experiences of people (Marshall & Rossman, 2014).
Christensen, Johnson, and Turner (2010) stated that phenomenological inquiry clarifies the meaning, structure, and essence of the lived experiences of a person or a group of people around a specific phenomenon. Patton (1990) explained “a phenomenological study is one that focused on descriptions of what people experience and how it is that they experience what they experience” (p. 71). Phenomenology is ideal for investigating the personal journeys and challenges of RNs. Researchers in the field of medical science often use phenomenological methods to study patients’ feelings about their illness or disease (Carel, 2011). For the present phenomenological inquiry, the focus is RNs’ experiences of horizontal violence, bullying, and intraprofessional conflict.

To determine the appropriate phenomenological approach for this study, I considered three types of phenomenological research design: existential, hermeneutic, and transcendental. Each provided unique approaches. Existential phenomenology is a process that describes subjective human experience as it reflects values, purposes, ideals, intentions, emotions, and relationships (Thorpe & Holt, 2008). Existential phenomenology addresses experiences and actions of the individual, rather than conformity or behavior (Thorpe & Holt, 2008). The individual is an active and creative subject in the research process, not an object of inquiry. Existential phenomenology offers great flexibility due to the subjective nature of the study and concentrates on the consciousness of the participant, not their reaction to an event (Sowder, 1991). However, existential phenomenology does not offer an organized method of data analysis compared to other forms of phenomenological inquiry (Sowder, 1991).

In hermeneutic phenomenology, the researcher combines an interpretive and descriptive approach to interviews. Kafle (2013) stated that hermeneutic phenomenology
is “focused on subjective experience of individuals and groups” (p. 186). It is an attempt to unveil the world as experienced by the subject through their life world stories (Kafle, 2013). Hermeneutic phenomenology goes beyond description to discover meanings that are not immediately apparent (Merleau-Ponty, 1996).

Transcendental phenomenology is the most appropriate methodology to explore RNs’ lived experiences of horizontal violence, bullying, and intraprofessional conflict in hospital nursing. In this approach, “everything is perceived freshly, as if for the first time” (Moustakas 1994, p. 34). Transcendental phenomenology is based on principles identified by Husserl that Moustakas translated into a qualitative method (Moerer-Urdahl & Creswell, 2004). In this approach, Moustakas (1994) embraced the common features of human science research, focused on the wholeness of an experience while searching for essences, and viewed experience and behavior as an integrated and inseparable relationship of subject/object.

In transcendental phenomenology researchers set aside prejudgments as much as possible and use a systematic approach to analyze data. Moustakas (1994) argued that transcendental phenomenology research promotes the notion of noema, not the real object but the phenomenon of the topic at hand. Noema captures the essences in greater detail, provides more awareness of the topic, and creates a deeper level of perception of participants’ experiences (Moustakas, 1994). Transcendental phenomenology is best suited for this research study because it provided me the ability to examine the different perspectives of the RNs experience of horizontal violence and bullying, in hospital nursing. Also, Moustakas (1994), simplified the research process by providing step-by-step guidance for conducting human science research (p.103), which include:
1. Discovering a topic and question rooted in autobiographical meanings and values, as well as involving social meanings and significance. Somewhere in the research process the researcher must engage in bracketing /epoché.

2. Conducting a comprehensive review of the professional and research literature.

3. Constructing a set of criteria to locate appropriate co-researchers

4. Providing co-researchers with instructions on the nature and purpose of the investigation, and developing an agreement that includes obtaining informed consent, ensuring confidentiality and delineating the responsibilities of the primary researcher and research participants, consistent with ethical principles of research

5. Developing a set of questions or topics to guide the interview process

6. Conducting and reporting a lengthy person-to-person interview that focuses on a bracketed topic and question. A follow-up interview may also be needed.

7. Bracketing /epoché, setting aside the personal bias and expectations of the researcher.

8. Organizing and analyzing the data to facilitate development of individual textural and structural descriptions, a composite textural description, a composite structural description, and a synthesis of textural and structural meanings and essences

To study the phenomenon of horizontal violence, bullying, and intraprofessional conflict, experienced by hospital nurses.

**Sample**

Numerous factors determine sample sizes in transcendental phenomenology qualitative studies. Creswell (1998) suggested five to 25, Morse (1994) recommended at
least six (as cited in Mason, 2010), and Dukes (1984) recommended studying between three and ten subjects for one phenomenology (Creswell, 2013, p. 157). In qualitative research, the sample should not be so large that it is difficult to extract thick, rich data, nor so small that it is difficult to achieve data saturation, theoretical saturation, or informational redundancy (Onwuegbuzie & Leech, 2007). According to Patton (1990), “sample size depends on what you want to know, the purpose of the inquiry, what’s at stake, what will be useful, what will have credibility, and what can be done with available time and resources” (p.184).

For this study, I used a purposeful sampling approach to identify six RNs who worked in hospital nursing and left a job due to conflict related to horizontal violence and bullying. This number of participants provided rich data describing individual experiences. The sample included RNs who met the following criteria: (a) must be a RN; (b) worked in hospital nursing; (c) left a job as a hospital nurse due to workplace bullying or violence; and (d) be willing to articulate experiences involving the phenomenon under investigation. The sample consisted of RNs with three levels of nursing education: diploma, associate degree, and BSN. All the participants met the criteria for this study; they were all RNs who worked in hospital nursing, experienced horizontal violence or bullying, and left a job in hospital nursing due to horizontal violence or bullying causing intraprofessional conflict.

**Sample Characteristics**

The study included one male and five female nurses. Three nurses self-identified as White and three Black with ages ranging from 28 to 55 years old. I protected the confidentiality of the participants, and did not collect actual names of the individual RNs
in this study. I assigned all participants pseudonyms. Demographic question Appendix D;

Table 1 shows demographic characteristics of participants and their pseudonyms.

Table 1

Demographics of Participants

<table>
<thead>
<tr>
<th>Name (Pseudonym)</th>
<th>Age</th>
<th>Gender</th>
<th>Nursing Degree/Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carolyn</td>
<td>34</td>
<td>Female</td>
<td>ADN (Associate Degree in Nursing)</td>
</tr>
<tr>
<td>Vivian</td>
<td>45</td>
<td>Female</td>
<td>BSN (Bachelor of Science in Nursing)</td>
</tr>
<tr>
<td>Susan</td>
<td>55</td>
<td>Female</td>
<td>BSN (Bachelor of Science in Nursing)</td>
</tr>
<tr>
<td>Mary</td>
<td>49</td>
<td>Female</td>
<td>BSN (Bachelor of Science in Nursing)</td>
</tr>
<tr>
<td>James</td>
<td>33</td>
<td>Male</td>
<td>BSN, MNS (Bachelor of Science in Nursing) (Masters of Nursing Science)</td>
</tr>
<tr>
<td>Cirri</td>
<td>28</td>
<td>Female</td>
<td>BSN (Bachelor of Science in Nursing)</td>
</tr>
</tbody>
</table>

Recruitment

Following Institutional Review Board approval from Nova Southeastern University, I contacted RNs at various hospitals across central and south Texas to attain a judgment sample of six RNs who experienced horizontal violence or bullying by other RNs in a hospital setting. The goal was to obtain a homogeneous group. I distributed 25 recruitment flyers (Appendix A). I asked RNs if they experienced horizontal violence or bullying by other RNs in the workplace or if they knew anyone who left a job in hospital nursing due to horizontal violence and bullying. In each conversation, I explained the purpose of the study. Each RN received a copy of a flyer to pass on to any RN who might tell me about their experience of horizontal violence and bullying. I used a snowball recruitment process to reach a variety of RNs who resigned from hospital nursing. In snowball sampling, participants identify other individuals to participate in the study. This process continues until enough people participate in the study (Creswell, 2002). I obtained signed consent forms, and set a time and place for interviews.
Setting

I conducted interviews in various settings for the convenience of the participants. Settings were neutral, private, and free of distractions. I used McNamara’s (2012) interview principles: (a) choose a setting with little distraction; (b) explain the purpose of the interview; (c) address terms of confidentiality; (d) explain the format of the interview; (e) indicate how long the interview usually takes; (f) explain how to get in touch with you later if necessary; (g) ask if there are any questions; and (h) do not count on memory to recall responses. I conducted interviews at different hospitals and one in a hotel conference room. To establish rapport with the participants, I shared information about my nursing career and professional experience. I put the participants at ease to stimulate an open dialogue. Once participants felt comfortable, they were eager to tell their stories.

Bracketing/Époché

To conduct a quality transcendental phenomenology study, bracketing and époché are important to data quality. Chen et al., (2013) suggest that bracketing is essential to the study before entering the data collection and analysis process. Bracketing is the ability to view lived-experiences without suppositions, prejudgments, or preconceived ideas (Moustakas, 1994). In the process of bracketing and époché, I tell the story of my experience as a RN, to provide the context for my interest in this phenomenon. The researcher must suspend personal prejudices to reach the core or essence through a state of pure consciousness by bracketing (Kafle, 2013).

At the beginning of this study, I knew that I needed to set aside my preconceptions and prejudgments about horizontal violence, bullying and intraprofessional conflict occurring among RNs, in hospital nursing. In this study
bracketing was accomplished in several ways, I engaged in discussions with RN colleagues and my professors, to assess their understanding of HV and bullying as a cause of the shortage of RNs in hospital nursing. This was an opportunity for me set aside perceptions and biases. I reflected on my experience as a RN in hospital nursing, and my observation of the destructive behavior of RNs in the hospital workplace. I tried to clear my mind, of some of the behavior I had witnessed, to be neutral and unbiased while being an empathetic listener. My objective was to rely on the participants’ experiences to tell their story and not on me. I used the research questions to guide the interview discussion while focusing on the research topic. At times during the interviews, it was difficult to be non-judgmental. To maintain the quality of the data, I abstained from commenting.

According to Moustakas (1994), epoché is the first step of the phenomenological reduction process. Epoché is a Greek word meaning to refrain from judgment, to abstain from or stay away from the everyday, ordinary way of perceiving things. The Epoché process requires a new way of looking at things, a way that requires that we learn to see what stands before our eyes, what we can distinguish and describe. (Moustakas (1994, p. 34). By clearing my mind through the epoché process, I reflected on my professional experience with the destructive behavior of horizontal violence and bullying between RNs in the hospital workplace. Since I never personally experienced the destructive behavior from another RN, I recalled my nursing experience over the span of my 30-year career, which was positive and rewarding. Through this process, I could enter each interview with an open mind and open ears, with a desire to hear a story about HV and bullying from the perspective of the RNs who had experienced the behavior. Each
interview was unique, and provided a different insight into a complex world of HV and bullying that the participants experience.

Denzin (1989) described bracketing/epoché with the following steps:

Locate within the personal experience or self-story, key phrases and statements that speak directly to the phenomenon in question; Interpret the meanings of these phrases, as an informed reader; Obtain the subject's interpretations of these phrases, if possible; Inspect these meanings for what they reveal about the essential recurring features of the phenomenon being studies; Offer a tentative statement, or definition, of the phenomenon in terms of the essential recurring features identified. (p. 98)

As the researcher and a RN with hospital nursing experience, I became interested in this topic of horizontal violence and bullying, when I noticed the behavior of RNs that concerned me. While I did not personally experience horizontal violence, or bullying, during my career, I noticed the behavior occurring among RNs, later in my career. I observed the behavior when I had family members who were hospitalized, a brother who died in a hospital in Oakland, California and a niece who died in Fort Worth, Texas, and I was asked to serve as their medical power of attorney. During this time, I noticed what I considered to be tension between RNs in the hospital. In one situation, a RN complained about her nursing colleagues and the working conditions, she revealed her plans to leave the job. What was most concerning was my 80-year-old friend, who was not able to get her heart medication because of a dispute between RNs? In all these situations some intervention was needed, because when conflict between RNs happens, the patient suffers the consequences. After observing these various behaviors, I needed to know what was
happening and why it was happening in hospital nursing. With a public health background, from the Centers for Disease Control and Prevention, I am keenly aware of the health care needs of an aging population, and the concern of a shortage of RNs in hospitals. I became interested in horizontal violence, and bullying when I observed, what I considered to be questionable behavior and listened to the nurses’ stories.

It is important to note that bracketing is essential to data collection and analysis in phenomenological studies. According to Creswell (2007), bracketing is never perfect; there are “researchers who embrace this idea when they begin a project by describing their own experiences and bracketing out their views before proceeding with the experience of others” (p. 60).

**Data Collection**

Transcendental phenomenology is useful in researching any topic where the basic elements of the study will be the life experiences of the participants (Creswell 2006). To explore horizontal violence and bullying among RNs in hospital nursing, data was collected through informal conversations with each participant using open-ended questions prepared in advance of each interview. Turner (2010) stated, “the standardized open-ended interview is extremely structured in terms of the wording of the questions” (p. 758). The primary research question was: What are the lived experiences of RNs who experience horizontal violence, bullying, and intraprofessional conflict in hospital nursing? See Appendix C for details of interview questions. A subset of interview questions was utilized to facilitate data collection.
Table 2

Sample Subset of Interview Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q. 1:</td>
<td>How long have you been a RN?</td>
</tr>
<tr>
<td>Q. 2:</td>
<td>What form of nurse on nurse horizontal violence, have you experienced in the workplace? (Horizontal violence is act of bullying, intimidation, horizontal hostility, sabotage, verbal abuse, psychological abuse, oppression and interactive workplace trauma (Dellasega 2009). Horizontal violence is act of violence perpetrated by a nurse against a nurse. Bullying involves “repeated efforts to cause another person physical or emotional harm or injury. It can be an actual or perceived imbalance of power.</td>
</tr>
<tr>
<td>Q. 3:</td>
<td>Have you observed or witnessed incidents of nurse on nurse horizontal violence in the hospital workplace? (i.e., bullying, verbal abuse, non-verbal, or physical assaults)</td>
</tr>
<tr>
<td>Q. 4:</td>
<td>Have you been singled out for any form of horizontal violence in the hospital workplace?</td>
</tr>
<tr>
<td>Q. 5:</td>
<td>Who was the perpetrator of the horizontal violence you experience, were they male or female?</td>
</tr>
<tr>
<td>Q. 6:</td>
<td>What form was the violent behavior, exclusion, verbal abuse or insults, physical abuse or sexual harassment?</td>
</tr>
<tr>
<td>Q. 7:</td>
<td>How often did these incidents occur?</td>
</tr>
<tr>
<td>Q. 8:</td>
<td>How did these incidents of horizontal violence make you feel?</td>
</tr>
<tr>
<td>Q. 9:</td>
<td>Did horizontal violence and bullying behavior impact your productivity in the hospital workplace?</td>
</tr>
<tr>
<td>Q. 10:</td>
<td>How did you cope with the problem?</td>
</tr>
<tr>
<td>Q. 11:</td>
<td>What effect did the behavior have on your work life and on your personal life?</td>
</tr>
<tr>
<td>Q. 12:</td>
<td>What incident(s) of horizontal, bullying, intra-professional conflict influenced your decision to leave a job?</td>
</tr>
<tr>
<td>Q. 13:</td>
<td>To what extent, did these incidents influence your decision to leave your job?</td>
</tr>
<tr>
<td>Q. 14:</td>
<td>How did the hospital handle the problem?</td>
</tr>
</tbody>
</table>

Gall, Gall, & Borg assert that all participants are always asked identical questions, but the questions are worded so that responses are open-ended (as cited in Turner, 2010). This open-endedness allows the participants to contribute as much detailed information as they desire and it also allows the researcher to ask probing questions as a means of
follow-up (Turner, 2010). When necessary, additional questions were asked to clarify and expand certain responses. The interviews were semi-structured to facilitate rapport, empathy, and flexibility (Smith, 1995). Boyce and Neale (2006) stated that “semi-structured interviews contain components of both, structured and unstructured interviews” (p. 5). The questions remained the same for all six participants. I used an open and deep interviewing technique, carried out in a dialogical manner (Sloan & Bowe, 2014). Each interview ranged from 45 to 60 minutes. At the end of each interview session, I debriefed participants regarding the purpose of the interview and the confidentially of their participation. After each interview, participants were given the opportunity for a one-hour follow up interview to review completed transcripts for accuracy. The participants could also receive transcripts through a secured email system. Each participant preferred to follow up emails or telephone calls, rather than an additional interview session. The participants could call me for follow up sessions at any time.

After data collection, the next step was data analysis. In transcendental phenomenology, a systematic approach to data analysis requires the researcher to;

“describes their own experiences with the phenomenon (epoche); identifies significant statements from participants’ interviews; clusters the statements into meaning and themes; synthesizes themes into descriptions of the experiences of the individuals (textual and structural descriptions), and constructs a description of the meanings and the essences of the experience Moustakas (1994).”

**Data Management**

After IRB approval, the participants were provided with a consent form to review before they agreed to participate in the research study. I explained in detail all
expectations as a subject in the research study (see Appendix B). I explained that the study would not identify specific nurses or their employers. Participants were identified by assigned pseudonyms. The hospital workplace is identified only as private, public and government operated. I used a tape-recorder during interviews to capture data. After completion of each face-to-face interview, I transferred the taped files to a password-protected computer. I transcribed interviews as soon as possible after completion of the session. Limited access to all files is available as these documents are in a secure location. I used headphones to listen to the tape recordings in a secured location. As I completed transcripts, I compared the audio files to the written transcript multiple times to identify commonalities and themes from the data and ensure accuracy of the information. I will keep the files for 36 months and then shred all paper copies and delete computer files.

**Data Analysis**

The phenomenological data analysis process began with transcription of each participant’s interview. I listened to each recording several times to ensure the digital recorder captured all the data. I transcribed each interview verbatim to ensure that the transcriptions captured the essences of the experience. I filled in any gaps of missing words or phrases to capture the significance of the statement. I focused on statements from the interview regarding horizontal violence, bullying, and intraprofessional conflict experienced by RNs in hospital nursing. Using Microsoft Word 2013, I highlighted meaningful statements and added comments in the margins of the page next to the statement to identify horizons for further analysis. I developed a list of non-repetitive statements that captured the essence of the participant’s experiences. I completed this
process for each interview to ensure that I did not overlook any significant participants’ statements. In transcendental phenomenological approach, this process is known as horizontalization, in which each statement about the lived experience of the participants, is given equal value. Moustakas (1994) described horizontalization as the process in which the researcher lists every significant statement related to the topic and gives each equal value. As a RN with experience in hospital nursing, I envisioned participants’ descriptions of their experiences and how it made them feel. Moustakas (1994) explained that in transcendental phenomenological reduction, each experience is considered in its singularity, in and for itself. The phenomenon is perceived as fresh and open. A complete description is given of its essential constituents, variations of perceptions, thoughts, feelings, sounds, colors, and shapes (Moustakas, 1994, p. 34. Through the transcendental phenomenological reduction process, the researcher creates textural and structural descriptions of the phenomenon from the transcripts. The process of data reduction allows the researcher to capture the essence of the data (Moustakas, 1994). In this step, I labeled relevant comments found in the data, and clustered them into groups. I grouped all the nonoverlapping and nonrepetitive statements into clusters and the clusters into themes as recommended (Moustakas, 1994). In this study, the term cluster refers to statements that share some commonality regarding an issue (Westbrook, 1994). I created a separate document of highlighted statements and themes. I used the themes to construct textural descriptions of each participant’s experience. For each participant, a structural description is a “vivid account of the underlying dynamics of the experience, the themes and qualities that account for how feelings and thoughts connected with the phenomenon are aroused, what conditions evoke the phenomenon” (Moustakas, 1994, p. 122-135). In
the process of textural description, the researcher describes the meaning of the lived experience of the individual (Moustakas, 1994). After creating the textural description of each participants’ experiences, I used imaginative variation to create a structural description of the qualities of the experiences. The objective of imaginative variation is to discover the underlying and triggering factors that contribute to experiences (Moustakas, 1994). Moustakas (1994) described the steps of imaginative variation as varying the frames of reference and the perspectives. The last step of the data analysis process involved integration of the textural and structural descriptions. According to Moustakas (1994) the structural essences of the imaginative variation must integrate with the textual essences of the transcendental phenomenological reduction. I integrated these two components to investigate the phenomenon of horizontal violence, bullying, and intraprofessional conflict, among RNs, in the hospital workplace.

**Validity and Credibility**

According to Lincoln and Guba (1985), valid qualitative “research must establish the trustworthiness and authenticity through the naturalist’s equivalents” (as cited in Creswell, 1998, p. 197). Creswell and Miller (2000) provided strategies to gain validity in qualitative research. One of the strategies is the method of triangulation in which the researcher approaches phenomena under study from a variety or a combination of research methods (Creswell & Miller, 2000). Using triangulation, the investigator utilizes several sources of data, methods of data collection, and theories to provide corroborating evidence (Lincoln & Guba, 1985; Patton, 1990).

In this study, I used data from qualitative and quantitative studies of horizontal violence and bullying in hospital nursing. I interviewed hospital administrator/nurse
managers and RNs not participating in the study about the phenomenon of horizontal violence and bullying in the hospital workplace. O’Donoghue and Punch (2003) recommended cross-checking data for regularities using multiple sources. Triangulation of data involves cross-checking the perspectives of participants. The interview data can be cross-checked for regularities, bias, and distortions. I cross-checked interview data against past studies on horizontal violence, bullying, and the shortage of RNs in the hospital workplace. I compared participants’ experiences to what was found in the literature relevant to the phenomenon of horizontal violence and bullying among RNs in hospital nursing.

After completing transcriptions, I analyzed common themes. Clarifying researcher bias is critical so that the reader understands the researcher’s position and any bias or assumptions that may influence the research question (Creswell, 2013). The researcher should create a clear and transparent audit trail of the data collection process. Audit trails allow readers to trace the researcher’s logic and determine whether the study’s findings may be relied upon as a platform for further inquiry (Carcary, 2009). According to Koch (2006) trustworthiness of a study depends on whether a reader can audit the events, influences, and actions of the researcher. Akkerman, Admiral, Brekelman, and Oost (2006) suggested an audit trail is a way to assure quality in qualitative studies. I maintained an audit trail through bracketing, transcribing interviews, and providing information about how I identified horizons, grouped data into clusters, and coded data.

**Chapter Summary**

The target population for this study is RNs because of their pivotal role in hospitals and the projected nursing shortage. Using a transcendental phenomenological
design, I interviewed six RNs who experienced horizontal violence and bullying in hospital nursing. The study included one male and five female nurses. Three nurses self-identified as White and three Black with ages ranging from 28 to 55 years old. Nursing education levels included associate degree to master’s degree in nursing science. I interviewed the participants using predetermined interview questions, and analyzed data through the lens of transcendental phenomenology to provide an understanding of horizontal violence and bullying from the lived experiences of the RNs. The next chapter will discuss the findings of the study.
Chapter 4: Findings

This chapter summarizes the findings of the semi-structured interviews that I had with six RNs. The interviews captured the essences of horizontal violence, bullying, and intraprofessional conflict, among RNs, in the hospital workplace. For this transcendental phenomenological study, the primary research question is; what are the lived experiences of RNs who experience horizontal violence, bullying, causing intraprofessional conflict in hospital nursing? Horizontal violence is intergroup conflict manifested in overt and covert non-physical hostility such as sabotage, infighting, scapegoating, and criticism (Dellasega, 2009), bullying, causing intraprofessional conflict in hospital nursing? Horizontal violence is a complex phenomenon that is a manifestation of oppressed group behavior, causing low self-esteem and feelings of worthlessness among nurses. The phenomenon has contributed to some RNs decision to leave a job in hospital nursing. For the RNs in this study, horizontal violence caused intraprofessional conflict and created a hostile, unsafe work environment which prevent the nurses from performing their professional duties. The essences of the finding are that all participants experienced feelings of isolation, frustration due to a lack of peer and administrative support in the hospital workplace. There were five themes that emerged from the data analysis. The five themes are: (a) alienation; (b) intimidation; (c) sabotage; (d) lack of intellectual respect; and (e) failed professionalism or intraprofessional conflict. Horizontal violence is a well-documented phenomenon that has been studied among nurses in hospital settings, but it continues to be a problem among RNs, in hospital nursing. There is a body of literature that address nurse-on-nurse incivility, including nursing students, but there are limited studies investigating horizontal violence and bullying among RNs in hospital nursing.
Some of the characteristics of peer-to-peer horizontal violence include, bullying, scapegoating, blaming, coercion, aggression, and intimidation. The qualitative results will be presented with regards to the themes identified. In the interviews, the participants described feelings of isolation and frustration in the hospital workplace, due to a lack of support from fellow RNs, nurse managers and hospital administrators. Figure 1 shows these themes.

![Figure 1](image)

*Figure 1. Thematic Structure of the Experience of Horizontal Violence, Bullying, and Intraprofessional Conflict.*

The study was guided by four secondary research questions, and a subset of 15 discussion questions. In answering the primary research question most of the participants indicated that they had experienced HV and bullying, causing intraprofessional conflict in their nursing career. At the time of the interviews, of the six participants, one had left the nursing profession, four went to work in other hospitals and one went to work in a different department of the same hospital. Some participants described specific instances where they experienced HV or bullying such as giving a report and when asking questions about a medical procedure for a patient. In question one of the secondary
research questions, I asked the participants what acts or actions would they describe as horizontal violence (i.e., acts of violence perpetrated by a RN against another RN) and bullying in the hospital workplace. Several of the participants spoke of incidents where they witnessed horizontal violence and bullying behavior towards young nurses, from superior nurse managers.

All the participants are committed to the nursing profession and providing quality care to hospital patients. Some RNs talked about feeling of isolation, helplessness and disillusion about nursing and the nursing profession. The textural description of the participants’ experience with horizontal violence and bullying was expressed in the following words: powerful and powerless, respect, intimidation, lack of professionalism and a hostile work environment. To help the reader better understand the participants and their experience of horizontal violence and bullying, I provided a textural description of each research participant (See Appendix E).

**Theme 1: Alienation**

Several of the participants spoke about feeling alienated by their nursing peers in the hospital workplace, which made it difficult to perform nursing duties. This theme provided insight into the challenges RNs face when providing patient care and revealed how RNs feel. Carolyn said,

> I felt all by myself, some of the RNs would say hello to me but it wasn’t a friendly hello”. She spoke about acts and actions from other RNs that made her feel alienated. I was made to feel like I was not part of the team, when I walked into the break-room to eat lunch, the other nurses would get up and leave. They would not talk to me. I began eating lunch, alone, in my car, in the hospital parking lot.
She described it as a sometimes-hostile work environment. She said that these unfriendly behaviors were occurring around her, but did not know what to call it, she thought they were just being “mean girls”.

I divided the theme of alienation into two recurring subthemes: powerless in a powerful environment (see Figure 2).

![Alienation Diagram]

**Figure 2.** Sub-themes under Alienation in the Hospital Workplace.

**Sub-theme 1: Powerlessness**

Several of the participants stated that they felt powerless in performing their nursing duties at times. Nurses need power in the hospital environment to influence patients and other members of the healthcare team. I asked a participant, as a RN, to describe what powerlessness feel like in hospital nursing. The participant responded that feeling powerlessness, made her feel inadequate, incompetent and not able to deliver quality nursing care. Several of the participants described feeling powerless because they were not able to get support from their peers and management. Carolyn stated, “as a new nurse with not much hospital nursing experience, I asked the Charge Nurse for help with a medical procedure, I never got the help”. Feelings of powerlessness in hospital nursing can cause a chain of events, and intraprofessional conflicts can occur. In the case of one participant, she left the nursing profession, and all participants left a job in hospital nursing at some point in their nursing career. James described his feeling of
powerlessness as a power struggle with management, “they told me to do things that were just, some things were just against policy and something is just not right”. James stated, when I try to use my authority to enforce hospital policies and discipline the staff, the Chief Nurses would not support me. He stated, “the chief nurse did not support me as a nurse manager and the staff did not respect me. These participants felt powerless because they had no control over what was happening to them in the hospital workplace, a powerful environment.

**Sub-theme 2: Powerful Environment**

The participants spoke about the culture of the hospital workplace that made them feel powerless. Traditionally, hospitals are powerful organizations with a shared perception of policies, procedures and practices. Within the organization culture of hospitals, some behaviors are tolerated and perpetuated. Researcher have found that employee’s behavior is a response to the condition of the work environment. All the participants blamed the culture of the hospital organization for the perpetuation of horizontal violence and bullying. James stated that at the hospital where he worked, the administrators knew about problem of horizontal violence and bullying among the nursing staff, but did little about it. He stated, “the chief nurse in the hospital workplace created chaos and conflict to keep the nursing staff at odds with each other”.

He stated, that because of the hospital culture and operating systems, RNs have no one to complain to, due to fear of retaliation. Cirra, stated that the hospital administrator, in the hospital where she worked, knew about problem of horizontal violence and bullying in the intensive care unit, but did nothing about it and the high turnover rate among RNs continued.
When participants followed standard procedures for reporting bullying and HV behaviors, they were made to feel that they were the problem. All participants experienced this lack of support, when faced with acts of horizontal violence and bullying, at some point in their nursing career. Feeling powerless in a powerful hospital environment caused the participants to feel alienated and to become disillusioned with the nursing profession.

**Theme 2: Intimidation**

All participants believed that intimidation and bullying are common practices in the hospital workplace. The theme of intimidation includes bullying, harassment and belittling.

This theme aligns with the research question what actions or behaviors do RNs describe as experiences of horizontal violence (i.e., acts of violence perpetrated by a RN against another RN) and bullying in the hospital workplace? All participants reported incidents of intimidation from a fellow RN while working in hospital nursing. For most participants, it was a daily occurrence that had physical and emotional consequences. Vivian described her experience with intimidation on her first nursing job. “It was huge intimidation…at that time I thought it was discrimination. I thought it was a way to get me out, they were trying to weed me out and I left the job”.

The reoccurring sub-themes that emerged from intimidation were bullying and harassment. Figure 3 outlines the theme and sub-themes of intimidation.
Intimidation

Sub-theme 1: Bullying

Bullying among nurses has been a concern in professional nursing since the late 1970s and early 1980s. There is compelling evidence that lateral violence and bullying are common in healthcare workplaces. According to the literature review, there are various reasons why RNs bully each other, but mainly it is the desire to have power and control over another nurse. Several of the participants spoke of experiencing or witnessing this negative behavior in the hospital workplace. Cirra, a nurse manager, described the behavior of a charge nurses towards a young staff nurse. The charge nurse belittled a less experienced RN in the presence of her peers. Cirra observed a charge nurse removing a medication (Heparin, a blood thinner) from the Pixis (medication dispensing machine) and grilling a new young nurse on the method of administration. When the young nurse admitted, she did not know how to give the medication, the charge nurse humiliated her in the presence of other staff members. Bullying among RNs in the hospital is a common behavior. Carolyn spoke about being so anxious about coming to work that as she passed landmarks on the way to the job, she became more and more nauseated. She described it as “bubble gut”. Susan stated that she was bullied by other RNs, which caused her to have an emotional breakdown and she left the nursing profession. Carolyn and Susan’s
experience, answers the **SRQ 2**: What is the impact of HV (RN on RN) and bullying on nurses in the hospital workplace?

**Sub-theme 2: Harassment**

Harassment involves a wide range of destructive behaviors, such as verbal abuse, threats, intimidation, humiliation, excessive criticism, innuendo, exclusion and withholding information. Most of the participants spoke of experiencing or witnessing incidents of harassment. Carolyn spoke about being instructed by a fellow RN to change a doctors’ order when she could not contact the doctor. When she refused, the RNs became upset and said, “you don’t trust me” and began harassing her. The refusal led to gossiping and condescending attitudes towards her from other nurses, and she eventually found employment at another hospital. Harassment is a factor that contribute to RNs decision to leave a job in hospital nursing. Mary described being harassed by the charge nurse when she could not complete her work by the end of the shift. She stated, there was a constant threat to get out on time. “I needed my job, so there was a lot of charting done off the clock, because you just can’t get is all done”. While some RNs may leave a job in hospital nursing due to harassment, some chose to stay. James described that the chief nurse at his hospital tried to force him to reprimand a staff nurse who had done nothing wrong. She threatened to take disciplinary action against him if he did not carry out her order. Participants spoke of incidents of bullying, intimidation, and harassment that led to intraprofessional conflict and the decision to leave a job in hospital nursing.

**Theme 3: Sabotage**

Sabotage and workplace bullying are forms of HV that occur frequently among healthcare workers. Acts of sabotage were described by some of the participants. Since
the focus of this study is HV, bullying and intraprofessional conflict, I was not sure how
to explain what I was hearing in the participant’s stories. I used items in the Briles’
(1999) sabotage survey questionnaire (BSSQ) and the sabotage, abusive and bullying
behaviors survey to identify sabotage behavior in the participants’ stories. Sabotage is
deliberately setting up a negative situation (Briles, 1999). Sabotage includes intentionally
withholding pertinent patient information and treatment (Briles, 1999). In this study,
sabotage is defined as the act of undermining or destroying personal or professional lives,
damaging personal or professional credibility which can lead to the destruction or
dismissal of self-worth. In the context of horizontal violence, sabotage includes
tampering, meddling, shaming, malicious pranks, malicious hacking, and withholding
pertinent information. Such behaviors can have unfavorable consequences, contributing
to intraprofessional conflict.

Participants described incidents of sabotage perpetrated by fellow RNs to the
extent that the safety and wellbeing of the patient was a concern. Vivian described an
incident of sabotage at the hands of fellow RN that could have harmed the patient.

*When I heard my patient’s IV pump beeping, I went to check, and found the IV
bag empty. The patient told me that another came into the room and did
something to the IV, saying it was supposed to go fast. I confronted the nurse, and
she replied, the pump was beeping, so I just changed the rate. I asked, why didn’t
you call me? I was so furious, I was so mad, I was ready to fight. The next day I
didn’t come to work. I just quit. I didn’t call them.*

Carolyn spoke about experience RNs who would not share information about
hospital policy and procedures (i.e. withhold information) with her. In horizontal violence
and bullying, a frequent method of victimizing someone was to cease talking when others entered the room and complain about another RN without speaking to them about it first.

**Figure 4.** Elements of Sabotage.

**Sub-theme 1: Meddling**

In this study meddling is a form of sabotage, that interferes with the work of another RN, that can influence patient outcome. Susan described what happened when she needed to give a patient a blood transfusion, and needed one RN to check the order and other pertinent medical information. Susan said,

*I asked a nurse and she said it was no time; in the mean while the blood is getting warmer and warmer. The patient did not get the blood, within a reasonable amount of time. I went into the laundry room and I called my friend in tears. I said, I can’t do this. This happened on Sunday and I put in my two weeks’ notice on Monday.*

Carolyn, spoke about more experienced RNs who would not share information about hospital policy and procedures (i.e. withhold information). Sabotage is deliberately setting up a negative situation (Briles, 1999).

**Sub-theme 2: Shaming**

Shaming is the act of humiliating or finger pointing with the intent of reducing self-worth. This type of behavior can have emotional consequences, that influence the
RNs decision to leave a job in hospital nursing. Cirri described the hierarchy of an intensive care unit where she worked. She stated that the *unit had a high turnover rate for RNs. Senior nurses often mistreated new nurses. When new RNs came to work in the unit, they were mistreated by the previous group of new RNs, and the practice continued.* She described a vicious cycle of sabotage behavior that undermined the goals of the hospital and patient safety. She left the job at this hospital after six months. Susan described her experience of being shamed by a fellow RN, when she was assigned to work on an orthopedic floor and she did not know how to operate the equipment. She said, I asked the charge nurse to show me how to adjust the traction on a patient’s leg, and her response was you are an RN, you should know how to operate the equipment. From the participants experience, shaming made them feel inferior and incapable to perform their nursing duties.

**Theme 4: Lack of Intellectual Respect Causing Conflict**

The theme of a lack of intellectual respect emerged from the data when participants described feeling inferior because of their nursing training, decision-making capabilities, or nursing skills. This theme aligns with the research question regarding how horizontal violence and bullying contribute to intraprofessional conflict. Participants described behavior that reflected a lack of intellectual respect, but could not give it a name. For example, lack of *intellectual respect* describes a form of horizontal violence among RNs in hospital nursing that could not be found in the literature. Participants spoke of experiences where they were made to feel inferior due to their nursing training. Carolyn a nurse with an associate degree in nursing, and was planning to go back to school for her BSN, described how a peer nurse with a BSN, tried to bully her into
changing a physician’s orders, without consulting the physician. Another participant, who
did not receive her nursing training in the states, spoke about how she was made to feel
inferior, by her nursing peers. Susan described intellectual disrespect from a fellow RN.

As an older nurse, I worked in hospitals in New York, and I years of nursing
experience but I was made to incompetent, by my peers. I felt that I was always
having to prove myself to others. I was not respected for my nursing abilities.

These RNs felt that intellectual respect should be based on individual
competency, not a
degree. For example, a RN with an associate degree in nursing may feel inferior
to a RN with a BSN or master’s degree. A RN who trained in another country may feel
less qualified than those trained in the United States. The participants in this study
commented that there should be intellectual respect among RNs, after all, “we all went to
nursing school and passed state examinations for our license.”

![Diagram of Intellectual Respect]

**Figure 5.** Elements of Intellectual Respect.

**Sub-theme 1: Professional Identity/ Occupational Identity**

In nursing as with any profession, the development of professional identity is
important. As an RN, professional identity is important to self-esteem; it is the image we
have of ourselves and the perception that is held by society and the patients we serve.

Professional identity in nursing as with other professions, help to shape our lives and
define who we are as a person and a professional. Professional identity develops throughout the life of the individual, through life experiences and education. It is an identity that encompasses core values, morals, self-awareness and decision making; treatment of coworkers and patients. All participants spoke of incidents that caused them to question their professional identity as a RN.

Experiences of horizontal violence and bullying caused the participants to re-evaluate their professional identity and loyalty to the nursing profession. Carolyn described behaviors of BSN nurses towards her that made her feel inferior for having an associate degree. Nurses questioned her ability to perform various medical procedures, such as insertion of urinary catheters. Vivian, an RN who received her nursing training in a different country, described her experience at her first nursing job, in a hospital in the United States;

I received a lot of hostile behavior from fellow RNs. They would look over my shoulder to see what I was doing, when I was caring for a patient. The nurses would question my knowledge, skills and ability to provide nursing care.

Linda said, I worked in a hospital in New York and was never mistreated by other RNs, until I came to work at this hospital, they are so unprofessional. I don’t know if I should say this, but I am a Sigma Theta Tau (honor society of nursing) nurse and RNs should not behave like this.

Cirri spoke of the behavior of experienced RNs toward less experienced or younger RNs. They always questioned the new nurses’ knowledge and problem-solving skills. The participants stated that in the hospital workplace RNs must be viewed and respected as equal partners with all members of the healthcare team.
Sub-theme 2: Hospital Workplace/ Organization Culture

The hospital workplace has an organizational culture that has been linked to horizontal violence and bullying among nurses. The culture of an organization has been found to be a major factor in horizontal violence, bullying and intraprofessional conflict. Organizational culture includes items such as customary dress, language, behavior, beliefs, values, assumptions, symbols of status and authority, myths, ceremonies and rituals, which define an organization's character and norms. Based on the model of circuits of power, workplace bullying is a function of four organizational factors: (a) organizational tolerance and reward; (b) networks of informal organizational alliances; (c) misuse of legitimate authority, processes, and procedures; and (d) normalization of bullying in the workplace.

All participants spoke of working in a hospital environment where horizontal violence and bullying was common, tolerated, and perpetuated.

James spoke of his experience as a RN in a VA hospital. He was in the military, and then worked for the VA hospital system. As a nurse manager, he supervised several RNs and other members of the healthcare team. His supervisor, a RN, undermined his management decisions, interpretations, and application of hospital rules, regulations, and policies. He described the organizational culture of the VA hospital as corrosive, a culture of low morale, poor management, and widespread distrust between workers and supervisors that effected delivery of health care to veterans.

Cirri spoke of the organizational culture of an ICU inside a large hospital, an area that experiences high turnover of RNs. She described a hospital environment that was harmful to nurse careers and patient outcomes, but no managers or administrators
addressed the problem. Intellectual respect in the hospital workplace is important to the RNs, self-esteem and job performance. A lack of intellectual respect is a form of horizontal violence and bullying, that can be destructive to RN and the organization.

**Theme 5: Failed Professionalism**

The theme of professionalism or the lack of, emerged from the data, because the participants often stated that their fellow RNs were un-professional. To address the issue of failed professionalism in nursing, it is important to define professionalism. In the literature, professionalism is based on the concept of caring for others, including your fellow RNs, and excellence in nursing practice. Professionalism is defined as the level of skill, competence and behaviors expected of a professional. For this study, professionalism is the expected behavior of professional nurses, governed by rules, work ethics, ideologies and dedication towards a common goal. Limited literature was found describing what it means to an individual to be professional. A lack of professionalism by RNs, in hospital nursing was conveyed in different terms by the participants.

![Failed Professionalism](image)

*Figure 6. Elements of Failed Professionalism.*

**Sub-theme 1: Professionalism**

All participants spoke of a lack of professionalism among their nursing peers and the need for professionalism among RNs in the hospital workplace. I asked the participants what professionalism meant to them. How do RNs communicate/convey
professionalism when interacting with their peers? What is professional behavior? Some of the responses were, professionalism is the attitude and behavior of a professional individual. One participant stated that professionalism means respect, “to communicate and respect me as an equal”.

Susan spoke about professional nursing achievements that made her stand out among her peers.

*I am a Sigma Theta Tau (i.e. honor society of nursing) nurse, I have two licenses, I have a BSN, and I am made to feel stupid by my fellow registered nurse. I am frustrated with the profession, very frustrated. In the nursing literature, when an experienced registered nurse stands out, because of their qualifications, they become targets for bullying.*

James has a master’s degree, but others often challenge his management skills and abilities. He spoke of an incident when a nurse left her patients unattended for a length of time and no one knew where she was. When she reappeared, she refused to give an account of her absence.

All participants described behavior they considered below professional standards for RNs that led to intraprofessional conflict in the hospital workplace. One RN spoke about how other nurses “backstab” each other and talk behind each other’s back. This behavior made her feel that she could not trust her nursing colleagues. Carolyn stated that the behavior of her nurse manager was unprofessional.

*“She would talk about you behind your back with other nurses. She wanted me to gossip about other nurses, with and tell on them, and when I refused she would*
pick on me. She would use her position and power to manipulate the nurses, playing one against the other”.

Professionalism in clinical nursing at a time of a looming shortage of nurses in hospital nursing is becoming more problematic.

**Sub-theme 2: Power Imbalance**

It is not possible to understand horizontal violence and bullying in hospital nursing without considering the concept of power. Horizontal violence and bullying in the hospital workplace, involves an imbalance of strength and power. Power imbalance occurs when there are asymmetrical relations of power among people, when one person has more control or influence over the other.

All the participants described incidents where they experienced and imbalance of power, involving a nurse manager or supervisor.

James spoke about the behavior of an experienced nurse manager who yelled and screamed in verbal altercations with the staff when things did not go her way. Hospital administration knew about her behavior, because several nurses complained. “I filed a complaint against her, but nothing changed”. Carolyn spoke of ingroup and outgroups of RNs, and the dispositional circuit of power. She gave an example of the behavior, stating that a new nurse manager came to manage the unit where she worked, and brought RNs from the other hospital with her, to the new hospital. There was tension between the two groups of RNs. “The nurses who came with her, were favored over us, they were given easy patient assignments, days off, and holidays off. Some of the nurses complained to nursing administration about the favoritism, shown by the new nurse manager, but it fell on deaf ears”.
Cirri spoke of an incident in which nurse managers used their position to give preferential treatment to some RNs. When there was a disagreement between nurses, the manager would take sides rather than remain neutral. In hospital nursing jobs, “I experienced a lot of hostile behavior, such as back talking, isolation, people looking over my shoulder to see what I am doing not in a professional way. This behavior made me uncomfortable, because I was not part of the in group”. This unprofessional behavior resulted in a lack of trust and respect for nurses and the nursing profession.

Horizontal violence is a complex phenomenon that is a manifestation of oppressed group behavior, causing low self-esteem and feelings of worthlessness among nurses. The phenomenon of horizontal violence, bullying, and intraprofessional conflict, has contributed to some RNs decision to leave a job in hospital nursing, at some point in their nursing career. Horizontal violence a phenomenon that can be influenced by the work environment. Influences can include organizational culture of the hospital, personality factors of both the perpetrators and the victim of horizontal violence, and stress in the workplace due to the shortage of nurses, high patient workload, increased responsibilities.

Chapter Summary

The essences of the finding in this study was that all the participants described feelings of isolation and frustration due to a lack of support from their fellow RNs and administration, including nurse managers, supervisors and hospital administrators. In this study of horizontal violence, bullying, and intraprofessional conflict among RNs in hospital nursing, I uncovered five themes from the data. I included quotes from the
interviewees to support each theme and sub-theme. The next chapter will include conclusions of the study and implications of the findings.
Chapter 5: Discussion

This study examines the experiences of RNs, with horizontal violence, bullying, and intraprofessional conflict, in the hospital workplace. Many RNs are leaving jobs in hospital nursing and some leave the nursing profession. A major shortage of RNs in U.S. hospitals is expected by the year 2025. This chapter will review the purpose and research design of the study. I will also link the finding in the study to the literature and theoretical framework. Also, I will discuss the significant contributions of the study to the field of conflict resolution and nursing. In addition to, presenting recommendations and implications for future research. The primary research question is: What are the lived experiences of RNs who experience horizontal violence, bullying, and intraprofessional conflict in hospital nursing? The study revealed five themes from the data analysis which included alienation, intimidation, sabotage, intellectual respect, and failed professionalism or intraprofessional conflict. These themes emerged from the stories of horizontal violence, bullying, and intraprofessional conflict as told by the participants in this study. This qualitative study used a purposeful sample of six RNs who worked in hospital nursing and left a job due to horizontal violence, bullying and intraprofessional conflict. Taped interviews were used to explore their stories and collect data. From the literature review chapter, this section is organized into themes, which formed the conceptual basis for a review of the literature that focused on the participant’ experience and perception of intraprofessional conflict.

Significance of the Study

By exploring the lived experiences of these RNs, with horizontal violence and intraprofessional conflict, the investigator:
• Found the oppressive social structure of the hospital workplace to be a contributor to extraprofessional and intraprofessional conflict amongst RNs.

• Exposed how destructive horizontal violence, bullying and intraprofessional conflict can be for the individual RN, patient care, the nursing profession and the hospital organization.

• Found that horizontal violence, bullying and intraprofessional does contribute to the RNs, in this study, decision to leave a job in hospital nursing.

• Found that researchers of horizontal violence and bullying among RNs in hospital nursing did not make a strong connection between horizontal violence and bullying leading to intraprofessional conflict, resulting in job dissatisfaction.

**Contribution of the Study to the Field of Conflict Resolution**

Over the past decades, there has been a large body of literature on horizontal violence and bullying among RNs in the hospital workplace, but it is unclear as to how long nurses have been enduring this type of behavior. According to Hutchinson et al. (2006), horizontal violence is an accepted phenomenon within the nursing profession, a ‘norm’, and therefore it is underreported. In the literature, underreporting is a common theme within the topic of workplace violence (Erickson & Williams-Evans, 2000; Hutchinson et al., 2006). This research has shown that horizontal violence and bullying among RNs in hospital nursing continue to be a problem. The research is an attempt to examine the experiences of RNs with horizontal violence, bullying and intraprofessional
conflict using theoretical frameworks that include human needs theory, critical social
theory, oppression theory, feminist theory, and intergroup threat theory to describe the
various aspects of a phenomenon.

Conflict is part of human existence; it is inevitable. When there is conflict in the
hospital workplace, it is called horizontal violence, bullying or interpersonal conflict
which is aggressive and destructive behavior of nurses against each other (Woelfle &
culture of the work environment influences professional nursing practice and behavior.
According to Augsburger (1992) conflict arises from competition as people seek to
control, subordinate, destroy, and exclude others. Weeks (1994), argued that conflicts
arise when the needs of the other party, our needs, or the needs of a relationship are
ignored. Based on the finding in this study, participants feel that nursing careers in
hospitals failed to meet psychological and professional needs.

Connection to the Theoretical Context

Abraham Maslow Human Needs Theory (1943) is based on a hierarchy of needs
that has been the foundation for the development of other theories, such motivation
theory. Maslow (1943) argued that some needs take precedence over others; that needs
that are basic to human existence, must be satisfied before other are addressed. According
to Maslow’s (1943) theory all humans have a need for self-esteem and self-respect.
Esteem is the human’s desire to be accepted and valued by others.

All the participants were influenced by the psychological need of self-esteem and
the respect of others. All the participants recalled incidents, where they were made to feel
inferior and alienated by their peers. McClelland’s (1987) need theory (need for
affiliation, need for power, need for achievement) is based on the concept of human motivation. The theory provides a conceptual explanation of the job satisfaction and work performance of the RNs, in the hospital workplace.

All the participants spoke of their professional accomplishments in the field of nursing. All the participants had BSNs degrees, except for one who is planning to go back to school. One participant spoke of being licensed in two states and being a Sigma Theta Tau (i.e. honor society of nursing) nurse. And one participant had a master’s degree. To these participants their nursing career was a major accomplishment in their life. Becoming an RN helped to define them as a professional and establish their identity. Professional identity is an identity that evolved over the course of their training and nursing career based on a set of core values, beliefs, and assumptions about the profession that differentiates it from other professions (Weinrach, Thomas, & Chan, 2001). Professional identity is deeply rooted in individual self-esteem and commitment.

To evaluate professionalism in nursing, Miller (1985a, 1985b) developed a model of professional behaviors in nursing. These behaviors included education in an institution of higher learning, documentation of a scientific background, participation in the professional organization, demonstration of autonomy and self-regulation, maintenance of competency, and communication (Adams, Miller & Beck, 1996). These professional behaviors are the foundation on which professional nursing practice and careers are built. All RNs strive to measure up to these behavior benchmarks, but the participants in this study found it difficult in their workplace. Incidents of horizontal violence and bullying created barriers to autonomy, maintenance of competency and communication. In the literature, professionalism is based on the concept of caring for others, including your
fellow RNs, and excellence in nursing practice (Wynd, 2003). Another important and common characteristic of professionalism and conflict resolution is communication. Apker, Propp, Ford, and Hofmeister (2006) identified the four C’s of professional nurse communication: (a) collaboration; (b) credibility; (c) compassion; and (d) coordination. These skills are necessary to maximize effective communication. Effective communication is vital to changing the attitudes and behavior of individuals in the social construct of the hospital workplace.

Critical social theory. provided the framework for me to examine the participants’ experiences with horizontal violence and bullying in the hospital workplace, from a social construct of the hospital environment. In nursing research, critical social theory has been used to explain the link to the practice of nursing, the fact that most nurses are women, the role of nurses in society and the relationship between nurses and those who are oppressed (as cited in Cody, 1998). Critical social theory seeks to inspire individuals to action, towards social change in the direction of freedom and justice (Held, 1980). Encouraging RNs to become proactive in their approach to managing and preventing horizontal violence, bullying and intraprofessional conflict. All the participants described how horizontal violence and bullying from peer RNs made them feel powerless, in the hospital environment. Power is a fundamental aspect of social behavior, but it is not always exercised for the benefit of others (Mahon, & McPherson, 2014). Power imbalances are grouped into two broad categories: role conflict and goal conflict. This is the results of overlapping competencies and responsibilities, preconceptions that professionals have of their own role, and stereotypic perceptions that professionals hold of members of other disciplines (Mariano, 1998). As a nurse manager,
James stated that he felt powerless, in supervising his staff because the chief nurse, his manager, would undermine his authority. Cirra, a nurse managed described what she observed in the behavior of a nurse managers who mistreated subordinates. This bullying behavior can destroy the RNs professional competences, and make it difficult for the RN to maintain and improve their profession identity (Lee et al., 2014). Critical social theory has been instrumental in changing the behavior and attitudes of society, and liberating women in the world. In this study, critical social theory refers to empowering RNs, as a means of change the attitudes and behaviors towards horizontal violence, bullying and intraprofessional conflict in the hospital workplace. It is suggested that critical social theory encourages individuals to promote emancipation from oppressive sociocultural systems (Held, 1980).

**Oppression Theory.** has been used to describe nurses as a group and their behavior. Freire (1968), characterized oppression as assimilation, marginalization, self-hatred, low self-esteem, submissive behavior, and horizontal violence. According to Charlton (1998), “oppression occurs when individuals are systematically subjected to political, economic, cultural, or social degradation because they belong to a social group…results from structures of domination and subordination and, correspondingly, ideologies of superiority and inferiority” (p. 8). In the literature oppression has been documented as one of the causes of horizontal violence and bullying among nurses (Hutchinson et al., 2006). Participants in the study described the behavior of their fellow RNs, but did not know what to call it, they were not familiar with the term oppression. They described being marginalized, and feeling of low self-esteem but did not attribute it the behavior of others. One nurse stated that when she would walk into the lunch room,
the nurses would get up and leave. Another participant stated that she became so upset about the way she was being treated, she developed what she called “bubble gut”. “When I had to come to work, I would get an upset stomach”. Freire (1968) identified the dynamics of group behaviors and linked it to increased horizontal violence and bullying in nursing. In this model, the dominant group interacts with a subordinate group, resulting in the subordinate group taking on oppressed characteristics. Bartholomew (2006) argues that the nursing profession is rooted in subordination which cause some nurses to react with feeling of anger from the oppression and display horizontal violence or bullying behavior towards each other. An example of such behavior is sabotage. Dunn (2003) explained that sabotage acts are directed towards coworkers on the same level within an organizational hierarchy. Sabotage includes intentionally withholding pertinent patient information and treatment (Briles, 1999). Sabotage may include meddling or interfering in patient care. An example is if a nurse manager withholds patient treatment information or fails to inform a nurse of protocol for treating a patient with a heart condition. Tampering with equipment in the hospital workplace is another form of sabotage. When a fellow RN tampers with the medical treatment of another RN, and not tell her, this is an act of sabotage. Sabotage is a form of horizontal violence and bullying, which is an expression of oppressed group behavior (Woelfle & McCaffrey, 2007). Such behavior evolves from feelings of low self-esteem and lack of respect from others which is supported by the theory of oppression. According to Brunt (2011) “oppression exists when a powerful, prestigious group controls and exploits a less powerful group” (p.7). Researchers describe nurses as lacking in self-esteem, autonomy, accountability and power support. It is argued that nurses who experience having limited control and power,
such as in decision-making processes within the work environment (Hutchinson et al.),
may exhibit signs of oppression, including horizontal violence and bullying.
Managers have been found to be key players in the oppression form of horizontal
violence and bullying. Leiper (2005) argued that the most common bullies are nurse
managers. Taylor (2001) states that bullying “tends to filter from the top down and is
often seen as an acceptable way of managing and getting promoted” (p.407). Oppressed
group behavior may influence the shortage of RNs in hospital nursing.

**Feminist Theory**, helps to explore inequality in gender relations among RNs in
the hospital. The theory aims to understand the nature of gender inequality and focuses
on issues of rights, power, and sexuality (Flax, 1987). It involves the study of women’s
roles in society which include their rights, privileges, interests, and concerns. The role of
nursing in health care is the epitome of women’s role in American society (Corley &
Mauksch, 1988). The nursing profession is dominated by females, but a growing number
of males are joining. Participants in this study consisted of five females and one male, the
one nurse with a master’s degree. While none of the participants spoke of experiences of
gender inequality, it does play a role in hospital nursing. Researcher have found that in
some hospitals, male nurses a paid more than his female co-worker, which can contribute
to intraprofessional conflict. Researchers argued that the status of nursing among
professions, and the treatment of nurses and nursing in institutional and inter-
occupational relationships can be directly related to the devaluing of the female gender
(Corley & Mauksch, 1988). It is important to note, I found that male RNs experience
horizontal violence and bullying like female RNs. The male RN in this study experienced
bullying behavior from his superiors, peers and subordinates, all females. These findings
were unexpected, because of the perception of male and female roles in the workplace and society. These roles are best described by the concept of masculinity and femininity which is a perception that is based on gender. In this perception, it is expected that males will be masculine and females will be feminine. According to Hofstede (2001, p 297):

Masculinity stands for a society in which social gender roles are clearly distinct:
Men are supposed to be assertive, tough, and focused on material success; women are supposed to be more modest, tender, and concerned with the quality of life.
Femininity stands for a society in which social gender roles overlap: Both men and women are supposed to be modest, tender, and concerned with the quality of life.

In the literature gender is key to the bullying culture and women were found to be the aggressor. Based on the findings in this study horizontal violence and bullying in hospital nursing is an equal opportunity behavior.

**Intergroup threat theory.** Or realistic group conflict theory (RCT), is based on a type of conflict that is inevitable in groups and organizations due to the complexity and interdependence of organizational life (Amason, 1996). Intergroup threat theory includes realistic threats, symbolic threats, ingroup anxiety, negative stereotypes, group esteem, threat, and distinctive threats (Stephan & Mealy, 2011). Hospitals are complex organizations. In the hospital workplace RNs experience threats from various individual, including patients, patients’ family members, visitors, members of the health team, hospital administrators and other RNs. All the participants described experiences of feeling threatened by administrators and nurse managers. Feeling threatened can occur when differences in education influence group behavior of RNs who compete for power,
prestige, and status in the organizational structure (AACN, 2001). An RN with less than a BSN may feel threatened by RNs with an advance degree, such as BSN, MSN or PhD. Registered nurses with advance degrees, may feel threatened by nurse managers or nurse administrators, who have power. Intergroup threat theory occurs when there is an imbalance in power, usually from the top down. Power imbalance does lead to horizontal violence and bullying between superior and subordinate. Based on the model of circuits of power, workplace bullying is a function of four organizational factors: (a) organizational tolerance and reward; (b) networks of informal organizational alliances; (c) misuse of legitimate authority, processes, and procedures; and (d) normalization of bullying in the workplace. These organizational characteristics foster opportunities for bullying (Hutchinson et al., 2010). I used Clegg’s model of circuits of power to understand how power imbalance relates to bullying in the hospital workplace.

Hutchinson et al., (2010) explained the flow of power in an organizational culture in three distinct models, independent circuits: episodic, dispositional, and facilitative. The episodic circuit involves power at an agency level, getting individuals to do what they would not otherwise do and characterizing the daily routine of work (Hutchinson et al., 2010). The dispositional circuit is the power of social integration, which focuses on rules of practice, meanings of relationships, and group membership. The facilitative circuit is based on systems of reward and punishment (Hutchinson et al., 2010). Bullying behavior in hospital organizations exhibits each component of the model.

**Implications for the Study**

Horizontal violence and bullying in hospital nursing is a global problem that continues despite the looming shortage of RNs. Nursing literature have reported the
effects of horizontal violence and bullying for more than 20 years. This study will add to the literature, arguing that horizontal violence, bullying, and intraprofessional conflict among RNs contributes to the shortage of RNs in hospitals.

Nursing is an occupation at risk for horizontal violence and bullying in the workplace. Most nurses in the hospital workforce are women and women are more likely to be victims of horizontal violence and bullying than men (Carter, 1999). More educational programs are needed to educate RNs, to the signs and symptoms of horizontal violence and bullying as it relates to intraprofessional conflict. Hospital organizations must recognize and acknowledge horizontal violence and bullying as a problem with grave consequences for the RN, patients, and the organization. Hospitals must assume responsibility for the intervention and prevention of horizontal violence and bullying in the workplace. Future research is needed to explore the connection between intraprofessional conflict and the RN shortage.

Limitations of the Study

The findings in this study emerged from the perceptions of six RNs who worked in hospital nursing. I relied on the nurses’ ability to recall bullying experiences. The data from these nurses was based on their recollection of past events and experiences. One limitation of this study is that the research focused on victims of bullying, not perpetrators. While perpetrators may be in the sample, they were not identified as such because their responses may have been different from those who are not perpetrators. Bystanders and non-bullied individuals may have chosen not to participate in the study. Another limitation is that race and gender were not a variable of the study. The nursing profession is comprised of 92% women (U.S. Bureau of Labor Statistics, 2015). All RN
participants were from different cities in the state of Texas, and worked at different hospitals (public, private, and VA hospital). Due to the sensitive nature of the topic, participants granted only one interview. Some nurses worried about confidentiality of the interview and possible retaliation from hospital administration. This study investigated experiences of individual RNs, but the researcher cannot validate whether some of the experiences occurred in the hospital where the nurses worked.

**Recommendations**

The findings of this study clearly demonstrate that RNs believe that horizontal violence and bullying is a problem in hospital nursing and may contribute to RNs leaving jobs in hospitals. The hidden role of hospital institutions in the perpetuation of horizontal violence and bullying is not apparent in this study. When horizontal violence and bullying results from individual conflict, “questions concerning power relationships within organizations and the way the organizational agenda is implicated, remains invisible” (Hutchinson et al., 2010b, p. 38). This type of behavior must be exposed in the hospital workplace. Hospital organizations must recognize their role and responsibilities in perpetuating horizontal violence and bullying in the workplace. Horizontal violence and bullying resulting in intraprofessional conflict must not be tolerated in the hospital workplace. To prevent horizontal violence and bullying, conflict management and resolution skills must be taught to RNs, and members of the healthcare team. Hospitals should:

- develop education modules and training materials on horizontal violence and bullying to educate all workers including RNs.
• provide a safe work environment. RNs must be encouraged to report incidents of horizontal violence and bullying without fear of retaliation, such as a conflict resolution practitioner/mediator or ombudsman.
• provide RNs an opportunity to share their concerns about horizontal violence, bullying, and intraprofessional conflict with management and administrators.
• hold perpetrators accountable for their acts of horizontal violence and bullying and lobby for universal anti-horizontal violence and bullying policies.
• allow RNs to assume an active role in horizontal violence prevention in the hospital workplace.

Educating RNs to recognize the signs and symptoms of horizontal violence and bullying before it leads to intraprofessional conflict, can be empowering. McKenna et al. (2003) studied five nurses who spoke out against horizontal violence in the hospital workplace, they found that the nurses felt self-empowered and comfortable when confronted with issues of horizontal violence and bullying. Feeling empowered is a factor in managing and resolving conflict including horizontal violence and bullying. Empowerment has many meanings, but in the context of this study, it means to restore to individuals a sense of their own value and strength and their own capacity to handle life's problems (Bush & Folger, 1993). Hospital organizations should assume responsibility for horizontal violence and bullying in the workplace by supporting and empowering RNs. Programs should be designed to raise awareness about horizontal violence and the benefits of conflict resolution training. Most importantly, hospital organizations need to
develop, implement, and enforce policies that address the disruptive influence of horizontal violence and bullying in the workplace.

Finding for this study could be disseminated to national and international nursing organizations, such as ANA, Sigma Theta Tau International, at their annual meetings. Seminars and workshops could be conducted in schools of nursing, nursing research groups, meeting of hospital administrators, such as the American Hospital Association. Also, this information could be published in nursing journals, such as:

- American Journal of Nursing a peer reviewed nursing journal
- The *AORN Journal* the official journal of the Association of periOperative Registered Nurses (AORN), is a peer-reviewed nursing journal in the field of perioperative nursing.
- *Human Resources for Health* is a peer-reviewed open-access public health journal publishing original research and case studies on issues of information, planning, production, management, and governance of the health workforce, and their links with health care delivery and health outcomes, particularly as related to global health
- The *International Journal of Nursing Studies* is a peer-reviewed nursing journal published by Elsevier. It covers the delivery of care in the fields of nursing and midwifery
• The *Journal of Research in Nursing* is a peer-reviewed nursing journal that covers the field of nursing

• *Journal of Professional Nursing*

• *Nursing Ethics* is an academic journal which analyses official documents and publishes articles on ethical and legal issues within the Nursing field. The journal aims to relate each topic to the working environment with a practical approach.

• *Nursing Management* is a nursing journal covering the practice of nursing management.

• *Nursing Times* the United Kingdom. The magazine and its website (www.nursingtimes.net) publish original nursing research and a variety of clinical articles for nurses at all stages in their career.

• *Nursing Standard*, a professional magazine that contains peer-reviewed articles and research, news, and career information for the nursing field.

**Conclusion**

The purpose of this study was to explore the lived experiences of RNs who at some point in their nursing career left a job in hospital nursing due to horizontal violence, bullying, and intraprofessional conflict. For years, researchers have studied the problem of horizontal violence and bullying with no definitive resolutions. This study provided information related to horizontal violence and bullying among RNs in the hospital workplace. Horizontal violence and bullying, is a real problem with real consequences. Hospital organizations must recognize horizontal violence and bullying as a problem impacting the RN workforce. An approach to solving the problem of horizontal violence, bullying and intraprofessional conflict is education. RNs should receive conflict
resolution training and learn effective communication skills for managing interpersonal, intra-group and intraprofessional conflict. Managing and resolving conflict in the workplace can result in a healthy work environment which is important for RN retention, patient care, and the mission of the hospital organization.
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PARTICIPANTS ARE NEEDED FOR A

Upcoming Study of Horizontal Violence Involving RNs

Have you or RNs that you know, left a job in hospital nursing because of physical violence, verbal abuse, bullying or intimidation from another RN? If so, you may be eligible to participate in this study.

My name is Joyce Goff; I am a registered nurse, and Ph.D. candidate at Nova Southeastern University, Department of Conflict Resolution Studies College of Arts, Humanities, and Social Sciences, Fort Lauderdale, FL.

As a participant in this study, you will be asked to: Tell your story and talk about incidents of physical violence, verbal abuse, intimidation or bullying from other RNs.

Your participation would involve 1, 2 or 3 interview sessions, each of which is approximately (45-60) minutes or more.

For more information about this study, or to volunteer for this study, please contact: jg876@nova.edu

All information will be kept confidential.
Appendix B: Participant Consent Form

Consent Form for Participation in the Research Study Entitled Registered Nurses Decisions to Leave Hospital Nursing: An Interpretative Phenomenological Analysis of the Experiences of Horizontal Violence, Bullying and Intra-Professional Conflict

Funding Source: None

Principal investigator
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(817) 595-5188

For questions/concerns about your research rights, contact:
Human Research Oversight Board (Institutional Review Board or IRB)
Nova Southeastern University
(954) 262-5369/Toll Free: 866-499-0790
IRB@nsu.nova.edu

What is the study about?
You are invited to participate in a research study. The goal of this study is to explore the lived experiences of registered nurses who choose to leave hospital nursing.

Initials: ________ Date: ________
Why you are being invited.

We are inviting you to participate because you are registered nurses who have experience working in a hospital environment. There will be 6 to 8 participants in this study.

If you agree to participate in this study:

If you volunteer to participate in this study, you will be asked by the researcher, Ms. Goff the following: Provide responses during an interview (60-90 minutes in length) regarding your experience of workplace violence (i.e. horizontal, lateral and bullying). Thereafter, you will have the opportunity to review the written transcript of your interview and make any corrections that may be necessary. Your approximate time to review your transcript is no more than 90 minutes.

Is there any audio or video recording?

This research project will include audio recording of the interview. This audio recording will be available for you to hear from the researcher, Ms. Joyce Goff, the IRB, and the dissertation chair, Dr. Urszula Strawinska-Zanko. The recording will be transcribed by Ms. Goff, who will use earphones while transcribing the interviews to protect your privacy. The recordings will be kept securely in Ms. Goff’s possession in a fire-proof safe with a lock. The recording will be kept for 36 months from the end of the study. The recordings will be destroyed after that time by shredding the tape. Because your voice will be potentially identifiable by anyone who hears the recording, your confidentiality for things, you say on the recording cannot be guaranteed although the researcher will try to limit access to the tape as described in this paragraph.

Initials: ________ Date: ________

Page 2 of 4
What are the risks to me?
Risks to you are minimal, meaning they are not thought to be greater than other risks you experience every day. Being recorded means that confidentiality cannot be promised. Sharing your opinions about the experiences you encountered may make you anxious or bring back unhappy memories. If this happens Ms. Goff will try to help you. If you need further help, she may suggest sources you may, but you will be responsible for the payment of such service yourself. If you have questions about the research, your research rights, or if you experience an injury because of the research please contact Ms. Goff at (817) 595-5188. You may also contact the IRB at the numbers indicated above with questions about your research rights.

Are there any benefits to me for taking part in this research study?
There are no benefits to you for participating.

Will I get paid for being in the study? Will it cost me anything?
There are no costs to you, but you will receive a $25.00 American Express gift card for participating in this study.

How will you keep my information private?
Confidentiality is a priority in conducting this study and is mandated by law; therefore, the questions you will be asked will not be specific to any information that could be linked to you to your involvement with this study. The transcripts of the tapes will not have any information that could be linked to you. As previously mentioned, the tapes will be destroyed 36 months after the study ends. All information obtained in this study is strictly confidential unless disclosure is required by law. The IRB, regulatory agencies, or Dr. Urszula Strawinska-Zanko may review research records.

Initials: ________ Date: ________
Appendix C: Interview Questions

**Interview Questions**

Interview Questions will be open ended, beginning with; tell me, in your words, the story of your nursing experience at ____________ hospital.

Q. 1: How long have you been a RN?

Q. 2: Have you ever experienced any form of nurse on nurse horizontal violence where you worked? (*Horizontal violence is act of bullying, intimidation, horizontal hostility, sabotage, verbal abuse, psychological abuse, oppression and interactive workplace trauma* (Dellasega, 2009). *Horizontal violence is act of violence perpetrated by a nurse against a nurse. Bullying involves “repeated efforts to cause another person physical or emotional harm or injury. It can be an actual or perceived imbalance of power.*

Q. 3: Have you observed or witnessed incidents of nurse on nurse horizontal violence in the hospital workplace? (i.e., bullying, verbal abuse, non-verbal, or physical assaults)

Q. 4: Have you been singled out as an individual for any form of horizontal violence at work?

Q. 5: Who was the perpetrator of the horizontal violence you experienced, were they male or female?

Q. 6: Was the perpetrator of the horizontal violence behavior a manager or a peer?

Q. 7: What form did the violent behavior take; exclusion, verbal abuse or insults, physical abuse or sexual harassment?

Q. 8: How often did these incidents occur?

Q. 9: How did these incidents make you feel?

Q. 10: How did you cope with the problem?
Q. 11: What effect did the behavior have on your work life and on your personal life?

Q. 12: What incident(s) of horizontal, bullying, intraprofessional conflict influenced your decision to leave a job?

Q. 13: To what extent, did these incidents influence your decision to leave your job?

Q. 14: How did the hospital handle the problem?
Appendix D: Demographic Questions

Demographic Questions

AGE: 25-30_______ 35- 40_________ Over 50_________

GENDER: Female_________________ Male______________

What is you nursing education (diploma, AD, BSN, other) __________________?

How many hours per week, do/did you work in nursing? ___________________

Are you currently working in a hospital, if so, what shift? _________________

What area do you work in? (ED, Medical Surgical, OB, ICU) ________________

How long have you worked in your current nursing? _______________________

How many hospitals have you worked in? ________________________________
Appendix E: Textual Description of Research Participants

Carolyn is a young RN, from a small town in Mississippi. She has eight years of nursing experience, she is married and have school age children, her husband was in the military. She has an associate degree in nursing but wants to go back to school for her BSN. Carolyn has been a nurse for eight years, she stated;

_I started out in a private sector hospital on a medical/surgical unit, I stayed there for two years. I’ve been a dialysis nurse, nursing home, long-term care supervisor and charge nurse. I have also been a hospice care case manager. I went back to the VA because I miss the patients. She stated, “if a patient has made it to the hospital, then they really need help; they’re really seeking help and I love being a part of, their healing and helping them._

Vivian is an RN who received her nursing training in London, England and moved to the United States, with her husband. She had to adjust to several things in a new country, such as, the language, culture, and in the hospital policies and practices. She has worked in only two hospitals in the U.S. She talked about her experience in the first hospital she worked in, it was in Chicago, Illinois. She talked about how she was treated by her fellow RNs, and that she did not understand the behavior or why it was happening. The behavior became so unbearably until she walked away from the job. She and her family moved to Texas, and she has worked at her current hospital for 14 years, where she has had an opportunity for career growth and development. She has been in her current job for 4 years, she is the only employee health nurse in this facility of probably over 1000 employees, she has a small office, where she provides occupational health services to hospital employees.
Susan is the oldest of the research participants. She worked for two years in New York and then came to Texas and worked for about six months. She is licensed in two states Texas and New York. She is very proud of her professional accomplishment. She said, “I am a Sigma Theta Tau nurse, I have two licenses and I have a BSN. She left the profession to stay home and raise kids. She went back to work after being away for 27 years. She went back into the profession because she needed health insurance and was divorced and needed to work and I keep my license current.

Mary has been an RN for six years, and worked in three different hospital. She is the primary wage earner for her your family, she has two young children. She has worked in her current hospital for three years. In her first hospital job, she started as a graduate nurse (RN I) and moved up to RN II, and then I left the facility after six years, she had a problem with the management. I felt I didn’t get enough nursing support when I needed it, from the nursing staff or the management.

Cirri a nurse manager, has worked in two hospitals and has been in her current job for three years. In a hospital where she worked in the ICU, she described the horizontal violence and bullying behavior as hazing. She observed behavior among fellow RNs, and attributed it to the culture of the hospital.

James is the only male participant in the study. He served in the military and now work in a hospital. He has a master’s degree in nursing and has worked in six hospitals. He has been at his current nursing job for six-months. He talked about the culture of the hospital, a lack of support from other nurses and management, power and unprofessional behavior of RNs towards each other.