CNE SERIES

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Sadly Caught Up in the Moment: An Exploration of Horizontal Violence

EXECUTIVE SUMMARY

- The behaviors associated with horizontal violence can have negative consequences for nurses, patients, and organizations.
- Participants in this study were sent a survey that listed nine behaviors associated with horizontal violence.
- They were asked if they had witnessed, experienced, or neither witnessed nor experienced the nine behaviors.
- Participants were also asked to respond to three open-ended questions intended to capture their uniquely personal experiences with horizontal violence.
- For all but one behavior, the majority of participants stated they had witnessed or experienced eight of the nine behaviors associated with horizontal violence in their workplace.
- In response to the findings of this study, an educational program was developed to assist nurses in recognizing and responding to horizontal violence.

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NOTE: The authors and all *Nursing Economic$* Editorial Board members reported no actual or potential conflict of interest in relation to this continuing nursing education article.

WHILE RESEARCHERS continue to explore horizontal violence for a more comprehensive understanding of the phenomenon and its root causes, there is currently agreement on two issues. Horizontal violence is prevalent in the nursing profession, and the experience of this behavior is psychologically distressing, threatening patient safety, nurse moral, and nurse retention (Joint Commission, 2008; McKenna, Smith, Poole, & Coverdale, 2003; Simons, 2008). While discussing this phenomenon at a nursing retention committee meeting, all but one of the 15 members present had a story to relate about a time when they experienced bullying. Strong emotions were evident in the telling of these stories; whether they occurred in the recent or far distant past. This led members of the committee to the central question of this study: Is horizontal violence occurring within our organization, and if so, how prevalent is it? Griffin (2004) defined horizontal violence as overt and covert actions by nurses toward each other and especially towards those viewed as less powerful. Based on this definition and using the most common behaviors, Griffin (2004) identified from the nursing literature, the nurses in our hospital system were surveyed to further explore this phenomenon.

Review of Literature

A review of the scientific nursing literature presented a picture of horizontal violence which can be delineated into three distinct categories: (a) prevalence and consequences, (b) root causes, and (c) how best to address the phenomenon in the workplace.

The prevalence of horizontal violence has been identified as ranging from 5%-38% in Scandinavian countries, the United Kingdom, and the United States (Johnson, 2009; Simons, 2008). Two Australian studies report 50% and 57% prevalence rates, and 86.5% of participants in a Turkish study reported experiencing aggressive behaviors at work (Johnson, 2009). In a study conducted by Farrell (1997), the majority of subjects described experiencing intra-staff aggression which was more troublesome and harder to deal with than aggressive behaviors from patients or their families and contributed to a work environment that was hostile. Nursing students reported being the target of verbal or emotional abuse from staff members in the clinical environment (Longo, 2007), and McKenna et al. (2003) discovered that new graduates are also likely to experience horizontal violence.

Recognizing that aggressive behavior in the workplace jeopardizes patient safety, the Joint Commission (2008) issued a sentinel event alert calling for organizations to address the behaviors

that "undermine a culture of safety." In a similar vein, the Center for American Nurses (2008) published a position statement acknowledging the affects on patient safety, quality of care, and how this phenomenon directly affects the organization's and profession's ability to attract and retain nurses. Hutchinson, Jackson, Wilkes, and Vickers (2008) developed a new model of bullying in the workplace. Embedded in this model is the notion that experiencing horizontal violence has negative health effects in addition to interruptions in work settings and career goals.

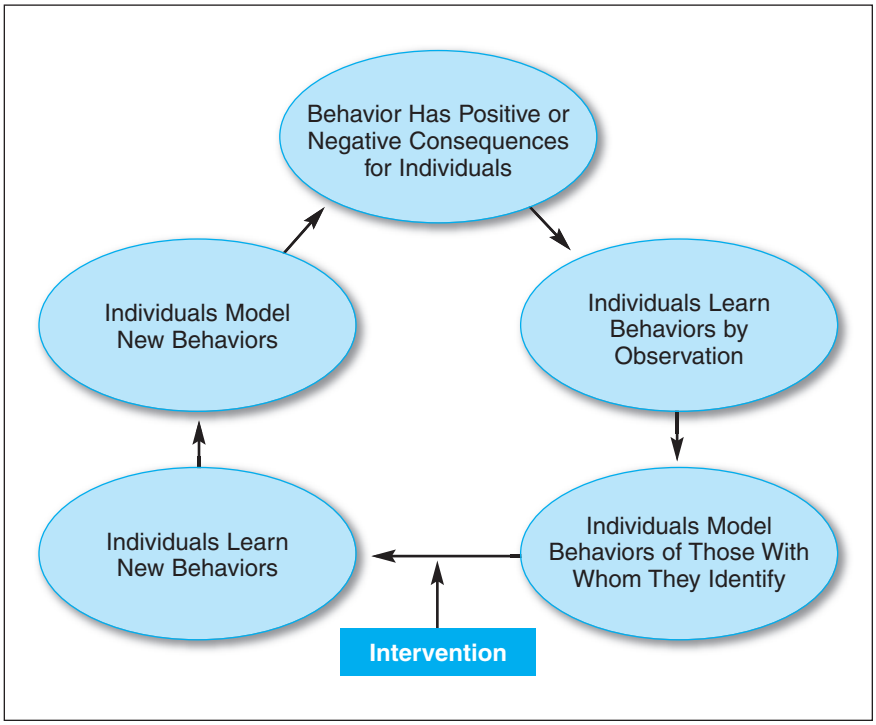
Researchers' interest has been piqued about horizontal violence for the past several decades with varying viewpoints on the cause. While some researchers believe this is a direct result of oppressed group behavior (Duffy, 1995; Roberts, Demarco, & Griffin, 2009), others contend that in order to fully understand and address the behaviors and potential outcomes associated with horizontal violence it is important to look at structures and circuits of power within organizations (Hutchinson, Vickers, Jackson, & Wilkes, 2006).

Reducing Horizontal Violence

The presence of horizontal violence in the workplace makes it difficult for an organization to improve the quality of care they provide or create a satisfied work force (Woelfe & McCaffrey, 2007). It is also difficult to decrease nurse turnover and attract the most desirable employees in an organization where horizontal violence exists (Center for American Nurses, 2008). The average cost of replacing a nurse who has left to work at a competing institution ranges from $22,000 to $64,000 (Jones & Gates, 2007).

Increased awareness has been cited as a first step in formulating a plan to decrease the incidence of horizontal violence in the workplace (Johnson, 2009; Simons, 2008). Cognitive behavioral techniques have been used successfully by nurses (Griffin, 2004). Jackson, Firtko, and Edenborough (2007) described the use of individual resilience strengthening as a way to decrease susceptibility to adversity within the workplace. Farrell (2001) advocated individual nurses can and should play an important role in changing their work environments.

Figure 1.
Horizontal Violence Intervention Model



Theoretical Framework

Bandura (1969), the author of Social Learning Theory, emphasized the importance of observing and modeling the behaviors, attitudes, and emotional reactions of others as a way to assimilate into a particular group. Much of our learning to navigate interpersonal situations is a result of emulating the behaviors we observe in the group to which we want to be accepted as a member (Bandura, Ross, & Ross, 1961; Bandura, 1969, 1977). Also known as *reciprocal determinism*, the aforementioned researchers believe the world and a person's behavior cause each other. Believing this to be true as well, this framework was selected to guide our study.

The literature about horizontal violence in the workplace revealed that individuals tend to emulate the behaviors of the group members they most intimately engage with as a way to be accepted by them. Stated another way and based on Bandura's theory, the workplace *(world)* and the employees *(individuals)* on some level cause each other's behavior *(reciprocal determinism).* When maltreatment of an employee(s) is occurring, members of the work unit may model the behavior of the individuals participating in the negative behavior as a way to be accepted by them (see Figure 1).

Methods

Design. A mixed-method descriptive design was used to fully describe the participants' experiences with horizontal violence and to achieve a more thorough and explicit understanding of the com-

Table 1.
Quantitative Results

Behaviors	Response %	Response Count
Nonverbal negative innuendo (i.e., raising eyebrows, face-making)		
Have witnessed this being done to someone.	72.2%	148
Have personally experienced.	54.1%	111
Have neither witnessed this being done nor experienced myself.	8.3%	17
Covert or overt verbal affront (i.e., snide remarks, withholding information, abrupt responses)		
Have witnessed this being done to someone.	66.7%	136
Have personally experienced.	58.3%	119
Have neither witnessed this being done nor experienced myself.	11.3%	23
Undermining clinical activities (i.e., not available to help, turning away when asked for help)		
Have witnessed this being done to someone.	50.0%	102
Have personally experienced.	46.1%	94
Have neither witnessed this being done nor experienced myself.	32.4%	66
Sabotage (i.e., deliberately setting up a negative situation)		
Have witnessed this being done to someone.	28.4%	57
Have personally experienced.	19.9%	40
Have neither witnessed this being done nor experienced myself.	64.2%	129
Bickering among peers		
Have witnessed this being done to someone.	72.1%	147
Have personally experienced.	48.0%	98
Have neither witnessed this being done nor experienced myself.	10.8%	22
Scapegoating (i.e., always assigning blame to one person when things go wrong)		
Have witnessed this being done to someone.	56.5%	113
Have personally experienced.	26.0%	52
Have neither witnessed this being done nor experienced myself.	36.5%	73
Backstabbing (i.e., complaining to others about one individual).		
Have witnessed this being done to someone.	77.0%	157
Have personally experienced.	53.4%	109
Have neither witnessed this being done nor experienced myself.	8.3%	17
Failure to respect the privacy of others (i.e., gossip/talking about others without their permission)		
Have witnessed this being done to someone.	76.0%	155
Have personally experienced.	46.1%	94
Have neither witnessed this being done nor experienced myself.	10.8%	22
Broken commitments and/or broken confidences (i.e., repeating something that was meant to be kept confidential)		
Have witnessed this being done to someone.	52.2%	106
Have personally experienced.	28.6%	58
Have neither witnessed this being done nor experienced myself.	37.9%	77

plexities surrounding this phenomenon (Connelly, Bott, Hoffart, & Taunton, 1997). Based on the seminal work of Duffy (1995) and Griffin (2004), the researchers developed a survey to answer their research question (see Table 1). The nine-item Horizontal Violence Behavior Survey was constructed from generated items carefully examining the wording and sequencing of each item put forth by Fink and Kosecoff (1988). For each of the nine negative behaviors listed, respondents were asked to choose from three responses namely, *experienced, witnessed, neither experienced nor witnessed* with the potential for multiple responses in each category. In addition to completing the quantitative survey, the participants were asked to respond to three open-ended qualitative questions.

Seven experts from various educational institutions, and qualified to judge the questions for relevancy, were asked to respond to the appropriateness of the instrument (Okoli & Pawlowski, 2004). Six experts rated each item on the

instrument a 4 on a scale of 1 (low) to 4 (high) with relevance and clarity; one expert rated each item 3.5. Based on the feedback from the experts, the researchers refined the items for clarity and word choice. The verbiage was changed in two of the nine items. Regarding survey question number two, the word *action* was replaced with *affront.* In the second instance, in question number six *scapegoat* was changed to *scapegoating*. These changes were made based on the belief of one expert reviewer that *affront* and *scapegoating* would more accurately capture the essence of the experience.

Setting, sample, and data analysis. With institutional review board approval, all nurses in the multi-institutional health care system were invited to participate in the study (see Table 2). An e-mail providing a link to the survey was distributed with three subsequent reminders over a 30-day time frame when data were collected. The quantitative data were analyzed using frequency and central tendency. The responses to the open-ended qualitative questions were thematically synthesized using the steps for qualitative analysis prescribed by van Manen (1991). Qualitative content analysis is a descriptive analytical technique that serves to identify the manifest and latent content of a text; in this case the answers to the open-ended questions (Brewer, 2006; Denker, 1995; Graneheim & Lundman, 2004; Reineck, Finstuen, Connelly, & Murdock, 2001).

Table 2.
Demographics of Sample (N=227)

Characteristics	%
Age Group (years)	
Up to 25	7
26-35	17
36-45	19
46-55	39
56-65	18
>65	1
Gender	
Female	93
Male	7
Race	
White	96
Black	3
Asian	1
Highest Education	
Diploma	9
AD	19
BSN	63
Masters	9
Years of Experience in Nursing	
0-10 years	31
11-20 years	25
21+ years	45
Years of Employment at Organization	
0-10 years	61
11-20 years	23
21+ years	16

Findings

Quantitative. The respondents (N=227) provided data on the nine identified horizontal violence behaviors. The highest reports of affirmative responses were in the category of personally having witnessed a peer as the victim of a negative behavior (28.4%-77%). In eight of the nine categories, a majority of respondents reported having personally witnessed the horizontal violence activity with scores in excess of 70% that included backstabbing (77%), failure to respect the privacy of others (76%), nonverbal negative innuendo (72.2%), and bickering among peers (72.1). The only behavior that was not witnessed by a majority was sabotage (28.4%).

The response range for personally experienced behaviors was 19.9%-53.3%. Six of the nine categories were 46% or more, and three of the nine were 50% or greater, including covert or overt affronts (58.3%), nonverbal negative innuendos (54.1%), and backstabbing (53.4%).

The data revealed that 8.3%-64.2% of respondents had neither witnessed nor experienced horizontal violence. The only type of horizontal violence not witnessed or experienced by the majority was sabotage (64.2%) (see Table 1).

Qualitative. The nurses were forthcoming in their responses to the three open-ended qualitative questions providing specific examples of behaviors they had witnessed or experienced. From the responses to these qualitative questions, the following themes were generated: (a) sadly caught up in the moment, (b) overt and covert maltreatment, and (c) commitment to positive change in their workplace.

Theme 1: Sadly Caught Up In the Moment

When asked about their experiences with horizontal violence, one-third acknowledged they had indeed engaged in these negative behaviors. The nurses who responded to this question were reflective in their comments, speaking from the perspectives of both perpetrator and victim. They at times excused their personal actions by reframing the circumstances that caused them to act in such a negative manner. Nurses used phrases such as "it's the culture," or "caught up in the drama." They expressed disappointment in their inability to keep their frustrations in check which sometimes resulted in behaviors that violated their personal and professional standards.

The nurses spoke of feeling "sadly caught up in the moment" about their participation in negative behaviors they generally would not exhibit. Nurses expressed surprise and concern about some examples of behavior on the survey identified as bullying. A nurse stated she always believed her ranting and venting were justified until she saw this behavior listed as an example of horizontal violence.

She stated, "I didn't know what it sounded like." Many of the nurses seemed confused that their conversations about their peers could be construed as horizontal violence when they believed they were only offering constructive criticism. A participant offered "When we talk at work about staff problems and difficulties, it's not meant to be gossip: It's meant to share, to get updated with what's happening on the unit." Another reiterated this confusion by injecting a comment about face-making "…that is done in fun." This sense of uncertainty about what was, and was not, acceptable behavior illustrated a need to clearly define horizontally violent behaviors.

Honesty and self-disclosure were conveyed in comments that began with "…unfortunately" and "…sadly." "I may know at times I am guilty of raised eyebrows and face-making, I try not to be, but it happens so fast."

Some respondents expressed awareness they had engaged in this behavior, but offered justification for their actions. Statements such as "They just weren't doing their job" and "They need to know what it felt like" were used. A nurse believed her unkind interactions with a peer were defensible. She shared, "Her performance was a hindrance to the unit." These respondents described negative behaviors as a response to what they perceived to be inadequate work performance by their peers. There was a sense they viewed their aggressive behavior as a necessary means to an end, especially if management failed to address a grievance when reported to them.

Theme 2: Overt and Covert Maltreatment

Nurses were given an opportunity to share any negative behaviors they had personally experienced or witnessed which did not fit into the category of behaviors already described in the previous questions. While no new categories of behaviors were identified, detailed descriptions were provided of negative behaviors they had observed, or been directly involved in.

The majority of overtly aggressive behaviors were verbal in nature. They ranged from "…yelling aggressively" to the use of "…verbally dismissive or demeaning remarks." Personally denigrating terms were not identified individually, but adjectives such as "slandering" and "degrading" were used to describe witnessed conversations. Some descriptions were more specific, such as the response from one nurse, "I have been on the receiving end of taunting, and been singled out and labeled." While no physically aggressive behaviors described in the survey were aimed at individuals, one respondent described "objects being thrown around the nurses' station."

Covert and passive behaviors described by participants centered on a lack of communication and included such things as "ignoring my requests for help," as well as "general inapproachability and cold demeanor." One nurse explained, "I have witnessed someone refusing to talk to a co-worker. No communication makes for a difficult day." These comments reflecting the inability to rely on team members when providing patient care created a sense of isolation for the nurse and were seen as having an impact on patient safety. One nurse described this experience, "Two nurses drew mustaches on a staff member's picture at the desk. They were confronted about their behavior and did not think they did anything wrong."

Comments related to managers and supervisors included examples of aggression being ignored as illustrated by this nurse's statement, "I reported a couple of incidents to my manager and nothing was done, the co-worker then had an even worse attitude toward me." While no nurse reported being aware of overtly aggressive behaviors aimed at her or him from a manager, many reported feeling they were recipients of negative covert behaviors. These included being ignored by a supervisor, not encouraged to apply for advancement, and not mentored professionally as were some of their peers.

Theme 3: Commitment to Positive Change in their Workplace

When asked to share their thoughts and suggestions about ways to decrease the amount of violence in their workplace, nurses spoke of their sincere commitment to improve relationships with their colleagues. The high number of responses to this question was interpreted as a desire on the part of the nurses to be active in the solution.

The nurses believed it was important to appreciate and celebrate differences among their ranks. Some nurses suggested hospital-sponsored continuing education programs focused on cultural awareness. One nurse shared, "What about a campaign to encourage all to 'do unto others as you would have done to you.' No one likes to be treated negatively so don't treat others that way either."

Collectively the nurses who completed the survey believed that most, if not all, needed to take responsibility for their part in perpetuating negative behavior. One nurse said, "By not participating in negative behaviors or condoning them, in a non-confrontational way, let the perpetrators know to maintain professional treatment of peers." Another shared, "Nurses need to take responsibility to do the 'right thing' for fellow nurses."

Survey participants provided thoughts about how best to tackle this dilemma. Their comments reflected the strong belief that all levels of management should be involved in solving the problem of horizontal violence in their particular workplace. One respondent shared, "Nurse managers need the tools to act on it and quickly stop horizontal violence."

Finally, a nurse focused her response on the necessity of encouraging personal responsibility stating, "Treating staff well and trying to minimize working short staffed so people do not feel burnt out and give themselves an excuse to be concerned with self over others." Another said, "I would suggest a strict 'no tolerance' policy and make sure managers, supervisors, etc. enforce it. You would not believe how much of this goes on every day...how it affects retention, and ultimately how it effects our patients."

Discussion

Participants in this study reported witnessing and/or experiencing many of the negative behaviors associated with horizontal violence. The range of positive responses in this study (19.9% to 77%) corresponded with what has been reported by previous researchers exploring this phenomenon (Johnson, 2009; Simons, 2008). The results of this study validated the appropriateness of Social Learning Theory as the framework to guide this study. According to Bandura (1969), individuals will mimic or role model the behaviors exhibited by the members of a group to which they wish to belong. Clearly some of the nurses in this study were surprised they were maltreating their peers by simply "going along with the crowd." Nurses freely spoke of being "caught up in the moment" and adopting the negative behaviors of their peers who were engaged in maltreatment of others in the workplace stating, "it's the culture." Some of the participants sought reasons to justify their actions toward their peers, when they emulated these negative behaviors. Comments left by 26 of the 65 nurses who responded to the question "Have you personally engaged in any of the described behaviors?" revealed they were unaware the behaviors they were mimicking were demonstrable of the tenets of horizontal violence

Individual responses to the qualitative questions provided rich descriptions of the nurses' experiences as observers and victims of this phenomenon. Survey respondents reported that not only did the single bullying incident have an immediate impact on nurse communication and team function, but lasting consequences. Behaviors that impact patient care specifically identified by the nurses in this study included being afraid to ask for help with a patient or ask a question for fear of being ridiculed, having requests for help ignored, and general lack of teamwork and communication. These findings were congruent with consequences identified by the Joint Commission (2008) and the Center for American Nurses (2008). The reporting of predominantly non-physical acts of aggression in our study supports the evidence found by previous investigators (Farrell, 1997; Griffin, 2004).

In that personal resilience can decrease vulnerability to workplace adversity (Jackson et al., 2007), consideration must be given to the role individual resilience plays when determining whether or not a hostile event has actually occurred. A healthy, professional work culture can provide an environment where it is possible to place some negative behaviors in a non-aggressive context.

Nurses offered suggestions for improvement focused on "fixing the problem." Study participants expressed a need for clear policies and enforcement by management that addressed disruptive behaviors and the consequences thereof. Specific requests were made by nurses for "awareness and education training" while others called for accountability, more professionalism, and the need to acquire and use non-confrontational tactics.

Strengths and Limitations Of the Study

A strength of the current study was the researchers' personal experiences of being members of an organization in which nurses openly acknowledged that horizontal violence existed. Using a mixed-method design to collect data, the nurses were able to share their experiences on a deeper and more vulnerable level. Another strength of the study lies in the number of the sample (N=227) as many previous studies reviewed were conducted with small, homogenous groups of individuals who were members of nursing units or nursing specialty areas. Finally, a sense of empowerment was voiced by many of the nurses who participated in the study. Several of the respondents shared statements similar to the following "…it feels good to talk about this" and "Now maybe something will be done." While content experts were used to rank and respond to the study instrument, nonetheless, a weakness of the study might be the use of the researcher-developed tool. Finally, although the population of nurses present in the study was diverse, the majority were Caucasian females. Absent from the study were representative numbers of males and participants from minority populations.

Significance to Nursing

Nurses as health care providers are in positions to identify and intervene on the part of their colleagues when they see or experience horizontal violence. With increased awareness and sensitivity, nurses may be better able to monitor themselves, as well as assist their peers to recognize when they are participating in negative behaviors that have the potential to escalate into violence towards co-workers. Identifying and understanding particular incidences when nurses are most vulnerable and apt to engage in negative behavior (heavy workload, short staffing, etc.) may have the potential to reduce the degree to which individuals get "caught up in the moment."

A work environment that allows horizontal violence to go

unchecked may impact nurse retention and nurse morale (Griffin, 2004). The Joint Commission's (2008) position on disruptive behavior and patient safety provides additional credibility in recognizing horizontal violence as a legitimate workplace issue. Nurse administrators may begin to develop management strategies and approaches to aid in the development of educational programs to address this workplace phenomenon. Establishing performance expectations that include workplace civility in nursing orientation programs and modeling professional behaviors provides a foundation to promote a healthy work culture. Nurse educators have a similar responsibility to develop nursing curricula that educate and encourage dialogue about horizontal violence to increase awareness and provide nursing students the skills to defuse and depersonalize bullying events.

Guided by the study results and with full organizational support, a plan was created to inform all nurses within the hospital system about the results of this study. A 30-minute educational program entitled "Sadly Caught Up in the Moment: An Exploration of Horizontal Violence" was developed that focused on heightening awareness by providing examples of negative behaviors. The intervention was composed of a review of each of the behaviors including appropriate responses when the behaviors were encountered. Additional components of this program included a review of available resources within the organization as well as the role of resilience in helping individuals deal with adversity. Since the development and offering of the educational program, 700 nurses in the organization have attended.

Summary

The purpose of the study was to determine the prevalence of horizontal violence in a multi-institutional hospital system. The stories nurses shared about the negative behaviors they experienced or witnessed were poignant and broadened our understanding and appreciation of the impact of horizontal violence for nurses generally and our nurse colleagues specifically. In their responses it was obvious many nurses were unaware of their participation in this phenomenon until they completed the survey and carefully reviewed the individual behaviors. Many expressed regret regarding these transgressions and described how they would like to react differently under similar circumstances in the future. While the major aim of this study was to determine the prevalence of horizontal violence within the organization, the findings clearly called for the development of an intervention to address this phenomenon (see Figure 1). As a result of the aforementioned educational program, a dialogue has begun among the nurses within our organization. The aim of these conversations is focused on encouraging an increased sense of professional accountability among nurses to break the cycle of horizontal violence in their individual work environments. **$**

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