An Integrative Literature Review

On

Bullying Among Nurses

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Abstract

Although recent studies on nursing stressors have been concentrating on the stress of patient care at the bedside, research have also shown that nursing environments are a major contributor of stress. The impact of working in a stressful environment and a perceived lack of management care for their nurses, have brought in a new problem, bullying among nurses. I conducted a literature review where I found that bullying among nurses is not a new issue, and it is not concentrated in the U.S. alone. Bullying among nurses is an international problem that affects not only nurses, but entire organizations, leading to nursing low self esteem and self doubt, which in turn increases the number in medical errors, leading to poor patient care, low patient satisfaction, and even deaths. Many nurse leave the profession as a consequence of these negative behaviors. Understanding the origins of these negative behaviors may help solve this problem or at least decrease the amount of the victims. A research was performed using bibliographic databases such as EBSCohost, ProQuest, PsychInfo, Medscape. Some information was found for organizations to take responsibility for some of these behaviors and their management. Proper training on professional behaviors needs to be implemented as soon as possible. Currently there is a shortage of nurses and negative behaviors such as this, only leads to unhappy nurses leaving the profession. In my research of some recent studies, a large number of new graduates were found to be leaving their first job in less than a year, declaring that one of their reasons was the complain of being bullied by other nurses. Very few articles were found where actual education was implemented to deal with these type of negative behaviors. If we ought to see an increment on patient satisfaction, a decrease in medical errors, a decrease on nurses calling in sick, and an increase in young nurses starting the profession, bullying needs to be addressed immediately.

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Chapter One

Introduction

Conflict among staff nurses have been identified as an increasing problem in healthcare settings around the world (Almost, 2006). The U.S. National Health Service (2008) reported that violence against nurses is significantly underreported, and this makes it difficult to point the events out or to develop effective strategies to reduce the violence (Anderson, 2011).

According to Felblinger (2008) workplace violence and bullying behaviors are intimidating forces that result in humiliating responses and menace the well being of the bullied nurses. Since these behaviors affect the organizational atmosphere and their negative effects tend to multiply if left unchecked. Interventions for bullying behaviors are needed for both, individual and administrative levels (Felblinger, 2008).

According to a survey released by the Workplace Bullying Institute in the fall of 2007, 54 million U.S. workers have been bullied at some point or seen other employees being bullied. Unfortunately, bullying behavior is hard to prove, since its definition can range from person to person (Bell, 2011). The negative effects of workplace bullying have been linked to decreased job satisfaction, increased job stress, higher turnover ratios, lack of team collaboration, higher absenteeism, damage to the work environment, delivery of poor patient care, and an increase in medical errors (Cleary, Hunt, & Horsfall, 2010). This negative climate among staff nurses has had a major impact on nurses' self-esteem, physical and mental well being, as well as the ability to provide excellent direct patient care (Almost, 2006).

Problem Statement

Workplace bullying is a very serious problem affecting the nursing profession. According to the Center for American Nurses (2008) bullying is defined as any act of repetitive verbal or

physical abuse, in which the victim suffers threats and humiliating and intimidating behaviors, and/or can also be an abuse of power conducted by an individual or group of individuals, against someone, interfering with the person's job performance, placing at risk the health and safety of the victim and the patients under the nurse's care (Murray, 2009). Job satisfaction is essential to the attraction of qualified nurses to the profession as well as the retention of licensed personnel (Murray, 2009).

According to an article published by the Journal of Nursing Management (2010) there is currently a worldwide shortage of nurses. This is especially noticed here in the U.S. where the nursing shortage is expected to increase by twenty percent by the year 2020 (Hayes, Bonner, & Pryor, 2010). In direct relation to this problem is the rising trend of a higher percentage of new graduate nurses leaving the work force within their first year of graduation (Morgan & Lynn, 2009). In a descriptive study, 551 nurses who had served their first year as nurses completed questionnaires. 34% of respondents reported having suffered some form of bullying and 1 out of 3 of these nurses indicated the desire to leave the profession due to the bullying and violence they experienced (McKenna, Smith, Poole, & Coverdale, 2003). The impact and implications of bullying are immense to the nursing profession, evidence has shown that these disruptive behaviors are psychologically distressing (Andrews & Dziegielewski, 2005). Bullying is a major contributor to job dissatisfaction which in turn forces many front line nurses to leave the profession due to the emotional stress endured (Almost, 2006). This problem has become so prolific that it led the Joint Commission to establish a new leadership standard of practice which holds a zero tolerance for disruptive, intimidating, and bully type behaviors (Joint Commission, 2009). With such a pervasive problem, the future of the nursing profession itself may be at stake (McKenna, et al., 2003).

Significance of the Problem

Horizontal violence and bullying have been reported widely among nurses resulting in serious negative outcomes pertaining to patients and other health care professionals (Almost, Doran, Hall & Laschinger, 2010). These disturbing behaviors lead to unconstructive behaviors among nursing staff and have a discouraging impact on the retention of valuable nursing staff (Andrews & Dziegielewski, 2005). For this reason, the most daunting tasks for managers to face are to create cultures of retention and to foster healthy work environments (Kramer, 2012). Job satisfaction varies according to the nurses' working environment. Almost (2006) documented that when conflict, such as staff's poor attitudes, aggressive behaviors, and willingly refuse to provide help, persists within the nursing environment, these behaviors bring dissatisfaction to the profession. Dissatisfaction has been connected to negative behaviors and the desire to quit the job (Almost, 2006). Unresolved interpersonal conflict also plays a role as it increases the level of stress and frustration among nursing staff. These unresolved issues lead to irritable and aggressive nurses who then release their inner frustrations, through bullying, other innocent coworkers, and ultimately increases the amount of hostile working relationships (Ehrhart et al., 2012). It is a vicious cycle, which is often caused by the stressful nature of the job itself, which often includes heavy workloads. However, if bullying is used as a coping mechanism, it is not something that should be tolerated (Ehrhart et al., 2012).

Purpose Statement

The purpose of this project is to example the literature which demonstrates the effects of bullying on the collaboration and communication among nurses and other healthcare professionals. The project also examined the influence of this behavior on the delivery of patient care and the resulting impact of the latter (Purpora, 2010). The role that bullying plays in the work environment will be investigated through its effects on the retention of nurses, their

impaired productivity and team collaboration, and how subsequent responses to bullying, trigger a lack of teamwork, fosters medical errors and poor patient care (Purpora, 2010).

It is inherent that these negative effects of bullying be removed from the workplace. This may begin by reviewing literature on the topic and searching for causes and solutions. As a possible solution, an appropriate code of conduct may be established and followed along with educational materials being provided in order to help eradicate these disturbing behaviors from the workplace (Sa & Fleming, 2008). In addition, the culpability that health organizations have in fostering these behaviors must be reviewed. This is especially so in regards to how some bullying may occur as a consequence of the increased demands for compliance and performance requirements placed on staff nurses (Sa & Fleming, 2008). In order to find an effective solution to bullying, it is also important to review the current literature to find solutions, or approaches previously utilized in an effort to stop the bullying cycle and to find out if any of these approaches have worked at all or in part to decrease some of these behaviors.

Throughout this project information about the causes, triggers and impacts of bullying will also be provided in a comprehensible integrated literature review, compiled from an abundant source of articles published in relation to the subject of workplace bullying. This review will also explore different aspects such as a) how is bullying affecting the care provided for patients and their families, b) the challenges of bullying to the organizations, c) the long term effects bullying creates to the intimidated victims and d) its effects on a nurse's self-esteem and how this promotes medical errors.

Chapter Two

Integrative Review of the Literature

According to Sheridan-Leos (2008) any hostile and/or aggressive approach or behavior by an individual or group members directed towards another member or members is considered bullying (Sheridan-Leos, 2008). Any overt or covert behavior, abusive and undermining language that the nurse perceives to be harsh or demeaning and disruptive, any condemnatory attack professionally or personally perceived as an aggression, or any intimidating body language, is considered bullying (Embree & White, 2010). However, conflict is inevitable within healthcare working environments and it has been defined as a struggle or contest between nursing personnel with opposing ideas, needs, beliefs, values or goals (Whitowrth, 2008). Conflict is considered an integral part of our modern working environments and thus a part of the nursing profession which is due to nursing jobs being competitive, complex, and stressful (Zakari, et al., 2010).

In a study conducted among 346 nurses in Saudi Arabia, four types of conflicts were considered: intrapersonal or internal conflicts within self, interpersonal or conflicts with another staff member, intergroup support or conflicts within the same department, and interdepartmental or conflicts with other departments. In addition, the Saudi Arabia participants' perceptions on what conflict conveys on professionalism were explored among the 82% of the participants who responded, and these nurses agreed that interpersonal conflicts are the most common type of conflicts within the workplace, having the strongest correlation with a lack of professionalism among staff members (Zakari, et al., 2010).

In this study by Zakari, et al., (2010) the responses also defined how the nurse's perception of lack of professionalism correlates with the workplace negative environment pushing registered nurses to lose interest in the nursing profession. One third of the participants

agreed that there is a connection between good nursing relationships and increased professionalism, when good relationships among nursing staff leads to good working conditions, professionalism is seen as a key to maintain nurses interested in the profession. Workplace factors play an important part on nurses desire to continue in the workforce. Some factors were mentioned, such as how nursing hierarchy within the organization and the type of assignments dealt to them play an important part on a nurse's satisfaction, since some nurses may react poorly to their particular assignment, especially when it increases their stress levels and causes them exhaustion. Another workplace related issue that may foster dissatisfaction is the perception in the amount of professional support received from supervisors, manager's and/or other higher leaders (Martin, et al., 2007). Additionally, mentioned in this study was another factor that generates frustration, demoralization, and decreases the perception of professionalism among nursing staff, and it is the frequent shortage of staff, lack of resources, or equipment malfunction. A lack of unit's staff shortens the nurse's ability to care for patients, increasing the tasks that the nurse needs to complete on time, and increasing stress levels and frustrations among nurses (Zakari, et al., 2010).

Hutchinson (2009) compares the characteristics of bullying among nurses with childhood bullying and states that the effects of bullying on a person's psyche are detrimental and can often cause long-term negative effects on the victim's self esteem and ability to perform their job (Hutchinson, 2009). Namie & Yamada (2010) provided some examples of similar behaviors between workplace bullying and childhood bullying. Some of these examples are: name calling, overly critical comments, belittlement or humiliation, exclusion from group activities, and terrorizing (Namie & Yamada, 2010). All of these behaviors fall under the definition of bullying that is being considered for the sole purpose of this project which is the following: behaviors that are characterized by repeated torturous acts of aggression against someone, intimidation,

humiliation, defamation of character, rude behavior, constant criticism, de-evaluating someone's character, persistent demeaning words and cruel acts that undermine the nurse's confidence (Stagg & Sheridan, 2010). In addition, bullying can occur within same nursing ranks or between managers and staff nurses (Hutchinson, 2009). Charge nurses or co-workers may sabotage a job assignment by not providing enough needed information to perform the task, grouping and teaming against a co-worker is also considered bullying (Whitowrth, 2008). According to Brinkert (2010) other common approaches frequently used by bullies, are the use of verbal and non-verbal hints or remarks. These behaviors may create conflicts among staff members, incrementing the tension and affecting everyone else around, even when someone is not directly involved in the conflict, but may be a witness to the hostile behavior. Verbal attacks may be easily distinguished because the aggressor could utilize an elevated and aggressive tone of voice when speaking to another nurse. This may happen when the aggressor holds a higher position such as charge nurse, supervisor or a manager (Brinkert, 2010). The non-verbal abusive behaviors can be a little harder to prove, since the aggressor can argue that the victim is assuming the hostility (Nemeth, et al., 2007). Non-verbal behaviors can be as simple as rolling the eyes up and ignoring someone's request purposely (Brown & Middaugh, 2009). These disruptive and aggressive behaviors may have a harmful effect on an organization, as they begin to multiply among other nurses. This may be especially so, when lack of response from management may be perceived as tolerance for these behaviors. Additionally, this lack of action can then transcend to other units as a common ignorance in the practice of proper authoritative procedures (Olender-Russo, 2009).

The difference between horizontal violence and bullying behaviors is slight. Horizontal violence may be isolated behaviors between nurses, without any positions of power between them, and can be perceived as more direct and aggressive behaviors which may include un-

welcomed and un-witnessed touching from the aggressor, and may only happen behind closed doors, when the victim and the provoker are alone (Nemeth et al., 2007; Simons & Mawn, 2010). Some of the characteristic behaviors that nurses perceive as horizontal violence are rude behaviors, physically pushing, abrupt and hasty behaviors, intimidating and hostile approach, loosely repeating what has been said, name calling, and shoving someone physically (Embree & White, 2010). These horizontal violence incidents and confrontations among co-workers are behaviors a lot more difficult to prove than witnessed behaviors, since many times, these incidents are un-witnessed and done behind closed doors (Embree & White, 2010).

Amendolair (2012) described caring as the essence of nursing and as once of the reasons nurses join the profession. Caring is what makes nurses feel that their professional identity enhances their well being. Unfortunately, in today's hospital settings, nurses frequently encounter barriers in their ability to provide care for their patients, reporting that with the excessive workloads there is a decreased in time to provide care for patients. Therefore, this inability to adequately attend to the most fulfilling aspect of their jobs and find meaning and value in their work, has contributed to a decline in job satisfaction (Amendolair, 2012). When a nurse does not enjoy the job anymore, and the level of stress overcomes the satisfaction of providing care and help to others, the nurse may consider to leave the job (Hayes, et al., 2010). Nurses are, of course, as human as anyone else and their personal life will undoubtedly be filled with their own set of issues. Relating to things such as marriage, family, kids and friends, and when job satisfaction declines and the tension among co-workers increases, the nurses own issues, that once were manageable, may become strenuous and intolerable. In turn, this inability to cope with any more stressors may lead nurses to walk away from one of the sources of their problems, which is their job (Hayes et al., 2010).

Some reasons that may contribute to negative behaviors in the workplace may also be the different emotional responses to stressors. Some may be the different ethnic backgrounds, because difference in ethnicity and culture may play a role on how nurses respond to criticism, and as a consequence, may lead to trigger some bullying behaviors among nurses (Olender-Russo, 2009). Some of these negative behaviors may be the result of the increased stress caused from high job demands, low job control or poor autonomy, low social support from peers and supervisors, difficult patient assignments, short staffing, the organization demands for yearly compliance, frequently changing performance requirements, and the lack of emphasis organizations place on unethical behaviors (Clegg et al., 2010; Ehrhart et al., 2012). Sheridan-Leos (2008) meta-analysis of the concept of bullying and horizontal violence, described that when some nurses experience unresolved stressors that persist for a long period of time, interpersonal conflict may arise. With interpersonal conflict some bullying behaviors and even horizontal violence may be used as a coping strategy. Recognizing these stress factors that trigger interpersonal conflict is important. Working on these issues may help managers find solutions to decrease the negative bullying behaviors. Decreasing interpersonal conflict may help reduce the violence among nurses. Sheridan-Leos (2008) described bullying behaviors mainly as a reaction to interpersonal conflict and not meant to target any single individual (Sheridan-Leos, 2008).

The following examples of job stressors may trigger nurses into behaving in a negative way toward one another: the ongoing changes in healthcare and hospital regulations and increasing documentation demands, some nurses may find these changes difficult to cope with. There are also constant job demands that sometimes increase when strenuous assignments are assigned, without enough floor staff to help with duties. The lack of license and certified floor staff may make it complicated for some nurses to attend to the needs and demands of their

assigned patients. Sometimes mandatory meetings or overtime, added responsibilities such as stepping as a charge nurse, or new documentation processes, may also increase the strain on nurses. Organization's continuous required annual trainings that must be completed within a timeframe, and make it difficult for nurses to complete within the short amount of work time provided to complete them (Sheridan-Leos, 2008). With all these stressors inherent to the nature of the nursing profession, adding factors such as different personality types and diverse cultural backgrounds, stress can easily reach the explosive point at which it is converted into negative energy towards one's peers (Brinkert, 2010).

Demarco et al., (2009) systematic review's aim was to review current literature on oppressed groups, such as nurses, and their behaviors. And to find additional reasons that may contribute to increased tension among nurses. The conclusion to this systematic review was that nurses were compared to oppressed groups and labeled as an oppressed group. Because nurses display both behaviors, passive aggressiveness and silencing, when confronted with stressful situations. One of the implications nursing managers were to confront, was to find solutions and maybe, improve the workplace behavior by utilizing preventive interventions to stop the cycle of oppression (Demarco et al., 2009).

On another systematic review by King-Jones (2011) a few qualitative studies were investigated, where sabotage and destroying someone's integrity were found to be major issues within nursing, and were also part of the bullying behaviors. The results of this systematic review compare nursing groups to oppressed groups. The author of this review states, that within the explored literature, there are suggestions that nursing instructors maybe teaching nursing students to have no voice during their nursing clinical time. Information was found where some nursing students reported that they were bullied by their preceptors and were made felt undervalued by them. Adding to this experience, some students were asked to be subordinate.

This systematic review points out a study conducted among 234 nursing students, where 51% responded having difficulty with their preceptors constantly. Most of the students who experienced conflict with their preceptors, declared that it was damaging to their self-steem (King-Jones, 2011).

According to Embree & White, 2010) a study found that approximately 60% of all new graduates are leaving their first job in less than six months after encountering damaging environments, created by disruptive behaviors against them or against other nurses (Embree & White, 2010). When bullying becomes too stressful, it may affect the nurse's physical and emotional health. Hutchinson (2009) declares that when job stressors affect the nurse's overall physical, emotional, and mental health, the nurse maybe influenced to leave the healthcare setting. The nurse may be incline to find a position somewhere else, where the conditions may be more favorable to a satisfactory quality of life. And maybe seek to be respected and valued by colleagues (Hutchinson, 2009). Registered nurses' turnover ends up costing twice as much as a yearly nurse's salary. The cost of replacing one RN can range from $22,000 to $145,000 and this depends on geographic location and the area of specialty (Jones & Gates, 2007).

According to Anderson (2011) a bullying behavior that should be a great cause for concern is verbal denigration, in the presence of patients, and public criticisms during working hours (Anderson, 2011). These behaviors are known to be increasing at a rapid pace and becoming a common practice within nursing staff. Some nurses may feel like they have to accept these humiliating acts of depreciation if they want to remain employed (Hutchinson, 2009). Sometimes nurses who witness their co-workers being bullied choose not to report any act of aggression. They may feel this way because they are afraid of retaliation. Instead, they keep their voices quiet and the witnessed behavior to themselves. This inability to report what they have witnessed may be adding more stress to their lives. Some nurses may choose not to report

because they may feel that their complaints will not be listened to, even if they report having witnessed the behaviors (Hutchinson, 2009). Some nurses may experience some emotional trauma as a result of having to cope with these disruptive behaviors. Some nurses may also experience feelings of insecurity that may lead to some physical long-term negative effects. When self confidence is undermined, the nurse may eventually feel insecure about her/his own ability to care for patients, and may be more inclined to make medical errors (Brown & Middaugh, 2009).

Brinkert (2010) summarizes some of the extreme costs of nurse-to-nurse conflict in the workplace. Some of these reasons were linked to medication errors, patient injuries and deaths, and nurse turnover costs, such as the recruitment and retraining of new staff. Nursing absenteeism is listed as a common coping strategy among some victims of bullying. Nursing absenteeism also places a burden on floor staffing, as well as, financially to the organizations. Pointing out the links of bullying to medical errors, patient injuries, patient deaths, and the direct and indirect costs for organizations that result from these mistakes. Some of the direct costs Brinkert (2010) mentions to be linked to medical errors, included litigation costs, lost management productivity, employee turn over costs, disability and worker compensation claims. Other direct costs included lost of contracts or provider status, regulatory fines, increased care expenditures due to adverse patient outcomes, and intentional property damage. Indirect costs cited were lost opportunities for advancement, emotional care costs, low morale, damaged team collaboration, increased cost to patients (Brinkert, 2010). Organizations have to comply with mandatory ratios, overtime salaries are paid to nurses who will cover for missing staff (Andrews & Dziegielewski, 2005).

According to Demarco, DiFazio, and Vessey (2010) conflict is a common behavior found among many healthcare providers. It is considered to be a natural part of any position within any organization. Conflict not only occurs among staff nurses, but also at other levels of the organizational ladder such as director to president, chief officer to director of nursing, manager to supervisor, supervisor to charge nurse, etc (Vessey, Demarco, & DiFazio, 2010). Almost (2006) points out the three most common types of conflict as one being among managers and supervisors, managers and staff personnel, and between floor staff (Almost, 2006). Cited was what could be the most difficult type of conflict, involving nurses against nurses (Woelfle & McCaffrey, 2007). Different areas of the healthcare industry are dealing with current budget cuts. Therefore, encountering shortage of staff members is not uncommon. Oftentimes, and due to staff shortages, staff nurses are unable get the help needed to provide complete and on time patient care (Winstanley & Whittington, 2002). Some of the reasons for nurses, that may force them incapable to provide help to other staff nurses, may be the increased job demands and responsibilities. Increased job loads and demands may be keeping nurses from helping others. Nurses may be focused on their own assignment and unable to help others. Job pressures may leave no time for nurses to help their co-workers with assigned patient care and duties (Winstanley & Whittington, 2002). Sometimes these type of stressful situations generate unsupportive job environments. Uncooperativeness among staff members may create hostile and negative conditions and may end in aggression among staff (Woelfle & McCaffrey, 2007). Lack of teamwork and collaboration may create feelings of dissatisfaction, frustration and powerlessness, diminishing nursing ability to concentrate on the task at hand. This may lead to poor concentration and resentment towards one another (Brown & Middaugh, 2009).

According to Sieloff (1999) from the University of Oakland in Rochester, Michigan, the nurses' feelings of powerlessness and helplessness have created an oppressed group behavior

that seeks the use of aggression against each other as a way to self-help and self-release

(Sieloff, 1999). The common feelings of low self-esteem, self-hatred and lack of respect for

others may be creating this atmosphere filled with negative and aggressive behaviors. Oppressed

groups of all kinds, including nurses, get to this state of oppression for many reasons. Some of

these reasons may involve poor organization, different personality traits, personal assumptions

and cultural styles of communication, all of which may precipitate frustrations, eventually

leading to exhaustion (Brothers, et al., 2010).

Oppressed groups tend to adopt self-relief negative behaviors. Some of these behaviors

may be attacking each other by critical accusations or humiliation. Instead of turning against the

creators of their disempowering feelings, such as their supervisors or managers, may times

attacking each other may seem easier or the fastest way to release their frustrations (Sieloff,

1999). When an oppressed group feels demoralized and frustrated, the most common known

cited coping practice employed to relieve these feelings, is bullying co-workers that are weaker

or seem powerless (Johnson, 2009). A peer review study by Brown & Middaugh (2009) found

that many nurses have limited or no control on organizational issues, struggle with work

regulations, have shorter breaks due to increased responsibilities, and are unable to have an

uninterrupted lunch, with little time to even use the restroom, therefore, nurses are considered an

oppressed group (Brown & Middaugh, 2009).

Due to the increasing number of medical errors leading to sentinel events, the Joint

Commission has directed a new leadership standard of practice. This new standard of practice

endorses zero tolerance for disruptive, intimidating and bullying behaviors within hospitals and

organizations. Healthcare organizations were asked to establish a code of conduct in order to

define what is deemed to be acceptable and non-acceptable behaviors (Joint Commission, 2009).

In addition, organizations must also create and implement a process to manage and eliminate any

inappropriate and disruptive behaviors. By educating all team members on appropriate behaviors that are professional and acceptable by the organization's code of conduct (Lally, 2009). Organizations are forced to hold all team members accountable for being models of professional and acceptable behaviors. Organizations also need to enforce the code of conduct equally and consistently among all staff members, regardless of position, credentials, or seniority (Joint Commission, 2009).

Despite the Joint Commission directive, organizations' hierarchy still plays an important role when following this new policy (Johnson, 2009). According to Johnson (2009) many national and international studies suggest that some times nursing supervisors, charge nurses and nurse managers can be the initiators of workplace bullying (Johnson, 2009). In a study by Daiski (2004) published in the Journal of Advance Nursing, the author interviewed some nurses who strived to be in higher rank positions at their current jobs, and to be able to join their upper hierarchy counterparts in an administrative level. However, by doing so, these new nurse leaders stated that they must adhere to the behaviors of their oppressors and side with their hospital administrators and physicians, many times against their own nursing co-workers (Daiski, 2004). Sometimes, first year new grads may be the most likely to be harassed by their co-workers. They are considered to be at the bottom of the food chain and to hold the least power.

In another article by the New Hampshire Nursing News, and increasing number of nursing students experience bullying as early as their first year in their clinical setting. These students are not only bullied by other licensed nurses, but also by their own instructors. This type of behavior may demoralize student nurses and may predispose them to make early critical medical errors. Students may be afraid they will be bullied if they ask questions during their clinical rotations. Sometimes this fear may push them to quit the program or be unable to advance due to the mistakes (Clark & Ahten, 2012).

Restorative Approaches

According to an article published in the Australian Nursing Journal (2011), different remedial approaches have been researched and employed trying to reduce negative behaviors and the impact of workplace bullying among nurses. However, there is little or no evidence that organizational behavioral restorative strategies, such as teaching to regain respect and trust among nurses, have been successfully implemented among nurses who have been bullied or among the aggressors themselves (Brothers et al., 2010). Some of the approaches found in the literature were categorized as individual-focused or organization-focused, and the strategies suggested to remedy the behaviors were education on conflict resolution, skill development, and providing corrective, regulatory or restorative support (Hutchinson, 2009); Baker, 1995). However, these methods seem to either be ineffective or poorly implemented. Evidence has been published showing that bullying and violence among nurses occurs as early as when new graduate nurses attend their first clinical settings (Brothers et al., 2010). According to Hutchinson (2009), many new licensed nursing have declared that they were introduced to workplace bullying by some of their most experienced working colleagues, and the newly graduated nurses learned to accept bullying after observing these behaviors as a common practice among peers which eventually led to their own tolerance and complacency (Hutchinson, 2009).

Overview of Conflict and Bullying Among Nurses

Bullying within nursing staff is a broad topic itself and so is workplace violence. A vast amount of published information on both subjects were found and analyzed for this project. Some of the differences found between the two subjects are the following: According to an article by Simons & Mawn (2010) horizontal workplace violence is seen as an event that happens once or twice with the same person and within same nursing ranks. Bullying is

described as a series of demeaning behaviors that may happen a lot more frequently. Behaviors usually determined to undermine a nurse's self esteem, and may also occur across all nursing ranks (Simons & Mawn, 2010). The purpose of this project is to conduct a comprehensive literature review, concentrating on the impact that bullying has created among nurses. In addition, to explore some of the consequences that these negative and inappropriate behaviors may cause on the quality of care provided to patients. Also, how bullying has affected the nurse's self confidence, and the collaboration among team members. This project also reviewed some of the resolution strategies that have been implemented by some organizations and the manager's role in these resolutions. The articles and information obtained for this project included documents dating from 2000 till 2011. In order to discuss any information on the topic of workplace bullying among nurses, this project concentrated on reviewing the published information from a variety of perspectives. Additionally, to be able to understand how and why there are conflicts among nursing staff, some history for clarification was researched on the triggers and influencing factors that were determined as precursors for bullying were included, and professional opinions were taken in consideration.

There is an enormous quantity of articles published about workplace bullying and the negative effects on a person's mental and emotional health that result from it. However, only a few articles were found that were dedicated on finding solutions to a common resolution. Several articles were found with different information and some ideas on conflict resolutions. However, very few were found that contained supported evidence that current resolutions were in present use by organizations.

Several reasons have been listed and published as precursors for bullying among nurses. Embree & White (2010) state that nurses are considered to be an oppressed group. Nurses commonly use aggression as a scapegoat from job frustrations. And as an oppressed group,

nurses may internalize feelings of anger developing assumptions and attitudes toward one

another. These assumptions may also create conflicts that bring more stress into the working

environment, and may lead to hostility and bullying (Embree & White, 2010). Bullying

behaviors have been found to be a customary internal practice in some workplaces. Some nurses

may learn these behaviors from their aggressors and can actually tolerate the behavior.

Sometimes, in order to survive and avoid further conflict, nurses may eventually become bullies

themselves and use violence against other nurses (Embree & White, 2010). On their data

collection Embree & White (2010) found some systematic factors that were considered to be

triggers for bullying behaviors. Some of these trigger factors were described as the increasing

pressures in the workplace, downsizing of needed staff, required extra shifts, lack of help with

current and difficult assignments, favoritism from the charge nurses and managers towards

certain staff members, mandatory trainings, and new policies and documentation processes

(Embree & White, 2010).

As more pressures and responsibilities are placed on organizations to provide optimal

care with a minimal budget. Some pressures may also be placed on charge nurses, and these may

also try to delegate more burdens on co-workers (Sheridan-Leos, 2008). Nursing managers not

only have to deal with the added organization stressors, but also have the challenge to work with

these demeaning and hostile behaviors (Brown & Middaugh, 2009). However, in a systematic

review by Cleary, Horsfall, and Hunt (2010) many bullies are known to be the managers and

supervisors themselves. Sometimes these nurses that held higher positions may withhold

important information needed for certain assignments. May assign jobs that can be under the

nurse's ability or may also ignore the bully's behaviors. On occasions they may even use

bullying behaviors themselves to obtain completion of assignments on time. Some of these

manager's bullying behaviors are described as an authoritarian or demanding style, and/or just a non-caring management style (Cleary, Horsfall, & Hunt, 2010).

The daily stressors of dealing with a job with elevated demands may lead to high emotional situations. Adding factors such as fatigue, exhaustion, feelings of frustration, powerlessness, forced shift rotations and extra shifts may be causes that contribute to unprofessional behaviors. Other factors may be the cultural differences and perceptions, communication styles, and morale sensitivity (Brinkert, 2009). As a way to cope with these high stressors, intimidation and aggressiveness may be used toward other nurses who are seen as powerless (Embree & White, 2010). With the new healthcare reform and the many new costs containment requirements, the job pressures may exacerbate for upper management (Sheridan-Leos, 2008). Some managers may be asked to make budget cuts, and some difficult staffing decisions may need to be taken. Decisions such as decreasing working hours for nursing staff or for the assistive personnel (Sheridan-Leos, 2008).

Afraid of retaliation, some nurses may already feel oppressed and unable to voice their own complaints. This may be especially so if they complain about an attitude or behavior they perceived as aggressive or demeaning (Brothers, et al., 2010). Sometimes, when the few nurses who do find the courage to verbalize their concerns and decide to do so, their attempts may be futile as they are ignored. Instead, their aggressors may be notified of their victim's complaints. This may lead to an increase to their bullying attacks and may push the victim to leave the organization (Brothers, et al., 2010). However, tolerating the bullying in order to avoid further conflicts is no solution either, as it only encourages the behavior and encourages others to join in it. Brown & Middaugh (2009) described the bully's behavior as person who will not stop, if met with complacency from their victims. A study was conducted among bullies on these type of aggressive behaviors. An anonymous questionnaire was given to the persons considered bullies

by their co-workers. They were asked about their own thoughts to their victims' responsive behaviors. A high number of responses verified that when the aggressors do not face any challenges from their victims, the aggressor may feel free to continue with their attacks (Brown & Middaugh, 2009).

The victims of bullying are usually described as powerless and insecure. However, there are studies showing the bullies as being insecure themselves (Sheridan-Leos, 2008). One factor described in the current literature is that some bullies may exhibit common characteristics in personality traits, such as self-centeredness, immaturity, manipulative manners, and defensiveness. Some may also suffer from low self esteem and disorganized work practices (Weinand, 2010).

In a descriptive study applied by Dunn (2003), in which perceived acts of workplace bullying and job satisfaction were correlated among 145 peri-operative nurses living in New Jersey, the nurses interview had a mean age of 47.7 and a median age of 46. The majority of participants were found to be female (98% of them) and 86% were Caucasian. The study was comprised of the sabotage savvy questionnaire (SSQ), and the index of work satisfaction (IWS). The SSQ contained forty questions, in a two-part form, asking the participants to recognize the existence of or deficiency of acts of sabotage. The first part of the SSQ questionnaire asked the participants to describe what their current work situation was and the importance of six workplace concerns: pay, autonomy, task requirements, organizational policies, interaction, and professional status. The second part of the questionnaire looked at how satisfied nurses were with their current jobs. Subscales were compared and correlations run using the individual one-way analysis of variance (ANOVA). The subscales were correlated to the overall scale of <0.0001 level of significance (Embree & White, 2010). The most common reported sabotage behavior was expecting the nurse to complete another nurse's work (M=1.74) (SD=0.64). The

second most common negative behavior reported was being criticized in the presence of others

(M=1.59) (SD=0.80). The third most common negative behavior reported was being ignored for

doing a good job (M=1.50) (SD=0.85). The two questionnaires' responses were analyzed using

ANOVA, and the IWS mean score was 11.91 (SD=2.42) on a range of 0.9 to 37.1 with a higher

score indicating a higher job satisfaction. A significant positive correlation existed between

victims of horizontal violence and IWS scores (r=0.35), and p=<0.01. No other significant

correlation was found between IWS and age, or years of experience, or culture backgrounds

(Embree & White, 2010).

Addressing Workplace Bullying

Workplace bullying among nurses has proliferated in such form, that it has created unsafe

practices and poor care for patients (Center For American Nurses, 2008). The problem has

caused such serious patient care complications that a sentinel event alert has been established by

the Joint Commission, and took effect on January 1, 2009. This sentinel alert focused on

addressing and stopping the behaviors that contribute to horizontal violence. The intention is to

implement new behavioral policies, and to educate everyone, nurses as well as non-nursing

personnel, concerning workplace bullying (Lally, 2009). These policies must also include

teaching professional practices and appropriate attitudes to all healthcare staff members in the

organization. Some other strategies pointed out by the Joint Commission, and are directed to

managers, is to develop and implement a code of conduct that adopts zero tolerance for

intimidating and disruptive behaviors, especially those instances that include assaultive

behaviors (Lally, 2009).

The Singapore nursing journal published an article by Katz & Wiley (2010), in which the

authors propose a conflict resolution strategy in a win-win approach. Their idea for a step-by-

step process to conflict resolutions was called a working circle. The purpose of this process is to

find a common solution and to resolve workplace bullying, in a non-confrontational and collaborative way (Tan, 2010). The step-by-step process consists of ten questions on conflict resolution styles, and eight key questions on deferring the nature of conflict (Appendix A). This step-by-step process focuses on finding out how differences in personality and assumptions affect the way bullying can be addressed (Fiol, Pratt, & O'Connor, 2009).

Another proposed approach to decrease bullying was published in issues in mental health (2010). The strategy proposal was to engage the individuals in an interactive conversation with managers and to remind the aggressor about the workplace policies against bullying. The strategy also proposed to clarify the violation of the code of conduct and address any unacceptable behaviors, as soon as the behavior was reported, stating expectations for behavior changes (Cleary et al., 2010). Griffin (2004), proposed teaching cognitive rehearsal, where focus groups were videotaped after a series of questions were given and their responses were later analyzed. Most of the questions were related to witnessing bullying in the workplace, or being a victim of bullying. Their reactions and descriptions of their emotions were videotaped for later review. They were also used for new graduate nurses, as an intervention to identify and confront early signs of workplace bullying behaviors (Griffin, 2004).

Another proposed approach to minimize bullying in the workplace was to involve the nurse educator in the beginning of the teaching process. Education began by pointing out the dangers that workplace bullying can cause, not only to the victim, but to the patients as well. This educational proposal to begin awareness as early as nursing school (Clark & Ahten, 2012).

A descriptive study was conducted in New Zealand as a part of a national survey. This survey was implemented to find out the psychological impact of bullying on first year graduate nurses (McKenna, et al., 2003). The questionnaire was designed to find information about interpersonal conflict among first year grads. An anonymous letter was sent out to all nurses who

graduated within the year prior to the survey being sent. A questionnaire was used to measure

the psychological distress of bullying and workplace violence. The Impact of Event Scale was

completed CN= 551 with a total response rate of 47%. Five hundred of the participants were

female, and 32 were male, 19 refuse to declare their gender. Out of these 551 participants, 114

worked in medical wards, 145 in surgical wards, 164 in other inpatient, 68 in mental health, 30 in

community clinics, and 22 on other areas such education, and administration. Two hundred and

fifty two were younger than thirty years old, 138 were between 30 and 39, 130 were between 40-

49, and 28 were older than 50. Ninety eight percent responded to their ethnicity with 84% being

European, and 16% were mixed between Asian, Maori, and other ethnic groups. Bullying and

workplace violence among peers was widespread equally in this study among all departments.

Most new nurses experienced violence within the first year of their career, over half of the

respondents declare that they had experienced feelings of undervaluation from their co-workers,

and 34% stated they had encountered rudeness, humiliation, and unjust criticism (Woelfle &

McCaffrey, 2007).

The Impact and Consequences of Bullying

The climate created by the behaviors of bullies in the workplace increased the stress

dwelt by bullied nurses and appeared to generate long-term negative psychological and physical

effects (Sa & Fleming, 2008). Nurses that were targeted and bullied were more likely to suffer

from anxiety and depression. The identified consequences are detrimental to the nurse's health

and well being, and can vary from insomnia due to the high stress, digestive problems, and

absenteeism that may lead to financial hardship, reduced self-esteem, and post traumatic stress

disorder (Winstanley & Whittington, 2002). Adding to these consequences, the victim may tense

and may end withdrawing from others and from patients as well, and suffer from feelings of

internalized anger, frustration, and chronic depression (Yildirim, 2009). Many times this left the

nurse with feelings of inadequacy about the ability to perform her or his job. Numerous times these victims are inclined to leave the nursing profession completely and seek a different career in where they may feel satisfied and fulfilled (Brothers, et al., 2010).

Nursing's primary focus should be the patient's care and well being. Unfortunately, when personal working relationships are impaired due to internal conflicts, the tension increases and consequently some nurses may be apt to commit more errors and or be susceptible to suffer at the job accidents (Eagar, Cowin, Gregory, & Firtko, 2010). The ability for some bullied nurses to concentrate on work issues may be diminished. The constant struggle to survive another working day dealing with their coworkers' discouraging behaviors may be too stressing (Yildirim, 2009). There is an established correlation between nurses who feel intimidated by other nurses and the risk to a patient's safety and care (Embree & White, 2010).

In a literature review by Brown & Middaugh (2009) where bullying was identified as predominant among the healthcare organizations included in the review, patients repeatedly complain of poor clinical care, deficient communication, and little attention from their healthcare providers (Brown & Middaugh, 2009). Bullying creates a negative environment because it decreases active engagement in the care of the patient (DeMarco, Griffin & Roberts, 2009). Unfortunately, this may cause even a qualified nurse to be prone to unsafe practices (Woelfle & McCaffrey, 2007).

Bullying is not confined to impact only nurses individually, but it also affects the working environment, patients and their families, and the organization (Almost, 2006). At the individual level the nurse suffers in her job performance. In the working environment when a nurse refuses to engage in teamwork, due to her own unresolved anger and frustrations, it will affect the group's atmosphere, creating a difficult situation for everyone, including the patients,

and when the patients are unhappy with their treatment and feel that their nurse does not

provide the care they need or seek, their families will then get involved (Embree & White, 2010).

Occasionally, family members may file a complaint against the nurse or send a letter of

dissatisfaction to the manager. During the investigation, if family complaints may not get

resolved as the family expects, these issues may escalate, costing the hospital time and money

(Woelfle & McCaffrey, 2007). According to a study by Brothers et al., (2010) when bullying

affects the organization, it can be very costly and time consuming. One of the issues some

workplaces face when bullying is present among their staff, is the high turnover ratio among

nurses. In this study about new hired nurses, time and money were spent in orientation and

training, these same nurses resigned in less than a year. The new nurses stated that when they

were confronted by the aggression and the abuse of their coworkers, their stress level

incremented and they were not going to tolerate the abusive behaviors (Brothers, et al., 2010).

The psychological consequences and the long-term negative effects that bullying brings to the

nurse can carry long-lasting economic problems for the organization as well. The aftermath of

the psychological distress on nurses can vary from increased stress to mental illnesses such as

depression, anxiety, and post-traumatic disorder (DelBel, 2003). Continuous exposure to this

climate can drain nurses from their desire to provide care for their patients or to participate in

organizational activities, and nurses will also lose their desire to obtain any recognition for their

efforts (Embree & White, 2010). When the organization fails to provide any solution for the

horizontal bullying among their nursing staff, nurses will lose all desires to remain with the

organization (Fujishiro, Gee, & B, 2011).

When nurses leave, it can be very costly to the corporation. The economic cost from the

nurse turnover rate at an organization has been reported to be from $22,000 to more than $64,000

yearly (Sheridan-Leos, 2008). The pressures of the workplace, overwhelming demands and

responsibilities, dealing with reduced budgets, may possible be grounds for continuance of workplace bullying (Hayes, et al., 2010). To change these negative occurrences of workplace bullying, it will require a series of steps that will also involve self-reflection, and a course of action that will require everyone, within the same organization, to attend trainings on professional behavior (Sheridan-Leos, 2008).

The national director of the Healthy Workplace Campaign was working on introducing the Healthy Workplace bill and passing this bill as a new law in 2007. Yamada (2001) drafted the first text for the healthy workplace bill (HWB), and it was then revised in 2009. Professor Yamada's idea for the bill grew out of his expertise on the topic of workplace bullying and the need to establish a new law to protect victims of workplace bullying. The HWB was first introduced in California in 2003 as AB1582. We have workplace laws that protect people against sexual harassment and racial discrimination. But we have no laws that protects nurses against bullying (Namie & Yamada, 2010).

The current workplace laws do not safeguard against psychological harassment nor is illegal to bully a co-worker. Another reason for the continuance of bullying and horizontal violence among nurses is the lack of these workplace safeguard laws (Woelfle & McCaffrey, 2007). The nursing culture bestows a perfect atmosphere for the bully to initiate these behaviors (Simons & Mawn, 2010). Entry-level nursing assistants and new graduate nurses are often seen as powerless, they can also be made to feel useless and unproductive, most likely when they raise questions about medications, assignments, or other job requirements (Roberts, Demarco, & Griffin, 2009). Formation of subgroups among nurses is common. These subgroups can also be used by some bullies to gain control over other nurses and subdue those, that are seen as a treat in the political ladder (Katrinli, Atabay, Gunay, & Cangarli, 2010). Some studies have shown that nurses worry more about bullying from their own colleagues, than from patients or visitors

(Weinand, 2010). This bullying atmosphere many time may create a lack of communication

among caregivers, implementing a work environment difficult to balance, incrementing the

possibilities for lack of care, incomplete orders, and medical errors (Lindy & Schaefer, 2010).

Chapter Three

Methods

The topic of workplace bullying among nurses was selected from an extensive list of relevant issues within the nursing profession, and from personal experience while observing other staff members in the workplace. For the sole purpose of examination and comparison in the literature review for this project, a wide-ranging literature research was performed for the integrative review, including a wide number of scholarly articles that were obtained from different academic databases as listed under the following paragraph research strategies. With the use of different key words, such as bullying or nursing, the appropriate literature needed to conduct the research was gathered. Several strategies were explored in each database, starting with a basic search using some relevant phrases and words related to the primary topic, horizontal violence among nurses, then to the final chosen topic, workplace bullying. Some combined words such as violence on the workplace, were also applied that were closely related to the main topic of bullying among nurses, and an advanced search mode was utilized. Some promising references were encountered, which were briefly scanned and then placed into a different folder for a later review. Some of the articles' list of references were also searched and scrutinized carefully for any relevance to the topic of bullying. Once a large number of written information was acquired, the articles were separated and selected according to their relevance to the topic and sorted into a hierarchy based on how pertinent they were. Some articles found were not in high relevance so modifications were made to the research criteria.

Research Strategies

Bibliographic databases such as EBSCohost, ProQuest, PsychInfo, Medscape, mapping search keywords, with key dependents and population variables, general database search featured

the use of wildcard symbols and truncation symbols to expand the research, ancestry

approach, a descendent approach (which starts from early studies), and key electronic databases.

The key electronic databases researched for this project are listed under the headline data

bases included. The key words used during the research process were: Conflict in nursing,

bullying, horizontal violence, conflict resolutions, manager's approaches, conflict and quality of

work, patient safety, oppression of self, team-work, adverse effects, etc. Additional research was

performed using phrase matching such as bullying among healthcare staff, horizontal violence

and nursing, manager's role in bullying, etc. More than 100 articles were found with similar and

comparable information and results were selected according to their inclusion and exclusion

parameters. An extensive review of all the data found was performed and the final number of

articles chosen for this project were fifty-one. These articles were selected due to their pertinent

information and content. The purpose of this project was to review the impact of workplace

bullying among nurses and its consequences on patient care, as well as to review any conflict

resolution related to the issue of bullying thus far.

Search Strategies and Key Words

An ample internet search approach was the initial methodology for this project, attempting

to acquire all available printed studies, including systematic reviews and data analysis regarding

the topic of interest, horizontal violence and bullying, and the current strategies on conflict

resolution. To do this, most designs with empirical qualities, such as quantitative, qualitative,

mixed or quasi-experimental designs, among any nursing area of expertise, were included. Some

books with related content to the horizontal violence among nurses were searched as well. Key

words used for methodology research were extensive, such as nurses and conflict, bullying

among nurses, managers and conflicts, horizontal violence and nurses, lateral violence among

nurses, nursing conflicts and patient outcomes, conflict resolutions, workplace violence, nurse's

job satisfaction and conflicts were also used as well as bullying and job retention, health and job satisfaction, conflicts and health consequences, negative workplace behaviors, oppression and horizontal violence, bullying and new grad nurses, satisfaction in the workplace, nursing shortage, nursing satisfaction, communication among nurses, addressing bullying, laws against bullying, manager's roles, organization's policies, etc. Other single words were also used to obtain the maximum amount of data possible, words such as: violence, manager, nursing conflicts, patients dissatisfaction, job satisfaction, work bullying, medical errors, conflict solutions, and words related to the theoretical framework were also used to search for related articles, Roy's nursing theory and theory in the workplace, Roy's theory and horizontal violence. Electronic databases turned in an incredible amount of articles; however, only less than one hundred were chosen for the purpose of this project. Studies were carefully selected according to the most current published dates. The articles found while searching for the most recent and pertinent information and the most consistent with the words utilized for the exploration were publication dates ranging from 2000 till the present year, giving a six-year collection of information. Only one article, published before 2000, from the Journal of Advance Nursing, was chosen for its content on the description of nurses being labeled an oppressed group. This article was a reference from another article published in 2006, and was examined for the sole purpose to illustrate the example given in the latest article.

Inclusion Criteria

The inclusion of published literature considered for the review and reference had to meet the required elements of the topic of interest, proper and updated information on horizontal violence and bullying among nurses, and current strategies for conflict resolution. Initially, the inclusion was horizontal violence in the workplace and its consequences for nurses and other healthcare providers, followed with bullying among nurses and its effects on patient care, this to

include all areas of expertise and to analyze data obtained from studies originated in other countries. Some of the data collected and chosen included data from studies about conflict with other healthcare providers as well. Although these studies did not provide with a direct correlation of the workplace bullying among nurses, the current data provided did allow for a greater integration and knowledge of information about the subject of inquiry. Areas of nursing included psychiatric acute care, critical care, medical/surgical, surgery, emergency room, and all areas in the maternity floor, to include labor and delivery, and pediatric acute care. Lastly, considered for inclusion were any studies that contained any correlation with hospital violence, manager's approaches and consequences of horizontal violence and bullying as well as conflict resolutions established by the Joint Commission, and the American Nurses Association. Also included were articles with Roy's theoretical approach that may be used to examine current conflicts.

Exclusion Criteria

The general term of bullying among nurses is very broad and a tremendous amount of documents were found in response to the search parameters. The importance of using exclusion criteria was reflected in the results, and many design components were left out and some limits were placed on the search for articles. Although schools of nursing were mentioned on some articles as to be part of the increasing bullying behaviors, since many students find horizontal violence being included into their clinical experiences, not all data found was utilized due to their irrelevant content to nursing students. Some other articles that also met the exclusion criteria were about medical schools and medical students in correlation to nurses and work violence. Some were about physicians and nursing conflicts, extended care and nursing homes, primary care and physician's offices, school nurses, home care nursing, hospice care, occupational and physical therapists, social workers, pharmacists, phlebotomists, prison nurses, and corporate

culture. Exclusions also included healthcare organization's higher ups, and bullying among other areas that were not nurse related. Since inquiring and searching on the topic "workplace bullying" brought a large volume of studies and published information, many expert opinions were left out due to their content being unrelated to nursing.

Data Bases Included

The review included comprehensive literatures, electronic databases including Based Medical Reviews: MEDLINE, CINAHL Plus with Full Text, Cochrane Database of Systematic Reviews, Academic Search Premier (EBSCO), Access Science, Alt Health Watch, ATLA, Business Source Elite, CIAO, CQ Researcher Plus Archive, Cambridge Histories Online, Cochrane Central Base of Controlled Trials, Database of Abstracts of Reviews of Effects, Proquest, Health Technologies Assessments, PsycINFO, NHS Economic Evaluation Database, ENSCO Host, MLA International Bibliography, Health Source: Nursing/Academic Edition, Psychology and Behavioral Science Collection, Oxford Reference Online, and Google Scholar.

Workplace bullying is a problem that is increasing internationally among nurses. Some relevant national and international websites and their literature correlating to the field of nursing and bullying were also considered. Healthcare guidelines found and considered during the search were in the U.S.: www.guideline.gov; in Canada: www.rnao.org/bestpractices and also http://mdm.ca/cpgsnew/cpgs/index.asp; UK: http//www.tripdatabase.com and www.nice.org.uk.

Chapter Four

Results

The following section will review, under the hierarchy levels of evidence, the results and will give a brief description of the articles found within each group. Some government regulations and systematic review articles will be reported in the following text. All the studies found, including all quantitative and qualitative literature, will be further explained in this chapter. To conclude, a complete explanation for the literature pertinent to the nursing and bullying environments will be presented.

High Level of Evidence

There were thirteen meta-synthesis studies, eighteen scholarly/expert opinions articles, and nine co-relational /concept analysis studies. The American Nurses Association published an article describing behaviors that damage teamwork and affect patients and that should be eliminated from the workplace culture either by promoting zero tolerance or other extreme measures (American Nurses Association 2010 House of Delegates resolution: hostility, abuse and bullying in the workplace, 2010).

The amount of articles found on the subject was incredibly abundant with over 150 articles co-related to the topic of workplace bullying. After careful revision of said articles was utilized the inclusion and exclusion criteria was considered. After considering the inclusion and exclusion criteria previously explained, only a small number of articles were kept for this project. After scrutinizing each of the articles found the final number selected was 40. The designated publications included in this review are listed in table 1. The final chosen articles were divided by their study type and under their hierarchy level of evidence.

STUDY TYPE (N-40)	N	%
Clinical Practice. Government Regulations	2	(5)
Systematic Reviews	10	(25)
Integrative Reviews	2	(5)
Exploratory Studies	3	(7.5)
Qualitative Studies	7	(17.5)
Quantitative Studies	7	(17.5)
Expert Opinions	6	(15)
Descriptive Studies	3	(10)

HIERARCHY LEVEL OF EVIDENCE	N	%
Level I	7	(17.5)
Level II	10	(25)
Level III	8	(20)
Level IV	3	(7.5)
Level V	1	(2.5)
Level VI	3	(7.5)
Level VII	8	(20)

Clinical Practice/Government Regulations

Two clinical practice articles found pertained information about government regulations for workplace bullying. One of the two articles indirectly proposes a political approach to raise enough awareness and public support to eliminate workplace bullying. The idea is to find enough public support from the state of California first to pass a regulation bill into a law. This bill proposal is to initiate regulations against workplace bullying in the workplace. If this bill becomes a law, the next step is to raise enough awareness about workplace bullying and bring the new law to a national level where all states could be included.

The second article published by the American Nurses Association, in collaboration and agreement with the Joint Commission, pointed out that disruptive behaviors are the main detrimental force behind the lack of collaboration among nursing teams. The results were less than stellar care for patients, which resulted in committing mistakes during patient care (Joint Commission, 2008).

Systematic Reviews Meta-Analysis

Ten systematic reviews and meta-analysis on workplace bullying were found and are described under Appendix B. Two out of these ten articles were not related to the area of nursing alone, but associated to other areas of work with an indication of workplace bullying and reasons and solutions to decrease this abuse.

The purpose of the meta-analysis study presented by King-Jones (2011) was to analyze the information found on numerous articles that were published with discussions and studies about horizontal bullying or bullying among nurses. The studies reviewed also contained discussions on how bullying affects nurses on their job performance and on their care provided to patients. Information was also found on bullying within the nursing education and how bullying affects

and impacts the socialization of newly graduated nurses. One of the key findings was that

horizontal bullying creates high levels of stress for most of the nurses that have to work and face

these negative behaviors. Further research was recommended to compare the impact of bullying

and patient care and bullying and medical errors. Due to the increase in the number of nurses

leaving the working force and the low retention rate in hospital settings, the study is also

predicting a shortage of nurses (King-Jones, 2011).

Roberts, Demarco, & Griffin, (2009) evaluated three qualitative studies with the aim to

review the current literature on oppressed group behaviors within the nursing profession. Having

an emphasis on possible interventions to change these behaviors, the findings were that nurses

were projecting oppressed group behaviors, due to their lack of autonomy, which intensifies due

to the increase in work duties and responsibilities (Roberts, et al., 2009).

The purpose in the concept analysis by Lamontagne (2010) was to clarify the correlation

within negative behaviors, aimed towards nurses by their peers in the healthcare system, and

medical errors and/or performance issues by staff nurses. Some of the findings were that

intimidating and disruptive behaviors, such as bullying in the workplace, are precursors to unsafe

medical practices and a decreased patient's quality of care. When patient's quality of care is

jeopardize, may lead to patient's and their families' dissatisfaction with their providers.

Dissatisfied clients or patients may lead to increase the cost of care due to performance

complaints and sometimes lawsuits against the organization (Lamontagne, 2010).

In a national and international meta-analysis by Andrews & Dziegielewski (2005), the

purpose was to clearly outline the issues managers face in relation to job satisfaction and the

nursing shortage and retention. It was also to provide the nurse managers with some ideas for

approaches to solve nursing conflicts. The findings were that the same issues that bring

dissatisfaction to U.S. nurses, and affect the retention of good staff nurses and the quality of care

they provide, are the same factors found internationally. Managers are given many responsibilities and sometimes they may not have the time to address problems at the individual level (Andrews & Dziegielewski, 2005).

In a hierarchy level V study by Felblinger (20008) a description of disruptive behaviors, associated with incivility and bullying is provided, and their connection to nursing clinical errors. Some of the results recommended that to prevent medical errors and retain quality staff, nurses need to feel safe in their workplace and free from intimidating and bullying behaviors. In addition, bullying was found to contribute to nurses' decreased productivity and increased unsafe practices (Felblinger, 2008).

Lewis (2006) examined bullying within nursing from a micro-sociological perspective and studied the causes for the continuation of bullying in the nursing profession. The findings strongly point out that bullying is a learned behavior within the nursing profession. Instead of being a psychological deficit, nurses learn to bully other nurses early in their careers as a survival skill and coping behavior (Lewis, 2006).

Embree & White (2010) conducted an analysis of the concept of nurse-to-nurse lateral violence. Their findings demonstrated that nurse-to-nurse violence or the aggression toward each other is an expression of job dissatisfaction. The lack of management support and increased position stressors culminates in the use of negative behaviors towards each other, and this can be either covert or overt and all in the effort to assuage their pent up stress (Embree & White, 2010).

Quantitative Studies

There were seven quantitative studies chosen for the purpose of this project, and their differences in the hierarchy levels are described on appendix C. On the first cohort, hierarchy level I, RCT study; the aim of this descriptive study was 1) to determine the prevalence of types of interpersonal conflicts and horizontal violence experienced by newly graduated nurses during

their first year at practice; 2) to describe the most distressing behaviors nurses experienced; 3) to measure the psychological impact and consequences of these issues on nurses; 4) to determine the type of training received to manage horizontal violence. The method was an anonymous survey mailed to nurses in New Zealand (*n-1169)* to which 551 returned their completed questionnaires, a response rate of 47%. The Impact of Event Scale was used to measure the level of distress experienced. The results indicated that 114 (21%) were practicing in medical wards, 145 (26%) in surgical wards, 164 (30%) in other inpatient services, 68 (13%) in mental health services, 30 (6%) in community services, 22 (4%) in other areas not easily recognized (including nurse education and administration). Over half of the participants reported being treated like a student by other nurses, over a third experienced having their learning opportunities blocked and were assigned heavy loads and increased responsibilities without proper support from colleagues. A small number experienced these behaviors more than twice: being undervalued (31%) by participants, having blocked learning opportunities (17%), emotional neglect (16%), feeling stressed by observing the conflict among other colleagues (16%), and being given too much responsibility without being provided proper support (23%). 34% of all respondents (*n=188)* responded being victims to rude, abusive, humiliating and unjust criticism. 5% (*n=25)* of participants reported being victims of sexual harassment, inappropriate racial statements 4% (*n=21),* verbal threats by 3% (n=18). Out of all participants, 1-2% experienced other forms of violence such as physical intimidation, attempted physical assault, and stalking (McKenna, et al., 2003).

In the next single RCT study, the setting was at a Veteran's Health Administration (VHA) Hospital here in the U.S. The method utilized was a survey of nurses throughout the hospital to assess their experience with violence and verbal aggression. The participants in this study were 198 nurses, all female, mostly married (56%), and 49% were between 30 and 49 years of age.

39% were older than 49 and 12% younger than 30. 53% were registered nurses and 26% were licensed practical nurses. Almost 64% had 10 or more years of employment in this hospital. Most (71%) were day shift, and the remainder (29%) equally divided between evenings and nights. A large number worked in ambulatory care (24%), nursing homes (23%), medical/surgical (16%), and spinal cord (15%). 690 nurses received a questionnaire, but only 29% of them returned them. The measures used in the questionnaire were inquiries about perceived climate of violence, general horizontal violence, verbal aggression, and injury. Some were about perceived danger, physical and psychological strain, and two subscales from the brief symptom inventory. The brief symptom inventory contained 18 questions used to measure anxiety and depression as aspects of psychological strain. Descriptive statistics including means, standard deviations, ranges, and internal consistency reliabilities were utilized. Results were obtained from the 198 nurses who completed the survey and returned the questionnaire. 56 out of 198 (28%) reported having been victims of violence within their last year of employment, and 39% of those stated that they were injured by that violence. The number that reported being the victims of verbal aggression were 114 out of 198 (58%). The positive correlations of perceived physical and verbal aggression with physical symptoms such as anxiety, insomnia, and depression were positively related (*r=.37),* suggesting a link between these two phenomena. The results from this study bring out more information and demonstrate how aggression, not only verbally but physically, is very common in the healthcare setting. It also demonstrates the impact that these negative behaviors have on the climate where the nurse works, affecting the nurse's well being and causing psychological strain (Spector, Coulter, Stockwell, & Matz, 2007).

In a non-experimental design, RCT model hierarchy level II, the aim was to test a theoretical model linking selected variables to intra-group conflict among nurses, management styles, job stress and satisfaction. The method utilized was used in a random sample of 277 acute

care nurses. A non-experimental survey design was sent to 600 registered nurses working at in-patient acute care hospitals, where they were selected. Two hundred and seventy seven questionnaires were returned, a response rate of 47.5%. Females were the majority of participants (98.2%); a large number had only a diploma education (71.6%); most work full time (68.7%); age average was 42 years old, and the average length of experience in the field was 17.8 years. Most of the nurses were assigned to a medical/surgical unit (39.8%), and critical care (32.8%), some work at the emergency department (13.9%), maternal unit (8.9%), and the lowest number of participants came from the psychiatry department (4.6%). All items were rated on likert scales, and all scales had acceptable internal consistency with reliabilities ranging from 0.76 to 0.92. The measured study variables were core self-evaluation, complexity of nursing care, interactional justice, unit morale, intra-group conflict, conflict management style, job stress, and job satisfaction. To obtain an accurate measurement, the questions were given a 1 for a very negative answer and a 5 for a very positive answer. The results of this study showed that nurses reported a moderately high level of core self-evaluation: scale 1-5, *mean 3.83*, interactional justice and complexity of care (scale 10-100, *mean* 53.50); whereas unit morale was reported as being average on their units (scale 1-5, *mean 3.12) p=<0.01*; nurses reported a low level of intra-group relationship conflict (scale 1-5, *mean 2.39) p=<0.01;* with other nurses who used an agreeable style of nursing conflict resolution (scale -8 to +8, *mean 1.45) p=<0.01*; and the outcomes of stress (scale 1-5, *mean 2.81) p=<0.01;* and job satisfaction (scale 1-5, *mean 3.11) p=<0.01.* This study demonstrated that core self-evaluation, interactional justice, and unit morale were significantly related to each other, having a negative effect on intra-group relationship conflict and job stress. The study concluded that work conflict has a direct negative effect on an agreeable style of conflict management and job satisfaction, and a direct effect on job stress. Job

stress had a strong direct and negative effect on job satisfaction and retention (Almost, Doran, Hall & Laschinger, 2010).

The following level II cohort study by Baron and Neuman (1996) investigated two major hypothesis related to aggression. The first hypothesis is that most aggressive behaviors occurring at the work setting are verbal, indirect and passive, rather than physical, direct and active. The second is that due to recent changes in organizations like downsizing, increased workforce diversity, layoffs, change in management, restructuring, budget cuts, etc, stressful conditions have proliferated and contributed significantly to the increase in workplace aggression. The participants were 178 full time employees, 92 females and 86 males, working in different organizations in both the public and the private sector. The participants' ages ranged from 20 years old to 60 years old (58% were between ages 25-44, 27% were 45-64, 15% from 19-24). Most held their current jobs from 1 to 5 years. Their ethnic backgrounds differed; 84.3% were Caucasian, 6.2% were African American, 4.5% were Hispanic, 2.8% Asian and the remainder described themselves as 'other'. The participants were asked to complete a questionnaire dealing with workplace aggression. They were asked to rate the frequency and type of aggressive behaviors personally perceived or witnessed in their workplace within their last year of employment. Both personally experienced and witnessed types of aggression yielded a very high score: 84.6, $p=<0.001$ for witness aggression and 61.6, $p=<0.001$ for experienced aggression. Hypothesis 1 tested to be right; participants reported that verbal and passive forms of aggression were used more than physical and active. The findings also support the second hypothesis: that the changes occurring in the workplace have a direct correlation to the increase in workplace aggression (Baron & Neuman, 1996).

Another RCT, cohort, level I study's aim was to compare the features and causes of horizontal violence and bullying in nursing students and nurses in order to assess the incidents

and take preventative actions and counter measures. The method was a retrospective survey conducted in three Italian university schools of nursing. 346 students filled a questionnaire that included questions about violence, mental health, job stress, and organizational justice. The results reported that 43% of nurses and 34% of nursing students had been the victims of physical or/and verbal violence at least once in their lifetime working in clinical settings. In percentages the data shows the following: physical assaults reported within the last 12 months (odds ratio [OR] 2.89, 95% confidence interval [CI] 1.35-6.18), nurses who received threats (OR 2.84, 95%, CI 1.39-5.79), victims of sexual harassment (OR 2.3, 95% CI 1.15-5.54). The conclusion that can be gleaned from this study is that horizontal violence is a very serious problem that is in urgent need of finding a preventive solution to control these negative behaviors in clinical settings (Magnavita & Heponiemi, 2011).

In another 2011 RCT, cohort, level II study, the purpose was to investigate informal communication and the use of advice networks among nursing staff, the structure of them, how are these related to the size of the nursing units, their characteristics to nursing and their relationship to job satisfaction. The method used was to collect social network data of 861 nursing staff of 35 units in-group projects and psycho geriatric units in nursing homes and residential homes in the Netherlands. Communication and advice networks were analyzed based on the number of staff in the units. Job satisfaction was measured using the Maastricht Work Satisfaction Scale for Healthcare (MASGZ), on a five point scale from (1)=very satisfied to (5)=not satisfied. Items addressed were: satisfaction with the unit's supervisor, promotion possibilities, quality of care, relationships with colleagues, and simplicity of tasks. The number of staff that completed the questionnaire was 474 staff member, a 55% response rate. Almost half (46%) were CNAs, the majority of respondents were female (95%), the average age was 38 yrs old (sd=10.6), most of the staff worked part time (77%), and the majority were permanent in

their positions (89%). The response rates on communication networks and advice networks were highly correlated (0.97, p=<0.001). The response rate was negatively related to the size of units. Overall job satisfaction was 3.46 (sd=0.19) ranging from 3.12 to 4.33. Multilevel analyses showed that job satisfaction differed significantly between individual staff members and units. In units with more residents and more nursing staff, the nurses communicated less with each other, and were prone to abstain from asking for advice. Thus, a significant relationship was found between job satisfaction and the number of staff in the units (p = < 0.05). The type of care was not significantly related to job satisfaction (p = <0.10). In units where communication networks were solid, nursing staff felt more satisfied with their jobs. The results of this study reflect that the size of the unit and the number of patients and staff do have a direct effect on job satisfaction, but the type of care or unit does not. The type of relationship among nurses also has a direct relation to the nurse's job satisfaction (van Beek et al., 2011).

Qualitative Studies

Of the published work, 7 qualitative studies were selected for their correlation to this project's topic of workplace bullying. Two studies were high quality, hierarchy level II, both single non-random, and one descriptive. Two of medium quality hierarchy level IV, one exploratory design and the other ethno-phenomenology design. And three were of low quality, hierarchy level VI, two studies of a phenomenological design and one of a descriptive-exploratory design.

Khalil (2009) ran an international study in Cape Town by distributing questionnaires to eight different hospitals' nursing staff, the aim was to obtain data and examine the violence among nurses. A combined ethno-phenomenology approach was used to understand the culture of nurses that permit violence to occur among them, and to explore the nurse-to-nurse experiences and reactions to violence. The population selected for this study, were all registered

nurses: 202 general nurses, 148 psychiatric nurses, 90 midwives, and 31 pediatric nurses. Confidential questionnaires were sent, however some participants chose not to respond to all questions. The study was designed on four different stages, the first stage was to capture all responses with close-ended questions, the second stage was to group responses into their respective specialty areas, and the third stage was to group again all responses according to levels of practice (RN) such as student nurses and managers. The final and fourth stage was the qualitative data analysis that consisted of a series of steps: The 1st step to capture all the raw data, 2nd step to examine responses for similarities and differences and the 3rd step to collate responses per question and then to examine the collated data in order to identify areas of similarities and differences among all hospitals. Out of the 471 participating nursing staff, 354 provided information on vertical violence, while only 270 reported physical violence among nurses.

From the 471 nurses who responded, 54% agreed there is violence among nurses (n=252, SD=36.65, CI=58.32), 24% were not sure (n=112, SD=17.45, CI=27.77), 13% indicated that they have not seen or experienced violence (n=63, SD=14.54, CI=23.15), and 9% abstained from responding (n=44, SD=8.67, CI=13.81). Some respondents selected all six types of violence; the results revealed that psychological violence was experienced by 45% of participants, vertical violence by 33%, covert violence by 30%, horizontal violence by 29%, overt violence by 26%, and physical violence by 20% across all participating hospitals. Although this study aimed to uncover all the different types of violence that occur between nurses, there are still more forms of it then what were covered even here. The conclusion from this study reveals that there is a need for proper education among nursing staff about violence and bullying. There is also a need for more education to learn to manage all forms of violence, through proper and continuous trainings, professional development programs and in-service training programs. Once

implemented, feedback must once again be collected to ensure that progress is being made.

But this implementation needs to be continued for as long as there are nurses (Khalil, 2009).

Hoye & Severinsson (2010) ran a single descriptive and exploratory design, hierarchy level VI, with the aim of the study to explore intensive care nurses' experiences of conflicts during situations in which they encounter cultural diversity. The method was to perform multi-stage focus groups interviews to sixteen critical care volunteer nurses. The analysis was focused on one main theme; conflict between the nurses' practice styles and professional perceptions of themselves and their families' cultural traditions. Participants reported a certain lack of respect by people from a different cultural background. Conflict occurred between the nurses' need to control their clinical environment and the perceptions of other cultures. The conclusion of this study is that there is sufficient evidence that nurses need to be more competent in the area of culture and religion. This can be improved through nursing curricula at all educational levels, and through continuing professional education. Hospitals can provide educational trainings on culture awareness and religious tolerance through a series of in-services (H√∏ye & Severinsson, 2010).

Lindy & Schaefer (2010) ran a hierarchy level VI phenomenological study, with the aim to find out what the nurse managers' perceptions of negative behaviors were, such as bullying encountered by staff nurses working for their units. The method used in this study was a qualitative research methodology; nearly 4500 people were recruited from a South Central Hospital in the U.S.A. There were approximately 40 nurse managers supervising nearly 1400 registered nurses and 600 unlicensed assistive personnel. Of those 40, 50% participated in the study (20) and one-on-one interviews were held in a private setting. Out of 20 participants 18 were females (90%), and 2 males (10%). The average age of the participants was 49.9 years, and 45% held a masters degree in nursing, and 35% had their baccalaureate in nursing. Their average

time of experience as managers was 14.8 years and their average time working at their present position was 8.5 years. The results were selected by themes and each manager responded to the open ended questions given with their own perception of bullying after having observed staff nurses' behaviors in their own units. All managers agreed that when they were staff nurses themselves, they observed negative behaviors however, few indicated observing any bullying during their managerial role, but stated that the staff does report these behaviors. The themes described by managers during their spectator role were verbal and non-verbal acts of bullying that were attributed to individual different personalities. For example, a participant described a bully's behavior as the same way that person commonly approached others, raising her voice to other nurses, being abrupt, demanding and rude, however, the manager just stated that it was that nurses' personal way of interacting with others and went on to describe how the nurse in question was a great nurse and that people interpreted her approaches according to their own individual personalities or personal beliefs. Another participant with over 14 years of experience went on blaming the victim for just taking that kind of behavior. A manager with 25 years of experience stated that the amount of work that nurses have increases their level of stress and this may be a contributor to the nurses' bullying behaviors. Another theme supported by a participant with 15 years of experience stated that there is always old baggage because nurses carry a lot of personal issues and this may also be a contributor to their behaviors (Lindy & Schaefer, 2010). Other themes were: three sides to a story, increased workload, and different manager's perspectives. In conclusion, the incidents described by the managers, of verbal and non-verbal abuse and bullying behaviors, were judged differently by each participant and their own ethical dilemmas. It is important for leadership and managers to use established guidelines to confront workplace bullying in a equal manner and to promote healthy work environments. In addition, senior leaderships should provide education to nurse managers on addressing negative bullying

behaviors and training and guidance on how to recognize these behaviors (Lindy & Schaefer, 2010).

In a hierarchy level II single non-randomized study conducted in Australia by Hutchinson, Jackson, and Vickers (2010) the aim was to explore the nature of bullying in the Australian nursing workplace. The method of this study was a series of semi-structured interviews with 26 nurses (n=24 registered and two enrolled) who had experienced bullying from two Australian health services. Most of the study participants had a wide variety of work experience, and were employed in different areas of health care. The content analysis from these interviews' transcripts was performed using the NVIVO 7 software program. The data analysis identified six major categories and sub-categories. The categories were as following: personal attacks, intimidation and threats, belittlement and humiliation, attack on professional competence, limiting career opportunities, and attack through work roles and tasks. Some of the sub-categories were obstructing work or making work life difficult, denial of due process and natural justice, and economic sanctions. The results showed that recognizing the instances of bullying is important to mediate through tactics and these must be presented to shed a light on the complex nature of the phenomenon of workplace bullying (Hutchinson, Vickers, Wilkes, & Jackson, 2010).

In a descriptive, hierarchy level II study by Simmons & Mawn (2010), the aim was to examine the stories of bullying among nurses based on actual or witnessed experiences. 104 newly licensed U.S. nurses responded to an open-ended question in a survey about bullying that was mailed to their homes. Four major themes were examined which related to bullying behaviors, perceived causes for bullying, and the impact of bullying behaviors on nurses. The themes were: structural bullying, nurses eating their young, feeling out of the clique, and leaving the job. The survey reported that 31% of the respondents had experienced bullying and 21%

stated they had been bullied in their workplace. The conclusion to this study places a new perspective on bullying and indentifies new findings on the understandings of bullying among the nursing force. These findings have shown that bullying is directly associated with job satisfaction, performance and retention. From these results, it is clear that it is imperative that more studies and additional research is needed to identify the real causes of workplace bullying (Simons & Mawn, 2010).

In another exploratory, hierarchy level IV study by Cowin, Eagar, Firtko & Gregory (2010), the aim was to explore the relationships between the scope of practice and communication among teams of nurses and the confusion that scope of practice may bring to nurses which the direct allocation of this confusion leads to situations where nurses feel bullied, stressed and harassed. Three major themes were studied, which were the concept of scope of practice and conflict, communication breakdown, and communication issues within nursing handover. The study design was conducted in three different hospitals in Sydney Australia, 30 registered nurses and enrolled nurses (4:7 in each group). Most participants were female (5:1), their ages ranged from 21 to 50 years old, their experience ranged from first year graduates to 20 years in the field. Under the theme of team conflict several perceptions were reported such as frustration and disregard for the nurse with the heaviest workload assigned, and the perceived lack of respect from RNs to CNAs. Horizontal violence and bullying were reported in the form of psychological harassment that may include intimidation, discouragement, threats, verbal abuse, humiliation, excessive criticism, and denial to access to other workplace opportunities. Many new nurses perceived injustices with the workloads assigned to them by senior RNs. Heavy workloads and the inadequate support from their peers have caused an inability to provide good care for their patients and then created direct impact on the nurses' stress and dissatisfaction with the profession. The conclusion to this study was the finding of the major

theme, the clarification of the scope of practice, and the definition of roles and responsibilities to prevent conflicts within nurses and nurse assistances. The results from this study stresses that constant miss-communication among team members provides a strong correlation to increased stress levels which then leads to workplace bullying, harassment, and horizontal violence among nurses (Eagar, et al., 2010).

Chapter Five

Discussion

Research indicates that workplace bullying is a series of negative behaviors that are common in healthcare settings, and have a direct effect on a nurses' job performance, satisfaction, and retention; furthermore, studies have established that these behaviors are on the rise in hospital settings around the world (Almost, 2006). According to Johnson (2009) the mixture of heavy workloads, difficult assignments, organizational changes, and differences in cultural backgrounds, provides a fertile ground for disruptive and bullying behaviors.

Interpretation of Results

The overall evidence regarding workplace bullying is broad, indicating that this is a very serious issue that is affecting the nursing profession and the care for patients as well (Joint Commission, 2008). Because nurses are required to accept multiple demands, not only from the organization and management, but also from co-workers and from the assigned patients as well as their families' pressures, these job demands cause positional stress which is difficult to avoid so nurses end up accepting this torrent of stress as part of their job; However, an escalating stress level is reflected in the nurse's attitude and care, and it is a significant contributor to workplace conflicts (Bell, 2011). When workplace conflicts go unresolved, these bring more pressure into the environment, increasing the demands to perform well, deteriorating the working relationships and leading to what is now known as bullying among nurses (Almost, 2009). Workplace bullying among nurses is an increasing problem that can't be ignored. Looking at the different literature, some of the definitions of workplace bullying are listed, per author, on table 2.

Table 2. Definitions of Workplace Bullying by Author

Author	Year	Definition
ANA	(2010)	Hostile, abusive behaviors, abuse from authority or higher position, Disruptive behaviors that undermine a nurse's capacity to care.
Allan, Cowie & Smith	(2009)	Behaviors such as intimidation, public humiliation, offensive name calling, social exclusion, and unwanted physical contact that has the potential to undermine the integrity and confidence or the nurse and reduce efficiency.
Anderson	(2011)	Covert behaviors such as denying people access to resources, assigning difficult tasks or going silent when someone enters the room.
Baron & Neuman	(1996)	Giving someone the silent treatment, spreading false rumors about the target, belittling someone's opinion to others, insulting, yelling, shouting.
Brothers, et al.,	2011	Repeated inappropriate behavior, direct or indirect verbal, physical or otherwise perpetuated by one or more persons against another in the course of employment, which could reasonably undermine an individual's right to dignity at work.
Brown & Middaugh	(2009)	Gossiping, eye rolling, sighing, humiliation, silence, sabotaging through withholding information or peer support, and excluding the victim from group activities.
Ahten & Clark	(2012)	Any inappropriate behavior, confrontation, or conflict ranging from verbal abuse to physical and sexual harassment between co-workers.
Cleary, Hunt & Horsfall	(2110)	Workplace behavior that could reasonably be considered humiliating, intimidating, threatening or demeaning to an individual or group of individuals and that is usually repeated over time.
Daiski	(2004)	Lack of respect, support from colleagues, verbal abuse or any behavior that contributes to disempowerment of nurses.
Embree & White	(2010)	Non-verbal innuendo, verbal affront, undermining activities, withholding information, sabotage, scapegoating, backstabbing, failure to respect privacy, and broken confidences.
Lally	(2009)	Scapegoating, backstabbing, infighting, disrespectful, aggressive, overt and covert behaviors.

Implications for Nursing

Nursing is a profession with competitive salaries and positions, and a profession that is expected to be on high demand in the near future. It is well documented in nursing literature that many nurses are in fact retiring and that baby boomers are getting older and will need nursing care. (Morgan & Lynn, 2009). The amount of nurses entering and staying in the workforce should thus be exponentially increasing, not going on the declining. Workplace satisfaction plays a major role in maintaining nurses in the workforce. The current job demands and work overloads, with limited peer help or short-staffed conditions place a burden on the nurses, who already feel the pressure of compliance to their organizations' demands (Cleary, Hunt & Horsfall, 2010).

On an extensive review of the literature, it was found that nurses internalize feelings of anger and repress their rage, which causes a cumulative effect, that eventually must find a release and so in a violent fashion these nurses then explode onto each other at work (Daiski, 2004). This can manifest itself through negative behaviors such as gossip, jealously, put-downs, blaming, and yelling at each other. This abusive behavior is described in the literature as workplace bullying (Almost, 2009; Hutchinson, 2009).

An extensive number of studies have concluded that bullying is on the rise, and it is a major contributor to job dissatisfaction. Bullying affects the collaboration between co-workers and nursing teams, causes undue stress to the victims and the witnesses to the behaviors, and it disrupts care for patients. Bullying behavior is described as a consistent pattern of negative behaviors that is directed to an individual or a group of individuals, and it can be horizontal bullying or managerial bullying. Covert and overt behaviors are used in bullying, some examples are: unfair assignments, sarcasm, eye-rolling, ignoring someone's request or a direct question,

refusing to provide help when available, refusing to work with someone, isolating or

excluding the victim from meetings or group gatherings, sabotaging others, etc. Bullying is

intimidating, insulting, and undermines self-confidence; in addition; it affects the nurses'

physical and mental health, and emotional wellbeing, as well as the patient's care.

Impact and Consequences

According to the literature, bullying has other consequences on the workplace. It causes

long-term negative effects on the victim's psychological health, it is malignant to the

environment, damages relationships among nurses, and causes negative patient outcomes,

increases turnover, and can lead to medical errors and unsatisfactory patient care. The negative

emotions that bullying has created among the victims, vary upon the amount of time the victim

has been exposed to the disruptive behavior and the consequences are detrimental. In addition,

some long term effects require counseling for the victim of the abuse, and the symptoms and

physical problems are described in the literature as: insomnia, anxiety, increased risk for

cardiovascular disease, depression, and increased physical sickness. For the organizations, this

negative behavior brings an increase in expenditures since bullying leads to high staff turnover,

dissatisfaction, low morale, increased absenteeism, decreased employee loyalty, organizational

apathy, loss of employee productivity, medical errors, poor patient care, and possible increase in

employee grievances and Equal Employment Opportunity cases, not mentioning the time and

money expended on the investigational process due to internal complaints against each other.

The Health Resources and Services Administration (HRSA, 2002)) has pointed out that the

nursing shortage in the United States is on the rise, and will reach crisis proportions by 2020.

The current expected shortage is only 29% of the pending crisis. There are many reasons listed in

the literature for this nursing shortage. In an article by Andrews & Dziegielewski (2005), several

important factors that contribute to nurses leaving the workforce were considered. The most

important factor for nurses considering staying in a position is the job satisfaction, which involves job morale and a positive environment.

The Federation of Nurses and Health Professionals conducted a study on morale as a measurement for job satisfaction (Hart, 2001), 68% of all interviewed nurses reported low morale in their current workplaces, 81% considered changing careers, and 55% expressed being unhappy with their current positions. In an international study, 711 hospitals among five countries were included. Out of these, the numbers reported for job dissatisfaction were as follows: Canada 32.9%, England 36.1%, Scotland 37.7%, and Germany 17.4%, including the U.S with 40%. The American Nurses Association conducted a study in 2001 via online survey to 4826 working nurses, 56.9% reported verbal abuse and threats at work, however less than 26% reported this to their employers. Another influencing factor for nurses leaving the workforce is the amount of stress which leads to health issues. When the job becomes demanding, the workloads are increased and there are not enough staff nurses to help out with the job demands. Increased stress will cause nurses to burn out and have job dissatisfaction. When two or more people are exposed to this type of stressful situations, their ability to handle differences of opinions diminishes. When there are high demands to comply with the organizations regulations and recognitions, but there is not enough staff to help out with their difficult assignments, nurses will feel unsupported by their peers and will feel the need to compete against each other for recognition. Bullying will flourish in unsupportive groups of people who are in stressful situations and who feel that bullying is the only way to release their frustrations. One of the reasons expressed for job dissatisfaction is the increased stress that bullying causes among nurses. Nurses take on increasing responsibilities and are expected to provide leadership in unpredictable circumstances, however many nurses encounter verbal abuse among co-workers when these latter are unable to cope with their own issues in the work place. Many victims of

bullying do suffer from post-traumatic stress disorder (PTSD), which may consequently have effects on their self esteem, job performance, and general health, especially if these effects are accompanied by anxiety, sleep disturbance, concentration difficulties, irritability, etc.

Nursing Practice

In the nursing practice bullying affects collaboration between teams and co-workers. Bullying has been described as an unresolved social conflict that is allowed to escalate to a high level, and which there is an imbalance of power (JOGNN, 2008). Since bullying is a persistent, repetitive, negative behavior or behaviors that have a detrimental effect on the nurse, eventually, the victim will direct attention and energy away from their assigned job and may end up making medical errors, or perform unsafe medical practices which may jeopardize a patient's life. The Joint Commission responded to these risks in 2008 by requiring health care organizations to set behavioral standards to address these negative behaviors in their own workplaces. Some nurses may respond different to attacks against them, by using their own defense mechanisms such as withdrawal, avoidance and even attacking others as a way to regain some control over their own situation. However, depending on the nurses' background, some opt to accept these negative behaviors as part of their job situation, and tolerate them rather than speaking out. These nurses keep their anger and frustrations to themselves. When one of these nurses chooses to attack others, the cycle of violence begins.

Curtis et al. (2007) interviewed a group of student nurses who had experienced bullying during their clinical practice, and 90% of these nurse students responded that their bullying experience most likely would play an important role in their intention to remain in the nursing field. On another study by McKenna et al. (2003), a group of first graduate nurses who had been victims of bullying or had witnessed other nurses being bullied, 62% of 3,266, reported that they were the victims of bullying, and 34% were considering leaving the profession. As bullying

behaviors continue to increase in the workforce, so does the amount of nurses in the field

continue to dwindle and diminished.

Education for Nurses

Health care organizations are required to increase awareness of this phenomenon by

educating nurses, and other healthcare staff members involved in the care of patients. JCAHO

(2008), raised a sentinel alert to push all healthcare organizations to implement an education plan

so that everyone would learn about bullying and thus lower the frequency of its occurrence.

Organizations were also required to come up with a system where they would measure and

monitor the new education program effectiveness. Other ideas given within the literature is about

identifying what is working well within the organization and what is not working, as a first step

to analyze the reasons for bullying. Other methods to reduce negative behaviors in the workplace

were identified within the literature as the empowering of nursing practice, the facilitation of

goal attainment, and the recognition of the significance of nursing, not only at the individual

level, but also as a team effort. In addition education on how background differences,

generational differences, and cultural differences play an important role on assumptions in

communication would be effective. Finally, teaching boundaries of appropriate interpersonal

behaviors and identified improper behaviors is essential.

Foucault (1980) studied broadly the relationship between men's power and men's

knowledge within a society. After finding out that power brings conflict between people's

relationships, a concept theory was initiated, in which knowledge equals power and power is

equal to knowledge. Pointing out that people naturally resist being controlled by others,

therefore, so power may bring some resistance to adaptation and to changes. This may create a

cycle of resistance to power among working relationships, and nursing is no exception. In an

article by King-Jones (2011), Foucault's (1980) theory of power was mentioned and analyzed as

a way to study nursing relationships and to find out answers to the nursing conflicts in the workplace. Utilizing Foucault's (1980) method as a mean to understand nursing conflicts, nursing faculty focused on how the profession of nursing was described as being oppressive by itself. Students need to come out of school with the required knowledge to work on their areas of choice. However, students were found not knowing how to maintain their own personal power and knowledge once they reach the hospitals and other healthcare organizations (Clark & Ahten, 2012).

Administration and Organization's Role

Due to the current and pending shortage of nurses, organizations need to address the severity of bullying in the workplace as a major influence in the decision to leave the profession. Healthcare organizations and Professional Nursing Organizations all over the world need to examine the current nursing working environments. Bullying behaviors are not only affecting the retention and future of nurses all over the world, but are also placing a risk in the delivery of patient care (Joint Commission, 2008). Abusive language and demeaning or degrading comments, affect the collaboration between team-members and breakdown the communication and relationships between caregivers, jeopardizing the care for patients (Anderson, 2011). When a person of authority, such as a manager or supervisor, utilizes repetitive threatening or abusive language to intimidate someone to comply in a timely fashion with the organizations requests, it is known as bullying (Hutchinson, Vickers, Wilkes, & Jackson, 2010). Horizontal bullying is when these negative behaviors occur within same level of nursing, and the similarity of disruption on someone's character is the same as bullying from an authority level (Longo, 2010).

In a study by Rosenstein & O'Daniel (2008) of 4,539 healthcare employees, 71% expressed that there was a connection between disruptive behaviors and medication errors, and 27% felt that disruptive behaviors contributed to patient mortality. Health organizations have the

responsibility for the patients' welfare and safety, and the need to show a concern for the frequency of workplace bullying. For this reason an outlined plan to address these disruptive behaviors must be implemented, and specific policies be in place and followed by all concerned. However, extensive literature points at managers' lack of time to address these issues in their work environment. Another important bit of information found in the literature was about bullying situations that were being handled badly by some managers, and the difficulty of confronting the bully when the managers have conflicting roles, such being the aggressor's friend or family member (Lewis, 2006). Ultimately, workplace bullying is damaging to the organization in both cost and time; and has an impact upon the nurses and their work environment, affecting their ability to perform safely and to provide the supportive care that patients require of them.

Limitations and Areas for Future Studies

Fourteen studies documenting limitations, four qualitative studies, three quantitative, one descriptive, and six systematic reviews. In a quantitative study by Almost et al. (2010) participants were selected from the provincial database, but the names of the nurses participating were the same who had previously agreed to take part in the research for own personal reasons. This choice may have caused selection bias, limiting the result's responses. In two reviews, a descriptive and a systematic, the definition of bullying was not established. This may have caused errors in the data analysis by not adequately addressing the responses related to this issue. Three integrative/ systematic review studies, one exploratory and one qualitative, each pointed out respectively, that the number of participants were too small and did not allow a complete generalization of the results beyond this sample of nurses. This limits the results to a smaller scale, and cannot be used as an overall response to the diverse experiences of other nurses. On the areas found of need for future studies, two systematic review studies concluded that more

investigation needed to be conducted into the real reasons for workplace aggression. And to link violence as a precursor of bullying, when some reports point out that some administrators do not provide support to the victims of bullying (Baron & Neuman, 1996; Brinkert, 2010). The nurses who were being bullied lacked the trust to come forward and report this type of abuse. The literature on these two studies demonstrate that the lack of communication between managers and staff is a reason why workplace bullying is tolerable and on the rise in all healthcare organizations (Brinkert, 2010). The results from two quantitative studies, due to the lack of response in their questionnaires, give different areas for future study and one of the areas that need to be further investigated is the reason why there are incidents being tolerated by new graduate nurses. Assessment needs to be done to find out if new graduate nurses are aware of what bullying behaviors are and how to recognize them.

There is also the need to find out the nurse's perception of bullying in the workplace. What may be rude to one nurse may be a common style of communication from another nurse (Brinkert, 2010). Of the areas covered on these two studies, none cover the ethnic differences and backgrounds from the nurses interviewed. Furthermore, two qualitative studies also concluded that more research needs to be done on the area of nurse students, since there is no clear evidence that school curriculums cover education on bullying behaviors and their negative effects on job satisfaction, nurses' morale, and patients' safety (Clark & Ahten, 2012). In a systematic review, led by a team of experts, the researched evidence does not provide enough information that implementing training processes and zero tolerance policies within the organizations has worked to decrease the cycle of bullying among nurses (Clegg, et al., 2010). The amount of studies reporting that organizations lack the correct approach to bullying was found to be extensive.

Organizational Perspective

There were thirteen studies (32%) that examined bullying from the organization's perspective, and the findings were that the organization's conditions perpetuated the continuance of workplace bullying; therefore, bullying is attributed to the organization's practices and demands. In a meta-analysis review, a series of commentaries documented from different healthcare settings located in Australia, England, Canada, Scotland and the United States, suggested that increased job stress is caused by increased organization's demands and requirements. The organization's lack of clearly defined rules of conduct, enforced policies, and workplace aggression education prevention, has led nurses to believe that bullying is an acceptable behavior. Organizations are often noted to have a lack of response to bullying behaviors, and their approaches are often taken as unhelpful to remedy the situation, since most choose to focus on other organizational priorities rather than to focus on their employees' needs.

When leaders within an organization choose to disregard bullying behaviors, these behaviors continue to perpetuate among staff, and become part of the nursing culture. In many cases the victim is someone who is unable to defend her/himself and ends up adopting a survival attitude, in which the victim may eventually become a bully. In the literature reviewed, a major contributor to increase work stress is the lack of response from managers and supervisors when bullying behaviors were reported, and when the organization's approach was to incriminate or rehabilitate those found guilty of bullying, and yet sought to look blameless for allowing those behaviors to thrive in the first place. In other words, when organizations do respond to bullying reports, they focus only on the individuals involved rather than addressing and accepting being part of the problem. According to Hutchinson (2006) some organizations do not take the responsibility well nor they accept being part of the problem of bullying among nurses. Which ultimately, this lack of responsibility or acceptance may label the organizations as an enabler

(Hutchinson, 2006). Hutchinson (2006) also documented extensive evidence that many times the victims of bullying were labeled as incompetent or less capable, and finding excuses why the bully could be targeting these nurses to perform a better job. During these cases, the bully is made to look as though they have a legitimate cause to abuse the victim. On another literature review study by Andrews & Dziegielewski (2005) documentation was found that in large organizations where more nurses witnessed the incidents of bullying, the reporting course of action will be a lengthy decision making process. Sometimes this process will take a very long time to be investigated and to be completed. Long processes and time consuming investigations may only be creating a perfect shelter for the bully to continue to victimize other nurses. In two other single descriptive studies, managers were found to perpetuate bullying behaviors and even were reported to be the bullies themselves. Since some managers were pushed to focus on productivity plus adhering to the organizations rules, some were found to utilize bullying as a management style to achieve their unit's goals. This was specially true if they were ought to compete against other units on productivity and to obtain a higher patient's positive response rate. Some managers were found rewarding bullies who help them achieve their goals. And some of the victim's complaints were disregarded and taken as a sign of weakness (Ehrhart, Kath, & Stichler, 2012).

Effects on Nursing Shortage

Organizations should examine the cost of losing more nurses and the implications of bullying. Extensive literature points at bullying as being a major precursor for nurses wanting to leave the profession (Brinkert, 2010). It is well documented by different professional agencies that the nursing profession is in crisis, and as the population ages, health issues increase. If the staff front line nurses and faculty come to an age to retire, it may not be long before the healthcare industry will suffer the consequences of this shortage (Morgan & Lynn, 2009). In a

quantitative Canadian study about satisfaction and retention of nurses, one major factor was

pointed out, and this was having good supportive relationships in the workplace setting. Added

factors that contribute to the nursing shortage are the job stress levels, decreased job satisfaction,

the increased demands placed on nurses, and the shortage in unit's other staff members (such as

CNA's, LVN's, etc); in addition, nursing care is seen as a time task oriented practice, where the

results demonstrate that nurses feel overwhelmed by the organizations' demands. When tasks are

not completed within a certain timeframe given (end of shift), the individual is seen at fault and

labeled as incompetent, or disorganized (Lindy & Schaefer, 2010).

Effects on Patient Care

Rude, demeaning, disinterested, arrogant, aggressive, and confrontational behaviors are

antecedents to bullying (Almost, 2006). Intimidating and disruptive behaviors are part of

bullying and are precursors to medical errors. When administrators choose to ignore disruptive

behaviors, these create an unhealthy and hostile work environment that can be easily perceived

by patients and their families. According to Brinkert (2010) when nurses are bullied, their

attention changes from the patients' care and well being to protecting themselves. Bullied nurses

will try to survive and defend themselves from the attacks (Brinkert, 2012). Many times some

victims of bullying will isolate themselves and will not communicate with other peers for fear of

humiliation. Their fear will stop them from asking for help on their difficult assignments, again

out of fear of being ridiculed (Yildirim, 2009). Nurses' isolation creates a lack in team

collaboration and promotes unhealthy environments which foster poor patient care and medical

errors (The Joint Commission, 2009). When the nurse is bullied, a self-blaming attitude develops

in consequence of this intimidating work environment; subsequently this attitude may cause the

victim to exhibit unsafe clinical behaviors. Numerous examples are found in the literature about

the connection between bullying and poor patient satisfaction (Almost, 2006; Almost et. al.,

2010; Brothers et. al., 2010; Purpora, 2010). Safety and quality of patient care is dependent

upon good teamwork, and communication among the unit's staff members.

Education for Prevention

The Joint Commission addressed hostile and disruptive behaviors, in the workplace, by

establishing new standards of care in January 2009 that require healthcare organizations to write

and promote a code of conduct, mechanisms to encourage staff to report bullying behaviors, and

a process to discipline offenders. In addition, the Nursing's Code of Ethics mandates reporting of

any disruptive behaviors in the workplace (American Nurses Association, 2001). Some

strategies studied are an ongoing education process that teaches nurses to recognize bullying

behaviors, and for nurse managers to admonish these behaviors and advocate for the victims.

Researched literature has opened the question for the need for more education on bullying,

beginning at the nursing school level (Halfer & Kramer, 2012). Current data reports that bullying

is not mentioned nor is it taught about in nursing school programs, neither is there any known

curriculum that teaches nursing students to recognize bullying behaviors (Lally, 2009). Some

strategies for successful work environments will be to develop education programs that teach

conflict resolution strategies for team members in all healthcare settings before it escalates to

bullying. Another approach listed in the literature is the implementation of zero tolerance

policies within organizations (Roberts et. al., 2010); however, there is ample literature showing a

need for future studies if zero tolerance ought to be utilized, since there is no conclusive

evidence yet that this approach has worked well. Administrators and Managers need to promote

a culture of safety and communication in which victims feel safe reporting the abuse; in addition,

Managers need to receive continuous professional development education on conflict

management and conflict resolution and learn to confront the situations with an unbiased

approach (Lindy & Schaefer, 2010). It is imperative that organizations also take time to develop

classes and provide education for nurses to help them recognize bullying behaviors and to provide easy access to report these abusive behaviors. Workplace bullying behaviors will take many years to eradicate from the nursing culture (Clark, 2012); however, today is a good time to start eliminating these behaviors step by step, until bullying can be controlled. With the nursing shortage, any approach to eliminate to decrease these disruptive behaviors is better than no action at all (Hutchinson, 2009).

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Appendix A

Step-by-Step Working Circle

Question 1: What's the situation?
Focus on the facts. What exactly is going on? Put all your emotions and opinions aside and consider the facts only. Think of yourself as a camera, moving to all angles in turn and snapping the facts as images of the situation. You'll only record people, places, and things involved.

Question 2: What's Negotiable?
Once you have a clear grasp of the situation, you can begin to determine both the important and noncritical components of your dilemma. Sift through the facts to identify what you're willing to negotiate, give away, or compromise in order to arrive at a game plan.

Question 3: what's non-negotiable?
Making a clear stand on each other's critical and non- critical items will enable both parties to deal efficiently with transgressions and not face unpleasant surprises.
Examples could include:

Question 4: What Have I Learned From the Previous Experiences? Previous experiences, even if unpleasant,
can provide information for future growth if communicated in a way that
Multiple challenges, and the lessons learned should empower us to deal with the prevailing one.
Having survived previous difficult situations, one would have learned a thing or two that is helpful to you today. For example, having been bullied and having a chance to treat the bullies as equals rather than avoiding them proves the importance of behaving like a considerate human being, rather than emulating the bad behavior of the bullies.

Question 5: How Do I Feel About the Situation?
Emotional conversation is only productive when it helps to clear blockages, which slow down the organization. If we paid a bit more attention to how people are feeling, we could significantly improve productivity and morale. Acknowledging worry goes a long way toward minimizing it. Facing the emotions inherent in any situation enables us to deal with them and move on.

Question 6: What's My Game Plan?
What are you going to do?
Use all the information accumulated from the first five questions to help draw up your game plan, for example: defensiveness, not make any accusation.

Question 7: what transformation will the game plan bring? Project the consequences of your plan. How would
you like to be transformed as a result?

Question 8: Will These Changes Ultimately Be Positive? Look to the future. Begin with this end in mind! Be
diligent in answering the first seven questions and you should be able to move rather briskly though this question.
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