Abstract

Sociology, Bullying

Abstract Horizontal violence is hostile and aggressive behaviour by individual or group members towards another member or groups of members of the larger group. This has been described as inter-group conflict. (Duffy 1995). Any work, which needs mutual understanding and co-operation, there clash or violence is a common incident. Service sector like nursing requires a lot of devotion and coherence, simply sticking together. But a silent poison has made its way into nursing and slowly eaten away at the core of the nurses, especially their behaviour. This epidemic is becoming so wide spread that everyone from administration to nurse's aides are affected by it. It is the epidemic of horizontal violence. Horizontal violence has become endemic in the workplace culture and it is an unacceptable and destructive phenomenon. To promote excellence in patient care and survive in a chaotic health-care environment, students and newly graduated nurses need information about horizontal violence; it’s characteristics, causes, consequences and cures. Horizontal Violence Horizontal violence is non-physical inter group conflict and is involved in overt and covert behaviours of hostility (Freire 1972; Duffy 1995). It is behaviour associated with oppressed groups and can occur in any aspect or area where there are unequal power relations, and one group's self-expression and autonomy is controlled by forces with greater prestige, power and status than themselves (Harcombe 1999). That’s why sometimes it’s called “ nurses eating their young. " It may be conscious or unconscious behaviour (Taylor 1996). It is, generally, psychologically, emotionally and spiritually damaging behaviour and can have devastating long term effects on the recipients (Wilkie 1996). It may be overt or covert. It is generally non-physical, but may involve shoving, hitting

or throwing objects. It is one arm of the submissive/aggressive syndrome that results from an internalized self-hatred and low self-esteem as a result of being part of an oppressed group (Glass 1997; MCCall 1995; Roberts 1996). It is the inappropriate way oppressed people release built up tension when they are unable to address and solve issues with the oppressor. In the majority of western cultures, a dominator model (Eisler 1993) of social organization enables workplace hierarchy to limit autonomy and practice of various groups of workers and therefore acts as an oppressive force. Workers are socialized into the oppressive structures and unequal power relations of the workplace system. Some groups of people within each particular workplace unconsciously adopt inflated feelings and attitudes of superiority. Some groups adopt unconsciously submissive attitudes, learned helplessness, within the workplace. The internal conflict, generated by conforming to structural pressures and, in some, subduing the desire for autonomy, whilst over inflating it in other groups, compounds the self-hatred and low self-esteem of certain groups of people and perpetuates the cycle of horizontal violence (Taylor 1996). Horizontal Violence is a symptom of the dynamics around oppression and a sense of powerlessness. It is to the workplace culture like water is to fish. It moulds, shapes and dictates the behaviour of those within the workplace culture. It is a form of bullying and acts to socialize those who are different into the status quo. Horizontal violence in the workplace is the result of history and politics in western society and the ideology and practices associated with the socialization and stereotyping of males and females in western culture. Horizontal violence is a system and cultural issue, a symptom of an emotionally, spiritually and

psychologically toxic and oppressive environment. Horizontal violence is not a symptom of individual pathology, although individual pathology flourishes in a climate that supports and condones aggressive behavior (Hastie). Horizontal violence includes: All acts of unkindness, discourtesy, sabotage, divisiveness, infighting, lack of cohesiveness, scapegoating and criticism. For example: * Belittling gestures e. g. deliberate rolling of eyes, folding arms, staring into space when communication being attempted - Body language designed to discomfort the other * Verbal abuse including name calling, threatening, intimidating, dismissing, belittling, undermining, humorous 'put downs' * Gossiping (destructive, negative, nasty talk), talking behind the back, backbiting * Sarcastic comments * Fault finding (nitpicking) - different to those situations where professional and clinical development is required. * Ignoring or minimizing another's concerns * Slurs and jokes based on race, ethnicity, religion, gender or sexual orientation * Sending to 'Coventry', 'freezing out' excluding from activities and conversation, work related and social. * Comments that devalue: * people's area of practice; * women; * others that are different to the 'norm'. * Disinterest, discouragement and withholding support * Limiting right to free speech and right to have an opinion * Behaviors which seek to control or dominate (power 'over' rather than power 'with') * Elitist attitudes regarding work area, education, experience etc " better than" attitude * Punishing activities by management e. g. Repeatedly sending someone out of area; bad rosters; chronic under staffing; lack of concern with mental, emotional, spiritual and physical health of employees * Lack of participation in professional organisations (a subtle form of self-hatred) however, busy family lives can preclude participating in

professional organizations (Hastie). Causes of Horizontal Violence Oppressive attitude Historically, nursing recruited young women who have value for patient care, service, and self-sacrifice. Coupled with the developmental level common to nurses entering the profession, they were perceived as “ less than" in maturity, critical thinking ability, skill capability, and power base in a medical model health care system composed primarily of (older) male physicians. These nurses, lacking power, autonomy, and self-esteem, took on the behaviors of the marginalized, looking to the powerful for approval and demeaning their own (Ferrell, 2001). Task orientation Nurses are valued by their ability to complete assigned tasks in a timely manner, promoting “ Caring as an Economic activity" (Hurley, 1999, p. 11). Nurses who spend too long on a task or on a patient without facing the consequences— a missed meal, a reprimand — work against nursing’s culture and reap dis-pleasure from peers. Yet these peers are needed as the source of “ how-to" in the workplace, in the “ real world, " so maintenance of the status quo is reinforced (Ferrell, 2001) Negative role socialization Randle (2002b) reports that student nurses completed their educational program with “ below average self-esteem, " (p. 143) having suffered from taking on the nursing role. A lowered self-esteem affects role autonomy and competence (Fredriksson & Eriksson, 2003). To survive in a high-stress position, vulnerable nurses are pressured to adopt interpersonal rules, learning how to respond submissively to those who have power over them and too often respond negatively to their subordinates (Randle, 2003a). Administrative retreat Nurse managers, implicated in horizontal violence through “ acts of omission, " (Ferrell, 2001, p. 30) avoid or are unable to deal with horizontal

violence and its ramifications. The prevalent attitude remains: nurses are employees first and individuals with rights second. Many nurses are acculturated to “ turn the other cheek, " believing that negative staff interactions are to be expected and tolerated. Educational shortcomings Students lack formal instruction in dealing with conflict, asserting their rights, and accessing resources to assist with the development of their professionalism (Chaboyer, Najman, & Dunn, 2001). Consequences of Horizontal Violence Griffin (2005) reports that “ Sixty percent of new-to-practice nurses leave their first professional position within six months because . . . of lateral [horizontal] violence. . . . Twenty percent of [these] new-to-practice nurses . . . leave the profession forever. . . . [involving a] $30, 000 to $50, 000 loss every time a nurse leaves a facility" (p. 3). The following list is divided into three stages as described by William Wilke (1996 3 - 5) Stage 1 (activation of the fight or flight response - circulating adrenalin) * Reduced self esteem * Sleeping disorders * Free floating anxiety Stage 2 (neurotransmitters depleted with lack of sleep - fatigue - brain over stimulated and oversensitive) * Difficulty with emotional control - bursting into tears or laughter or irritable and angry in response * Difficulty with motivation - self-starter seems to be 'burnt out'. Stage 3 (brain's circuit breakers activated) * A relative intolerance of sensory stimulation * A loss of the ability to ignore things that before were manageable * Changed response patterns which superficially resemble a change of personality (brain circuit breakers induce person to actively reduce incoming stimuli) Other outcomes include: - Disintegration of a caring, supportive, kind, and empathic identity - Devaluation of self (Randle, 2003a, pp. 398-399). Hastie (2002) suggests the

role of horizontal violence in: - Sleep disorders - Low morale — apathy — disconnectedness - Irritability - Burnout - Hypertension - Eating disorders - Impaired interpersonal relationships - Removal of self from the workplace — sick leave, absenteeism - Resignations (pp. 3-4). Nurses are valuable patient resources who must reject toxic environments that affect them personally and professionally, impact their rights, and their ability to care. Interestingly, five nurses in one study who spoke out against horizontal violence reported positive outcomes from “ standing up for myself, " “ feeling stronger in myself, " (McKenna et al., 2003, p. 95) and benefiting from support. Self-care, being seen and heard, and becoming empowered are critical approaches to impact horizontal violence. Current Situation Estimates of lateral violence in the nursing workplace ranges from 46—100% (Stanley et al. 2007). Nursing literature abounds with examples of prevalence. In one study, one-third of nurses perceived emotional abuse during their last five shifts worked (Roche). In another survey, 30% of respondents (n= 2, 100) said disruptive behavior happened weekly, and 25% said monthly (Advisory. com). And a study of emergency room nurses found that 27. 3% had experienced workplace bullying in the last six months with many staff bullied by their managers, charge nurses or directors as well as physicians and peers (Johnson, Rea). In USA, the healthcare sector leads all other industries, with 45% of all nonfatal assaults against workers resulting in lost work days in the USA. (BLS, 2006) . From 1993 to 1999 approximately 765, 000 assaults occurred against healthcare workers resulting in days away from work (BLS, 2006; BLS, 2001). From 2003 to 2009 - - 8 registered nurses were FATALLY injured at work (BLS, 2011) - 4 RNs received gunshot wounds (RNs)

leading to their death - 4 RNs received other fatal injuries - 8 of 8 RNs were working in private healthcare facilities (not state or local government) - 8 of 8 RNs were 35-54 years of age Workplace Violence Reported by Registered Nurses * In USA 2009 there were 2, 050 assaults and violent acts reported by RNs requiring an average of 4 days away from work (BLS, Private Industry, State and Local Government, 2011). * Of the 2, 050 NONFATAL assaults and violent acts: - 1, 830 were inflicted with injuries by patients or residents - 80 were inflicted by visitors or people other than patients - 520 RNs were hit, kicked, or beaten -130 RNs were squeezed, pinched or scratched requiring days away from work - 30 RNs were bitten * In 2009, the Emergency Nurses Association reported that more than 50% of emergency center (EC) nurses had experienced violence by patients on the job and 25% of EC nurses had experienced 20 or more violent incidents in the past three years. Cures for Horizontal Violence Modular RN to BS nursing students and faculty (Module I, Group 31) at Roberts Wesleyan College (RWC) in Rochester, NY informally surveyed their peers regarding horizontal violence. Of 33 RN responses, 91% had experienced horizontal violence; 94% had seen horizontal violence taking place; and 76% believed that the level of horizontal violence in nursing was moderate to severe. Yet there is hope. Horizontal violence is being discussed; its impact on patient care is now recognized; nurses increasingly assert their rights; and administrators are enforcing safe environments (Fischman, 2002). Methods of dealing with horizontal violence include: - Feedback from an RWC survey supports education — college courses, “ inservices, seminars" (Vonfrolio, 2005, p. 60) — as a path to impede horizontal violence. - “ Rules for relationships, " (Chaboyeret al.,

2001, p. 530) posted at worksites promote supportive relationships, professional role socialization, and team building (Dunbar, 2005; Farrell, 1997). - That individuals in conflict learn assertive responses and “ fight fair" (“ Fighting Fair, " n. d.). - Dealing with any horizontal violence promptly. Consequences follow written policy (Hastie, 2002). - Agreement by staff to refuse to engage in abuse, affirm their rights, and access necessary resources (Hastie 2002). - Adherence to OSHA regulations regarding violence in the workplace (New York State Nurses Association [NYSNA], n. d.). - That data gathering, confronting, verbal and written grievances, and legal action are employed without reprisal (Leiper, 2005). - Nurse Managers committing to role model and enforce a change in unit culture that includes adequate mentoring and holding fast to nursing’s vision and values (Dunbar, 2005). Strategies for management to avoid horizontal violence and create a safe, happy workplace: Successful strategies come from the top and require an ongoing commitment to culture change concerning horizontal violence. So according to specialists (Hastie 2002), a qualified manager should implement the following strategies to avoid horizontal violence in his or her organization - 1. Gain knowledge about Horizontal Violence and its causes, conduct regular meetings with a designated committee and institute a program to address this issue; supervise its operation and success 2. Undertake a formal thorough analysis of your unit's culture. 3. Ensure there is a process for dealing with this issue in your workplace and follow it 4. Have a policy about harmonious workplace relations, support and encouragement of students, new staff members and staff generally. 5. Foster an environment of open collaboration, exploring and healing of issues, rather than fault-finding and

blame. 6. Support workers' autonomy and initiative and promote a learning culture 7. Provide education about processes to promptly report incidences of victimisation; support and encourage people to do so. 8. Monitor staff morale and address issues which negatively impact upon morale 9. Ensure that staffing is adequate, that rosters are fair and allocation to areas is fair within your unit/institution; ensure that all staff have equal opportunity for advancement and education. 10. Engage in self-awareness activities and in reflective practice. Ask for feedback from staff about your management practices and not just from close associates 11. Institute open, honest and supportive dialogue through peer review - strategies which are process based, not personality based. 12. Revise and articulate core values of institution and health care, make one core value a topic at each team meeting 13. Engage in self-care activities as above Access to appropriate counseling services in the workplace is essential for staff involved in this issue. Information about these services should be displayed in an easily observed place. Professionalism begins with the individual. How will professional nurses and nursing students choose to look at, relate to, and value their peers to promote collegiality, accountability, and trust? Nurses have long looked to others, the environment, and society as major factors restricting nurse autonomy and credibility. Addressing horizontal violence is a significant step in nurses joining together , taking control of our profession, and positioning ourselves for responsive patient care. References: 1. Duffy, E. (1995, April), Horizontal violence: a conundrum for nursing. Collegian. Journal of the Royal College of nursing Australia. 2(2), 5-17. 2. Freire, P. 1972, Pedagogy of the Oppressed, Penguin Education, England. 3.

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