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Male Perspectives of Lateral Violence in Nursing

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Abstract

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Abstract

Lateral violence is an intentional and harmful behavior in the workplace by one employee against another. In nursing lateral violence has impacted the performance of nurses as well as patient care. Research suggests that lateral violence behaviors are still prevalent in the nursing workplace and that there have been few interventions to change these behaviors or address the power dynamics that cause them. Though most of the research on lateral violence has been conducted on female nurses, the population of male nurses is growing. Thus, the purpose of the study was to explore lateral violence in the workplace from the perspective of male nurses. A phenomenological approach with Marion Conti-O'Hare's theory of the wounded healer as the theoretical framework was used to address the research question on male nurse perception of lateral violence in nursing. The data for this study were drawn from interviews of 10 male nurses who were recruited with criterion sampling. Exploratory questions and vignettes were used to gather participants' responses. This allowed for larger themes and core ideas to establish codes. The data were analyzed using thematic analysis. The results of the study indicate that lateral violence is a problem in nursing and that there is a gender bias that perpetuates this phenomenon. Results of this study have the potential to contribute to positive social change regarding male perception of lateral violence in nursing by encouraging interventions for lateral violence based on communication differences between genders.

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Chapter 1: Introduction to the Study

Lateral violence is an intentional and harmful behavior in the workplace by one employee against another (Coursey, Rodriguez, Dieckmann, & Austin, 2013; Thobaben, 2007). Lateral violence occurs in the workplace for many nurses and has been explored in nursing literature for at least three decades (Roberts, 1983). The focus has been on the female perspective and has related primarily to female nurses (Anderson, 2011; Lamontagne, 2010; Parse, 2010; Racine & Petruka, 2011). However, male representation in nursing has been growing since the 1970s. About 2.7% of registered nurses were men in 1970 compared with 9.6% in 2011 (U.S. Census Bureau, 2013). Additionally, except for a small decline in 1980, male representation among licensed practical and licensed vocational nurses has grown from 3.9% in 1970 to 8.1% in 2011 (U.S Census Bureau, 2013), and the total number of male registered nurses reached nearly 350,000 full-time employees in 2016. Although there has been an increase in numbers, the representation of male full-time employee registered nurses in the workforce has remained at 11% for the past 5 years (Center for Interdisciplinary Health Workforce Studies Publications & Data, 2017) and males remain a minority in the nursing profession. Nursing scholars have recommended that the curriculum of nursing needs to change to meet the diverse changing population in the profession (Meadus & Twomey, 2011).

This qualitative study was conducted to explore male perspectives of lateral violence in nursing. The purpose was to gain a clearer understanding of lateral violence by incorporating the perceptions of male nurses through interviews to identify the language that these male nurses use to describe the experiences in the nursing work

environment that may perpetuate the phenomenon. The findings from this study can contribute to future research and interventions to address factors perpetuating the phenomenon of lateral violence in nursing. This chapter will include the background, problem statement, purpose statement, research question, the theoretical framework of the study, the nature of the study, definitions, assumptions, scope and delimitations, limitations, significance, and a summary.

Background

There are a number of terms associated with behaviors or acts of bullying among nurses such as intra-staff aggression, workplace violence or aggression, and social or relational aggression (Gaffney, DeMarco, Hofmeyer, Vessey, & Budin, 2012). Lateral violence in nursing involves acts of aggression by one colleague toward another (Longo & Sherman, 2007) and constitutes emotional, verbal, or even physical abusive behavior that humiliates, degrades, or shows a lack of respect for the dignity and worth of a nurse colleague (Longo & Sherman, 2007; Rowell, 2008). Lateral violence also involves intimidating behavior such as condescending language, angry outbursts, refusal or reluctance to answer questions pertaining to patient care, impatience, and threatening body language (Alspach, 2007). Finally, lateral violence can involve criticizing or belittling a colleague in front of others, sabotaging a chance at promotion, withholding pertinent information, or isolating a colleague out of group activities (Longo &Sherman, 2007). These acts of destructive behaviors among nurses toward one another may affect the self-esteem and the self-confidence of nurses (Rowell, 2005).

Nurses are responsible for patient care and have many tasks they must balance,

but lateral violence can disrupt the delivery of physical, spiritual and emotional services to patients, and may shorten the careers of nurses. Lateral violence can lead to low self-esteem in nurses, increased stress, disorders of the gastrointestinal tract, post-traumatic stress disorder, insomnia, phobias, and depression (Brothers, Condone, Cross, Granske, & Lewis, 2011). Another major impact of lateral violence in the nursing field is the breakdown of communication among nurses not only with their colleagues but with patients and families (Brothers et al., 2011). Communication among nurses involves the ability to share information related to patient care including asking each other questions as well as providing feedback to each other, seeking clarification, or validation of care. Thus, the decrease in peer communication can threaten patient care (Purpora & Blegen, 2010). According to the American Nurses Association (2015) code of ethics, individuals meeting a nurse should have their rights honored and they should be treated with dignity and worth; nurses have the responsibility of collaborating with other nurses to provide the best possible care for their patients. With lateral violence among nurses, this code of ethics is compromised, affecting the welfare of nurses and patients. The problem is perpetuated if nurses do not recognize the issue of lateral violence, but if nurses are instructed and socialized to advocate for one another, the incidents of lateral violence in nursing would be greatly minimized (Brothers et al., 2011).

Research has indicated how prevalent lateral violence is in nursing. For example, McNamara (2010) revealed that out of 1,428 respondents to a survey, 85% reported having experienced lateral violence in the form of yelling, degrading comments, or physical confrontations. The study also showed nurses were at a higher risk of workplace

violence than in any other profession. Additionally, 17% of 1,500 respondents reported being familiar with lateral violence and of these, 78% stated the events could have been prevented. Another article showed that 55% of individuals who were visiting patients had witnessed some form of unsuitable treatment of nurses toward one another (Association of Critical Care Nurses, 2007).

A subtler form of lateral violence may be from the gender bias in the field of nursing. Although female nurses have capitalized on opportunities presented in nursing from the feminist movement, male nurses enter into a profession that is considered to be a female profession (Loughrey, 2008). Men in nursing are often referred to as not just a nurse but "male nurse" (McLaughlin, 2010). Male nurses also perceive an inherent bias in nursing education, exacerbated by the underlying assumption of nurses as female in lectures and textbooks that causes them to feel left out and underrepresented in their profession, which is evidenced by the ubiquitous use of the pronoun "she" when referring to a nurse (Inoue, Chapman, Wynaden, 2006). Further, according to the Bernard Hodes Group (2004), male nurses have reported experiencing open and direct discrimination as well as subtle criticism from their peers and coworkers in addition to the employing institutions. The characteristics and behaviors of nurse educators has been highlighted as negative with male students recounting that it was not necessarily what was said but how they were addressed (Bell-Scriber, 2008).

The multiple, devastating effects of lateral violence in nursing can cause serious harm to nurses as well as patients. This study will describe the perception of this phenomenon from the perspective of male nurses. The exploration of these inappropriate

behaviors may be the key to identifying and hopefully correcting this phenomenon.

Problem Statement

The problem this study addressed is the issue of lateral violence in the nursing profession from the perspective of male nurses. Male nurses account for 10% or less of the total nurse population in most developed countries (McDowell, 2015). There has been relatively little research on men working in occupations seen as female occupations such as nursing, especially regarding the male perspective on lateral violence in nursing (McDowell, 2015).

Lateral violence results from internalized feelings such as anger or rage in individuals or groups that leads to behaviors like blaming, gossiping, putdowns, and expressions of jealousy (Legal Definition, 2008). Lateral violence may also stem from low self-esteem, perception of powerlessness, oppression, and strict hierarchy (Embree & White, 2010). Lateral violence in nursing has psychological, social, and physical consequences and may also result in impaired nurse performance and negative patient outcomes (Embree & White, 2010). Because of lateral violence in nursing, about 60% of new graduate nurses leave their first nursing job within the first 6 months (Rowell, 2008). Other issues relating to lateral violence in nursing include increased leave of absence because of stress in addition to a high volume of sick calls (Rocker, 2008). Lateral violence can also jeopardize patient care (The Joint Commission, 2008). Research has shown that nurses became less compassionate toward their patients from being bullied by their colleagues, and nurses have admitted to making errors in patient care because they were upset over incidents of aggression directed toward them (Johnson, 2009).

The prevalence of lateral violence in nursing may be due to the profession being largely female while being led by male physicians (Longo & Sherman, 2007, p. 35). Thus, lateral violence in nursing is perpetuated because of the perception of oppression among nurses (Longo, Newman, & Piyakong, 2013). Oppressed groups feel alienated and lack a feeling of autonomy and control over their working conditions, which perpetuates the cycle of feelings of powerlessness and low self-esteem. These nurses do not want to risk retaliation from their superiors and their frustration is manifested as conflict between coworkers. These behaviors may eventually become normalized within the environment, and the victimized staff will show these same behaviors toward new victims (Longo et al., 2013).

Although there is significant research on the lived experiences of nurses regarding lateral violence, there is limited research comparing male and female perceptions of the experience of lateral violence in nursing (Evans, 2004). There is a lack of findings on the perception of lateral violence among or toward male nurses. However, a survey of 955 nurses (879 females and 50 males) indicated that male nurses had experienced a higher frequency of the behaviors of lateral violence. Thus, lateral violence is not isolated to a gender (Dumont, Meisinger,Whitacre, & Corbim, 2012).

Due to the potential dangers caused by lateral violence in nursing, there is a need to end these behaviors, which undermine safety in nursing. This should be done by first acknowledging and addressing the issue to eliminate the phenomenon. Thus, this study was conducted to address the issue of lateral violence by gaining information on the perspective of male nurses regarding lateral violence.

Purpose of the Study

The purpose of this study was to explore the perception of male nurses of lateral violence in nursing. I explored male nurses' perceptions of this phenomenon within the context of their work environment, the meaning they gave to the phenomenon and any associated behaviors, and the language used to describe it. The evaluation of lateral violence in nursing can be challenging because of the different perceptions of what lateral violence is and whether it exists. There are some nurses who may perceive that negative behaviors like lateral violence in the workplace results from job stress while others may perceive these behaviors as a blatant form of violence (Nicotera et al., 2015). These differences in perception are defined as *denial of agency*, meaning the individual does not see their responsibility or ownership for the outcome of their actions (Giddens, as cited in Stanley, Dulaney, & Martin, 2009).

Research Question

What is the lived experience of a small group of male nurses regarding lateral violence in nursing?

Theoretical Framework

The theoretical framework guiding this study was the theory of the nurse as the wounded healer (Conti-OHare, 2002). According to this theory, nursing is considered one of the helping professions, and nurses enter this profession because of a desire to alleviate the suffering of vulnerable individuals because they themselves have either experienced or witnessed traumatic events. The coping skills of an individual may be ineffective because of his or her exposure to traumatic incidents, which may overwhelm and

immobilize coping strategies. The nurses' ability to recognize the impact of unresolved issues is important to their professional and personal effectiveness (Conti-O'Hare, 2002).

The theory of the nurse as the wounded healer was based on the concept of the wounded healer by Carl Jung (Christie & Jones, 2013). Conti-O'Hare (2002) incorporated Jung's assumptions into the discipline of nursing by noting that nurses need to be aware of their wounds to process and transform their pain and achieve transcendence. The concept of nurse as a wounded healer allows nurses to view their pain as a part of growth and development. The therapeutic use of self is dependent on the degree that the trauma is transcended. Once this transcendence is achieved, the nurse's personal experience of healing can be used to help others. Emotional distress and self-destructive behaviors may result if the nurse is not able to recognize personal experiences of fear and pain (Conti-O'Hare, 2002). This theory directly relates to my study of lateral violence and contributes to its origins. My open-ended research question elicited more information for analysis through the lens of this theory. I discuss this theory in more depth in Chapter 2.

Nature of the Study

The phenomenological approach was used to address the research question on the perception of lateral violence in male nurses. Additionally, previous research has justified the use of vignettes along with interview questions to obtain participant responses, as they are useful in studying ethical issues and also in studying topics which are potentially sensitive (Katrinli, Atabay, Gunay, & Cangarli, 2010). Vignettes are useful in qualitative research because they can be used to elicit norms within a culture, which in this study

were male nurses whose perceptions about lateral violence in nursing was evaluated.

Using the phenomenological approach helps to gain a deeper understanding of concepts (Creswell, 2014), which in this study was the phenomenon of lateral violence in nursing. I explored the individual and unique experiences of the nurses and what lateral violence means to them. By conducting a phenomenological study, the respondents were able to relay specific experiences. The intent of this research was to explore the lived experiences of male nurses who have been victims of lateral violence as well as nurses who have not experienced lateral violence as a problem in nursing. By exploring personal recollections as the primary source of information, there was a focus on interactions, experiences, and successes and failures in the face of lateral violence. From this general perspective, I intended to explore the meaning of lateral violence to male nurses and to see what information emerges.

Definitions

Lateral violence: There is no universal definition for lateral violence. However, it is generally considered verbal or nonverbal behavior that results in the recipient of the behavior feeling threatened, attacked, or professionally isolated. Lateral violence has also been referred to as workplace bullying, horizontal violence, and incivility in nursing. The American Nurses Association (2011) defined lateral violence as "physical, verbal, or emotional abuse" (para. 1). The Academy of Medical-Surgical Nurses (2008) defined bullying as "an offensive, abusive, intimidating, malicious, or insulting behavior, or abuse of power by an individual or group, which makes the recipient feel upset, threatened, and which may cause them to suffer stress" (para. 2). Finally, according to

Becher and Visovsky (2012), lateral violence is an act of aggression, unwanted abuse, or hostility that results in a negative work environment. Lateral violence implies that the behavior is initiated by a nurse or nurses toward another nurse.

Recognition: The individual experiences an awareness of a situation that negatively affects him or her, and recognition occurs. This recognition occurs through self-evaluation and thought processes or with the assistance of others (Conti-O'Hare, 2002).

Transcendence: Transcendence occurs when the individual reaches a higher level of understanding that can be either spiritual or higher thinking. This understanding can be used to have more therapeutic relationships with others (Conti-O'Hare, 2002). The process of transformation leads to transcendence; the difference between the two terms can be compared to discovery and recovery.

Transformation: Transformation is a changing of internal feelings based on using past experiences and insight to increase understanding of the present and future (Conti-O'Hare, 2002).

Walking wounded: Individuals with unaddressed physical or verbal trauma in their lives. When the individual has not dealt with this trauma effectively, there is an alteration in their ability to cope with current stressors, and there are negative results (Conti-O'Hare, 2002).

Wounded healer: Individuals who achieve expanded consciousness through self-reflection and spiritual growth. When the trauma is processed and converted, healing occurs. There is a scar that remains, allowing the individual to have a greater ability to

understand the pain of others (Conti-O'Hare, 2002).

Assumptions

One of the assumptions of this study was that the male nurses interviewed in the study understood the phenomenon of lateral violence among nurses. There was the assumption regarding the understanding of how these nurses make sense of the phenomenon and the language used to help understand the meaning of lateral violence. This allowed for affective reporting of the perception of lateral violence by the male nurses. By interviewing these male nurses, I was able to explore the essence of the phenomenon of lateral violence in nursing and also address the research question.

Scope and Delimitations

This was a qualitative study on male nurse perceptions of lateral violence in the discipline of nursing. The study did not include female nurses in exploring this phenomenon because the goal was to gain an understanding of how male nurses perceive lateral violence in the nursing workplace. Data were obtained from taped interviews conducted after presenting the participants with vignettes, which were scenarios of situations that could be perceived as incidences of lateral violence among nurses in the workplace. The purpose of the vignettes was to provide situations that invited the respondents to draw upon their own experiences as to behaviors depicted in the vignette. Vignettes are useful for collecting situated data related to values, beliefs and norms within a group, and have been used by researchers of various disciplines to explore social issues (Barter & Renold, 2000; Jenkins et al., 2010). I did not observe real-time interactions in a nursing work environment for this study.

The vignettes and the interviews were included as part of semi structured interviews with 10 males who were working in a nursing setting. The male nurses were solicited on a voluntary basis from these settings through an advertisement for the study through the intranet of these settings. The sample size of 10 was chosen for representation as well as for their experience with lateral violence and their ability to reflect on these experiences.

Limitations

This sample of nurses was small, a limitation of the study, but was able to meet the requirements of my study to obtain information not previously obtained about a male perspective of lateral violence in nursing. Additionally, data saturation was obtained with 10 interviews. Data saturation is when there is sufficient information to replicate the study (O'Reilly & Parker, 2012; Walker, 2012) and when further coding is no longer feasible (Guest et al., 2006).

As a nurse, I was able to negotiate my role as a researcher and maintain objectivity in this study. I continued awareness of my own personal beliefs and biases to not have them impact the study. I kept my committee members informed during the data collection, review, and analysis processes in order to maintain objectivity throughout the study. My experiences as a nurse also gave me the advantage of common ground with the participants and an insider's perspective of the nursing work environment. This research and the responses of the participants was positively influenced by my role as a nurse and an understanding of the culture.

Significance

Research has shown that though some nurses confront bullying, most do not confront those bullying them because they perceive that they lack the suitable confrontation skills (Mahon & Nicotera, 2011). Thus, there is a need for organizations to empower nurses and make sure that they have suitable communication skills and training to help recognize lateral violence and then address it. Leadership in nursing organizations should address lateral violence by setting up interventions encouraging fair and equitable workloads as well as respect among nurses for their colleagues (Griffen, 2011). By addressing these issues, there can be an improvement in nursing retention and better outcomes in nursing care. Because nearly 60% of newly graduated nurses resign within the first few months of employment because of lateral violence, it is important to address these issues early in the nurses' careers to decrease the incidents of lateral violence and decrease associated cost burdens to organizations have to recruit and train new nurses because of the high turnover (Embree & White, 2012). It is important to have the male nurse perspective on lateral violence because the male nurse population is growing. My hope was that this research would contribute to positive social change with regard to the male perception of lateral violence in nursing.

Summary

Lateral violence in the nursing workplace results in a hostile environment because of poor relationships between nurses. Lateral violence has been reported to increase stress, frustration, and loss of collaboration among nurses. This disruption of relationships among nurses may pose a threat to patient safety (Hutchinson, Vickers,

Jackson, & Wilkes, 2008; Johnson et al., 2010; The Joint Commission, 2009; Katrinli et al., 2010). Thus, the purpose of this study was to improve the understanding of the male nurse perspective of lateral violence in nursing. Interviews with male nurses were conducted to explore their perception on lateral violence in the nursing workplace. The study may enhance the understanding of negative nurse-to-nurse interactions from the perception of male nurses through stories of nurses experiencing the phenomenon of lateral violence in the workplace.

Chapter 2: Literature Review

Introduction

The discipline of nursing is based on caring, compassion, sympathy, and empathy, and the primary purpose of health care is to address the physical, spiritual, and emotional needs of patients (Adams, 2014). But the work environment of nurses involves interpersonal relationships in complex political and social contexts (Vessey, DeMarco, & DiFazio, 2011). Nurses are responsible for the care of their patients and have many tasks they must balance, which creates a stressful environment (Almost, Doran, McGillis Hall, & Spence Lashinger, 2010). Additionally, at least 90% of the nursing profession is composed of women, who are often considered to be an inferior group by society and in the health care field (Hunta, 2012). This stressful and potentially oppressive environment can lead to lateral violence where a nurse or group of nurses acts aggressively toward another nurse or group of nurses (Thobaben, 2007). These behaviors may affect the self-esteem and the self-confidence of nurses (Rowell, 2005). The purpose of this qualitative study was to explore male perspectives of lateral violence in nursing.

This literature review provides a theoretical foundation based on the nurse as the wounded healer and a review of the relevant literature on lateral violence in nursing. Also included in this chapter is an analysis of research on the perceptions of nurses on lateral violence in nursing with a focus on the male perspective, providing an understanding of the impact of impaired relationships among nurses with a focus on the perspective of the male nurse. This chapter also includes the literature related to the incidence and prevalence of lateral violence in nursing.

Literature Search Strategy

To provide a comprehensive literature review, peer-reviewed journals were surveyed from the following Walden University research databases: CINAHL Plus, Pro Quest Nursing and Allied Health Source, PsycInfo, and PsycArticles. A thorough search of Google Scholar was also conducted to obtain information on the impact and perception of lateral violence among male nurses, though no articles were found specifically on this subject. Search terms that were used included lateral violence, bullying in nursing, workplace violence, male nurses and wounded healer. Although there is research on female lateral violence, there is a lack of research on lateral violence among male nurses (Almost, 2006; Alspach, 2007; Bartholomew, 2006; Becher & Visovsky, 2012; Blair, 2013; Bowles & Candela, 2005; Brown, 2010; Christie & Jones, 2014; Croft & Cash, 2012; Dehue, Bolman, Vollink, & Pouwelse, 2012; Dunn, 2003; Embree & White, 2010).

Theoretical Foundation

Theory of Nurse as the Wounded Healer

Conti-O'Hare's (2002) theory of the nurse as a wounded healer is based on Jung's (1953) definition of a wounded healer as a psychologist compelled to treat individuals because of personal psychological wounds. The wounded healer may help others when there is recognition of the psychological wounds and a transcendence of the associated psychological pain by the healer (Groesbeck, 1975). Conti-O'Hare explained that nurses may have experienced trauma from which they may or may not have emerged in a healed or restored manner; this "woundedness" in some cases helps nurses be empathetic to their patients. Nurses who have healed from their trauma can help their patients and foster

relationships with coworkers conducive to a healthy work environment (Conti-O'Hare, 2002). According to Marion Conti-O'Hare, the theory of nurse as a wounded healer applies to any nurse who has been traumatized regardless of gender.

The theory of the nurse as wounded healer provides insight into why lateral violence occurs, and a working model of the theory can be used to resolve the personal and professional pain as the motivation for lateral violence in nursing (Christie & Jones, 2014). Two assumptions of the theory are (a) nurses and managers need to be aware of the occurrence of lateral violence in the workplace, and they need to rectify lateral violence and (b) to perform in a manner promoting health in the patient population, nurses must first promote health within themselves and each other (Christie & Jones, 2014). The nurse as the wounded healer theory also helps describe the effects of lateral violence, which are considered persistent and harmful to the experiences of nurses (Sanner-Stiehr & Ward-Smith, 2013). If the steps are not taken to address the emotional trauma of a nurse, the sustained negative effects will result in a harmful worldview, which will have a negative emotional impact on the individual and any relationships as long as it persists (Sanner-Stiehr & Ward-Smith 2013). If nurses deny their unresolved conflicts and vulnerabilities, they project their woundedness on patients and colleagues and are unable to empathize with others (Conti-O'Hare, 2002). Nurses must recognize and transform their fear and pain so that they are able to transcend and progress to becoming wounded healers (Conti-O'Hare, 2002; Hutchinson et al., 2006); if the trauma is addressed, patient care will not be affected (Zerubavel & Wright, 2012).

The nurse as a wounded healer theory can be used with the Q.U.E.S.T. model for

self-transcendence to guide individuals in healing (Conti-O'Hare, 2002). The Q.U.E.S.T. model consists of a series of steps, the first of which is to question the impact that the trauma has had on the life of a nurse. The next step is to uncover or explore patterns associated with the trauma. The nurse will then explore the experience in terms of what they think about the traumatic events. The next step is to search for what these traumatic experiences mean to the nurse. The final step is to transform and transcend, and at this step the nurse may transcend traumatic experiences and become a wounded healer (Conti-O'Hare, 2002). Thus, as nurses complete these steps, they can return to their baseline of emotional stability (Conti-O'Hare, 2002). Individuals lacking the ability to effectively perform the steps of the Q.U.E.S.T. model will sustain their psychological traumas and commit acts of lateral violence (Sanner-Steihr & Ward-Smith, 2013).

The nurse as the wounded healer theory is suitable for guiding research on lateral violence and framing reactive and proactive approaches to lateral violence in nursing (Demir & Rodwell, 2012; King-Jones, 2011; Lovell & Lee, 2011; Reknes et al., 2014). The nurse as a wounded healer theory by Conti-O'Hare (2002) is useful for the discussion of lateral violence in nursing because it can help people recognize how lateral violence affects nursing. Because of the pressure on the psyche of nurses, there is a need to vent their negative emotions. The recipients of these negative emotions are victims of lateral violence (Johnson & Rea, 2009). By recognizing the issue of lateral violence, nurses may seek to empower themselves over psychological pain or fear, which can help them have better relationships with other nurses and administer the best possible care to their patients.

The origin of the wounded healer. The concept of the wounded healer comes from Greek mythology and has been perpetuated for more than 2,500 years (Groesbeck, 1975). According to the legend of the wounded healer, Chiron was a centaur who was wounded but survived because of his immortality; therefore, he was able to move past his pain to heal the suffering of others through understanding of how to help others to heal (Groesbeck, 1975). Jung was the first psychotherapist to reference to the construct of the wounded healer, applying it to psychologists who were wounded while trying to help their patients heal (Zerubavel & Wright, 2012). Jung later shifted his conceptualization to "only the wounded physician heals" (Jung, 1963, p. 134). This statement refers to the struggles of psychologists to be effective when they are affected by emotional trauma (Gordon, 2012; Zerubavel & Wright, 2012). When psychologists help others to heal, they are finding a way to heal themselves. The wounded healer gains an understanding of what his or her patients are experiencing because he or she has felt the same pain (Groesbeck, 1975). Wounded psychologists can heal their patients by their challenging experiences (Jung, Adler, & Hull, 1977).

Another part of Jung (1953) expanding the concept of the wounded healer is that all individuals experience some sort of psychological trauma at one time or another. Both conscious and unconscious factors from these experiences affect individuals' behavior. Seeing these conscious and subconscious factors coexist is necessary for the individual to transcend the effects of the trauma. This transcendence allows individuals to extend themselves beyond the experience resulting in their healing and finding purpose and sense in their experiences (Jung, 1953).

The assumptions of Jung (1953) were incorporated into the discipline of nursing, showing the need for nurses to recognize personal and professional wounds so that they can process and then transform their pain to transcend it. Conti-O'Hare (2002) developed the theory of the nurse as wounded healer based on Jung's work because of the need for nursing to have a healing process. The theory of the nurse as the wounded healer suggests that the nurse goes from being the "walking wounded" to the "wounded healer." Healthcare providers need to have a psyche free of problems to be effective at their job of healing (Christie & Jones, 2014). When nurses are not able to recognize or process their experiences of trauma, emotional distress, and self-destructive behaviors occur (Conti-O'Hare, 2002).

This construct of the wounded healer today is found in various disciplines such as religion, psychiatry, and psychotherapy and has been used to describe the relationship between doctors and their patients, where the wounded doctor is considered the agent helping the patient in achieving health (Christie & Jones, 2014). However, one distinction is that the medical model may consider psychological issues associated with physical conditions, whereas a psychological model helps see both the physical and psychological issues as components in human experiences (Shimabukuro, 2003). The implication is that the wounds of the healer may result in empathy for clients or patients and better care (Zerubavel & Wright, 2012).

Applying the theory of the wounded healer to lateral violence in nursing. Nurses experience stress that is compounded by the stressors of personal relationships and daily living, which leads to a need to vent negative emotions (Calkin, 2013). The

victims of this venting are often coworkers and vulnerable peers of these nurses. The term *vulnerable peers* refers to nurses who may have less experience or lack support in the workplace. The psychological wounds of nurses may be caused by either personal or work-related stressors, and the resulting lateral violence is directed toward those perceived to be weaker or lesser. These victims of lateral violence may then perpetuate the cycle by acting out with lateral violence. As the lateral violence becomes a more common occurrence, the effects consume and negatively affect the staff (Hutchinson et al., 2006; Johnson & Rea, 2009).

Historical Background on Men in Nursing

Men historically have held a major role in nursing before the field became predominately women. Nursing had an exclusive male representation prior to the 1800s (Yullyzar, 2014). This phenomenon of male dominance in nursing was perpetuated because of an association of nursing with religious orders and the military (Rajacich, Kane, Williston, & Cameron, 2013). The first nursing school on record was established about 250 B.C. in India, which was exclusively for men because of the belief only the men were "pure" enough for the role of a nurse (Thunderwolf, 2005). Additionally, the Parablani were exclusively men who set up a hospital in 300 A.D. to provide nursing care for victims of the Black Plague, knowing they themselves would succumb to the disease (Kazhdan, 1991). Men in nursing continued with early religious orders until the Crimean war in 1853, when Florence Nightingale was regarded as the first modern female nurse. The Mills Training School for Men Bellevue Hospital and the St. Vincent's Hospital School were established for men in 1888, but the Pennsylvania Hospital School of

Nursing established a school for male nurses and one for female nurses in 1914 (Thunderwolf, 2005).

The nursing field changed to mostly women in 1901 when the Army Nurse Corps was formed. During this time, only women could serve as nurses. During World War I and World War II, there were shortages of nurses. Women were encouraged to attend nursing school with offers of tuition, stipends, uniforms, and room and board (Thunderwolf, 2005). Although nursing started out as a profession for males, it evolved into a profession for females during World War I and World War II. This has continued today, as according to the U.S. Census Bureau (2016) in 2011, there were 3.5 million working nurses, and 3.2 million were female and 330,000 were male.

In ancient civilizations, men were identified as caregivers for the infirm (Kirk, 2012). However, during the Florence Nightingale era (1820–1910), the perception of nursing became feminized. Additionally, men may have different experiences when training to become a nurse (Anthony, 2004). Western societies socialize men to limit expressions of emotions, yet the core behavior of nursing is compassion and caring. This socialization may have a different impact on male nurses performing their roles and dealing with lateral violence in the workplace. In the sections that follow the presence of men in nursing and issues of gender as well as advantages of male nurses are discussed.

Men as a Minority in Nursing

Men are underrepresented in nursing programs even though nursing schools market their programs to everyone (Kirk, 2012). Although research has suggested that nurses do not believe male nurses are discriminated against, nurses have expressed a

perception of nursing as being a feminine profession, which may lead to isolation and self-doubt for male nurses (Kirk, 2012; Okrainee, 1990). According to the U.S. Census Bureau (2016), a gender disparity exists in the nursing profession. The most recent data showed that of 3.5 million nurses, 3.2 million were female and 330,000 were male. The percentage of registered nurses in the United States has grown from 2.7% in the 1970s to 9.6% in 2011. This disparity occurs in nursing even though researchers have shown men are equally qualified to perform as nurses (Doo & Kim 2008)

Male nurses in the profession could allow for an alternate approach to solving problems in nursing because males are primarily an untapped resource (Doo & Kim, 2008). However, men have struggled to maintain their status as nurses and to promote men in the nursing field (Stokowski, 2012). For example, the superintendent of the Pennsylvania Hospital men's school of nursing fought for the rights of men to participate actively in the American Nurses Association. After the Korean War in 1955 men were again allowed to serve as nurses in the military. State-supported schools barred men from attending until 1981 when this practice was deemed unconstitutional by the U.S. Supreme Court in a case brought against these schools (Thunderwolf, 2005). Schools are now actively recruiting men to have higher male enrollment in nursing programs (Thunderwolf, 2005). The American Assembly for Men in Nursing was set up in 1971 to represent men in the field of nursing (American Assembly for Men in Nursing, 2016). The American Assembly for Men in Nursing (2016) launched recruitment initiatives to encourage more men to enter the nursing field with the "Call 20 x 20: Choose-Nursing" initiative. The goal of this initiative is to have 20% male enrollment in American nursing

programs by the year 2020.

Issues of Gender Advantages of Male Nurses

The number of male nurses is small but growing; however, there has not been a progression of the integration of female and male nurses regarding their duties (Simpson, 2011). Although nursing is a female-dominated profession, a patriarchal relationship favors males in nursing, as evidenced by a disproportionate number of men in the higher paying positions in nursing (Simpson, 2011). According to the U.S. Census Bureau (2016), about 41% of nurse anesthetists are men earning an average salary of $162,900 per year. Additionally, the minority status of men in the nursing field has resulted in men having advantages promoting their careers (Kleinman, 2004; Wang et al., 2010). These advantages are usually associated with stereotyping men as being capable leaders, which is reinforced by the power differentials perpetuated in patriarchal societies that are present in the healthcare industry (Wang et al., 2010). Male nurses are assisted by the patriarchal culture of institutions perpetuating male advantage, and this culture is consciously and subconsciously perpetuated by female nurses who nurture the careers of their male colleagues (Wang et al., 2010). Despite men being a minority in the field, they are more likely to be promoted to leadership roles as well as earn higher salaries.

Despite these advantages for men's careers in nursing, there is evidence to suggest that male nurses are exposed to workplace violence more often than female nurses (Hegney et al., 2012). In a study by Hegney et al. (2012), 72% of male nurses as compared to 45% of female nurses reported they were exposed to workplace violence. However, further research is still needed because of the small sample size of male nurses.

Another study was conducted by Ericksen and Einarsen (2004), who tested the hypothesis that male assistant nurses were more exposed to lateral violence than their female colleagues. The results of the study showed there was a higher incidence of perceived bullying by the male nurses. The percentage of male nurses reporting having been exposed to lateral violence was 10.2%, which was twice the amount of females who reported an incidence of 4.3 percent. Kwok et al. (2006) conducted a study to evaluate lateral violence among nurses. The response rate to their questionnaire was 420 out of 1650. The ratio of female to male nurses was 34:3 and the incidence for female and male nurses was 75% and 88% respectively. According to Kwok et al. (2006), there was no significant difference between the two groups.

Lateral Violence in Nursing

My review of the literature showed lateral violence and associated behaviors has been described by various researchers (Almost, 2006; Becher & Visovsky, 2012; Brown, 2010; McNamara, 2010; Simons & Mawn, 2010). Lateral violence has been defined as an intergroup conflict which is an expression of either blatant or covert hostile behaviors (Alspach, 2007). It is also defined as a pattern of behavior used to control, or devalue a colleague (Sheridan-Leos, 2008). Lateral violence includes any form of unwanted hostility or abuse within the workplace (Bartholomew, 2006; Stanley, Martin, Michel, Welton, & Nemeth, 2009). Lateral violence was defined by Thobaben (2007) as "hostile, aggressive, and harmful behavior by a nurse or group of nurses toward a co-worker or group of nurses via attitudes, actions, words, and/or behaviors" (p. 82). McNamara (2010) defined lateral violence in nursing as verbal abuse, unsuitable language,

harassment, and intimidation. According to Blair (2013), there are three categories of lateral violence: verbal, physical and psychological. Verbal violence was described as condescending language, rude comments, or verbal attacks. Sexual misconduct was included in the category of physical violence, and physical violence is the only category with existing laws where the perpetrators can be prosecuted. The category of psychological violence is considered to be the most subtle and is the most difficult to address from the perspective of management (Blair, 2013). Psychological violence includes an attack on an individual's integrity or professional reputation, a lack of collaboration with colleagues, inappropriate reprimanding of a colleague in the presence of patients or family members of patients, blaming colleagues when something goes wrong or withholding information pertinent to patient care (Blair, 2013).

According to Egues and Leinung (2013), the pervasive act of lateral violence in nursing is responsible for the term 'nurses eat their young'. Brown (2010) stated the phrase "nurses eat their young" has been used for many decades in the nursing field. Brown described this phrase as a "dirty expression" which is harsh and abusive and should be removed from the nursing field vernacular.

Roche (2010) discussed the effect of impaired personal relationships among nurses, particularly poor work performance including accidents and mistakes detrimental to the well-being of the patient, and results in substandard care. Farrell (2006) noted the discipline of nursing has a long tradition of a hierarchical structure of power, and as such, younger and inexperienced nurses are often victims of lateral violence. Farrell (2006) also stated the escalating tension among nurses result in their inability to perform quality

work and will result in substandard care of patients. Embree and White (2010) described other common forms of lateral violence as withholding pertinent information affecting patient care, deliberate sabotage by coworkers, nonverbal innuendos, broken confidences, and scapegoating.

The behaviors associated with lateral violence in nursing have been so deeply ingrained in nursing practice that nurses may not even recognize they are engaging in such behaviors as bullying or violence (Griffin, 2011). Griffin (2011) referred to findings in a study showing nurses who were employed on a medical-surgical unit were subjected to a higher amount of lateral violence than nurses who worked on specialty units. Croft and Cash (2012) stated lateral violence has been a reality in the nursing profession, and has been explored in depth for the last three decades.

Almost (2006) conducted a review of the literature related to lateral violence in nursing. Almost (2006) found there is evidence nurse-to-nurse conflict is a significant and global issue. A number of researchers have found lateral violence in nursing has a severe impact on job performance and patient care (Stanley, Dulaney, & Martin, 2009; Townsend, 2012).

Lateral Violence in Nursing: A Global Issue

My review of the literature showed conflict among nurses in the workplace has been identified as a significant issue globally. Studies conducted in Canada and Australia have revealed a frequency of lateral violence in nursing is a cause for concern (Croft & Cash, 2012; Laschinger, Grau, Finegan, & Wilk, 2010; Smith, Andrusyszyn, & Laschinger, 2010). The incidence of lateral violence in Japan was reported by Lambert,

Lambert, and Ito (2004), who found nurses shared their experience of lateral violence and their intent to leave their positions. Ninety three percent of the nurses in Japan were female and 6.8% were male, in South Korea 98.7% of the nurses were female and 1.3% were male, in Thailand 94.6% of the nurses were female and 5.4% were male, and in Hawaii 93.45% of the nurses were female and 6.6% were male. According to McKenna, Smith, Poole, and Coverdale (2003), a high level of interpersonal conflict existed among the New Zealand nursing population. The gender breakdown of the study by McKenna et al. (2003) was 513 (94%) female and 32 (6%) male. The vast disparity of statistical data is representative of grossly unequal presence of female nurses versus male nurses (American Assembly for Men in Nursing, 2016).

Effect of lateral violence on the nursing profession. The harmful effects of lateral violence in the nursing field are numerous. Victims of lateral violence express a decreased sense of well-being, complicated by impaired physical and mental health issues, including depression and anxiety (Dehue, Bolman, Vollink, & Pouwelse, 2012). Other reported effects include sleep disturbance and symptoms consistent with posttraumatic stress disorder (Randle, 2003; Vessey et al., 2011). One of the most harmful effects is the inability to retain nursing staff that has experienced lateral violence leaving the profession (Becher & Visovsky, 2012). Brothers et al. (2011) discussed the harmful impact of lateral violence on the health of nurses, noting an increase in stress, depression, posttraumatic stress disorders, insomnia, disorders of the gastrointestinal tract, phobias, and decreased self-esteem. Brothers et al. (2011) referred to the code of ethics in the guidelines of the American Nurses Association (2015), which states all

nurses have the right to be treated with respect and dignity. Nurses have the duty to be protectors of their own morality and should also be self-respecting (American Nurses Association, 2001).

Similar to the work of Sheridan-Leos (2008) and Morrow (2009), McAllister and Lowe (2011) discussed the first several years of practice of nurses as a formative time when confidence is built. The results of multiple studies show new graduate nurses are more likely to be the victims of lateral violence, which has an adverse impact on self-esteem and confidence (Maddalena, Kearney, & Adams, 2012; McKenna, Smith, Poole, & Coverdale, 2003; Simons & Mawn, 2010). According to McAllister and Lowe (2011), many nurses have maintained the nursing profession is not as nurturing as perceived by those outside of the discipline, and the profession can be physically and psychologically challenging

Effect of lateral violence on new graduate nurses. New graduate nurses essentially lack the voice to verbalize the frustrations associated with lateral violence, and as a result are more susceptible to experiencing bullying. According to Heinrich (2007) this perception of not having a voice stems from the risks of discussing lateral violence because of fears of alienation, or reprisal. Farrell, Bobrowski, and Bobrowski (2006) confirmed this position. They stated the subject of workplace aggression occurring with lateral violence was avoided because it is unseemly to discuss these negative behaviors among nurses within the context of the caring role. According to White (2006), newly graduated nurses need mentoring as they may not be familiar with their expected duties, and these nurses are usually hired for the night shifts where the perception is, they do not

work as hard as other staff nurses. This serves to increase the level of frustration among these newer nurses (White, 2006).

Lateral violence or bullying was also found to be more prevalent among newly graduated nurses than among seasoned, more experienced nurses (Griffin, 2011). Some of the more common examples of lateral violence or bullying include:

- spreading rumors and gossip;
- humiliating the nurse because of their limited skills and lack of experience;
- failing to support newer inexperienced nurses;
- exclusion from socializing both on and off the job;
- making fun of another nurses' demeanor or appearance;
- betraying confidences that were meant to be private;
- refusing to share information that may be pertinent to the care of a patient;
- sabotaging the nurse to make them appear incompetent;
- manipulating or intimidating the other nurses into doing something;
- use of hostile body language, such as eye rolling (Griffin, 2011).

In the study conducted by Sheridan-Leos (2008), 551 new graduate nurses reported experiencing lateral violence. The reason these nurses felt subjected to lateral violence was a result of their lack of experience required for them to perform their jobs adequately. The nurses also thought they were neglected, and overburdened with responsibility beyond their level of training.

Mahon and Nicotera (2011) explained conflict among nurses occurs when interdependent individuals have values, goals, and views they perceive are being

thwarted by the values, goals, and views of the other individuals. In a study conducted by the Institute of Safe Medication Practices (McNamara, 2010), results showed nearly 81% of nurses reported intimidating behaviors toward nurses by their peers. Of this percentage, 31% of these behaviors were reported by newly graduated nurses (Mahon & Nicotera, 2011). The behaviors associated with lateral violence were described as rude, humiliating, or intimidating encounters, which caused nurses to have feelings of being inadequately supported and undervalued (Mahon & Nicotera, 2011).

Financial effect of lateral violence. Another effect of lateral violence is the financial burden on organizations employing nurses. According to Blair (2013), $4.2 billion in 2006 was the annual cost of replacing nurses who have left the field because of lateral violence. Studies of cost analysis show the cost of turnover in nursing, which involves hiring and training new nurses, can range from $22,000 up to about $64,000 per nurse (Becher & Visovsky, 2012).

Effect of lateral violence on patient care. Lateral violence affects both nurses and their work performance. The most disturbing effects are on teamwork, staff relations, and the outcomes of patient care (Rosenstein & O'Daniel, 2005). Rosenstein and O'Daniel (2005) stated lateral violence was directly linked to medical errors, such as errors in medication administration and other adverse events affecting patient safety. McNamara (2012) also discussed the harmful effects of lateral violence on the safety of patients, stating these abusive behaviors can lead to actual and potential mistakes and have a negative impact on patient safety. One of the more disturbing effects was reported in a study by Lanza, Zeiss, and Rierdan (2006) conducted in a Veterans Administration

hospital. The results of the study showed patients experienced delays in care and treatment resulting in prolonged and untreated pain, misdiagnosis, and even death.

Literature Review Related to Key Variables and Concepts

Incidence and Prevalence of Lateral Violence in Nursing

The actual incidence and prevalence of lateral violence in the nursing field may be difficult to ascertain because lateral violence is often unrecognized and underreported (Becher & Visovsky, 2012). Researchers have suggested 65% to 85% of nurses surveyed reported incidents of lateral violence (Stagg, Sheridan, Jones, & Speroni, 2011). Lateral violence often transcends practicing nurses and has been reported by nursing students. In a study conducted in Australia, 50% of the nursing students reported having experienced lateral violence during their clinical rotations (Curtis, Bowen, & Reid, 2007).

Farrell (2006) used a qualitative approach to describe the perception of nurses on the nature and extent of violence in the nursing work environment. Farrell (2006) stated many nurses expressed concerns about their colleagues' aggressive acts toward them. Nurse managers were criticized for their lack of efforts to implement supportive or corrective measures and preventing recurrence of these behaviors. Much of the lateral violence reported could be attributed to a breakdown in the rules of the relationships, such as the inability to keep confidences among nursing staff, the lack of cooperation among nursing staff, and violation of privacy among colleagues (Farrell, 2006).

A descriptive study by McKenna et al. (2003) explored the prevalence of lateral violence among 1,169 New Zealand nurses in their first year of practice. One hundred percent of the nurses in the study acknowledged the experience of some form of lateral

violence. McKenna et al. (2003) stressed the significance of the first year of nursing practice as a time when nurses build confidence in their practice; therefore, lateral violence is damaging during this time. Sheridan-Leos (2008) also explored the high risk of lateral violence for new graduate nurses in a study of 551 new graduates who reported having experienced lateral violence. These nurses stated the violence occurred in the form of humiliating, rude, and abusive comments. More than one-third of the participants indicated this violence resulted in barriers to effective learning and skill development. The nurses further stated they felt neglected and were overburdened with responsibility inappropriate for newly graduated nurses, compounding the anxiety as victims of lateral violence.

Prevalence of lateral violence among new graduate nurses. Findings by Morrow's (2009) were similar to those of Sheridan-Leos (2008). Morrow conducted a literature review exploring the experiences of newly graduated nurses and their transition from novice during the first year of practice (2009). Morrow (2009) wanted to identify the implications of the need for support from management for new graduate nurses, as identified in the literature review, along with gaps in knowledge about the phenomenon of lateral violence in nursing. The literature review also showed the first few months of practice could be stressful and challenging for new graduate nurses, as these months are a critical time for the nurses to build confidence.

Other themes of lateral violence in nursing. The other themes emerging in the review of literature noted role ambiguity and stress, the perceptions of expectations, values and moral integrity related to lateral violence among nurses (Morrow, 2009;

Newton & Mckenna, 2007). I will further elaborate on these themes in the following paragraphs.

In a study conducted by Stanley, Martin, Michel, Welton, and Nemeth (2007), the incidence and severity of lateral violence was evaluated in response to a presentation given on lateral violence in nursing. The subjects responded to a survey entitled the 2005 Lateral Violence in Nursing Survey (Stanley et al., 2007). This survey was designed to measure the perception of the incidence and severity of lateral violence among nurses. There are three constructs for analysis in the Lateral Violence in Nursing Survey (LVNS): oppressors, perceived seriousness, and mediators. These constructs are operationally defined by Roberts (2000) as oppressors referring to the characteristics of leaders, the organization, and the behaviors of the coworkers are barriers to productivity. Perceived seriousness is the perception of the effects which lateral violence has on the individual and the group. The mediators include characteristics of the organization and its leaders along with the behavior of coworkers that will provide constructive action to eliminate lateral violence. These constructs were derived from the oppressed group theory according to Roberts (1983) as well as Becker's (1974) health belief model. According to Becker (1974), perceived benefits, susceptibility, severity, and barriers are the primary constructs of the health belief model. According to Stanley et al. (2007), 663 out of 1850 responses were received. The findings of the study reported a 46% response showed instances of lateral violence in their workplace setting. Stanley et al. (2007) maintained lateral violence in the workplace was identified as a major cause of stress and tension. The study findings showed 65% of the nurses surveyed reported there was a

frequent occurrence of lateral violence among nursing staff, therefore study heightened attention to the importance of the role of management in setting a culture suitable for a healthy work environment. The gender breakdown of the study is as follows: there were 604 female nurses 91.1% and 47 male nurses 7.1% (Stanley et al., 2007).

In a study by Walrafen, Brewer, and Mulvenon (2012), nurses described their participant's experiences with nurse-to-nurse bullying. Ninety-three percent of the nurses in this study were female, and 7% were male. The results indicated that 77% of the respondents had witnessed or experienced lateral violence. The behaviors, including bickering among colleagues, nonverbal negative innuendos, breaches of privacy and figurative backstabbing, were similar to those found in other studies (Morrow, 2009; Sheridan-Leos, 2008; Stanley et al., 2007). The study by Walrafen et al. (2012) differed slightly from the previous studies because they looked for common themes, which were described as covert and overt maltreatment, a commitment to positive changes in the nursing workplace, and the nurses being sadly caught up in the moment. The nurses described these feelings of being "sadly caught up in the moment" as negative behaviors toward each other that are atypical. Based on the reported survey results, the nurses expressed concern and surprise about behaviors identified as lateral violence. Some of the nurses believed venting or ranting was justified until the results of the survey indicated this behavior was an example of lateral violence. The responses provided insight into the perspective of nurses, who were predominately women, as observers and victims of lateral violence (Walrafen et al., 2012).

Interventions for Lateral Violence

Much evidence of the incidence and prevalence of lateral violence in the nursing profession exists (Griffin, 2011; Jackson, Firtko, & Edenborough, 2007; Stagg, Sheridan, & Speroni, 2011). Managing and eradicating lateral violence is needed for the optimal functioning of nurses. The interventions described in this section address the need to support nurses to find ways of reducing stress and other triggers that may result in the perpetuation of lateral violence.

Cognitive Rehearsal

Several types of interventions have been proposed to eliminate or to reduce lateral violence in nursing. One method described by Griffin (2011) was cognitive rehearsal, a strategy whereby individuals imagine a difficult situation, and a therapist guides them through facing the situation and successfully dealing with it. Similar to a study by Griffin (2011), the work by Stagg et al. (2011) used a nurses' training program for nurses to evaluate the effectiveness of cognitive rehearsal as an intervention for lateral violence. The results were similar to Griffin (2011) because they indicated staff nurses gained increased awareness and knowledge about lateral violence among nurses through the process of cognitive rehearsal.

Jackson et al. (2007) also discussed the need to identify helpful strategies to improve the personal resilience in nurses. Jackson et al. conducted a literature review on the strategy of personal resilience in response to adversity in the workplace. Their findings showed nurses could build personal resilience in many ways, including having work-life balance and spirituality, keeping a positive attitude, being reflective, and

building supportive and nurturing relationships with coworkers.

Mediation

Another intervention described by Gerardi (2004) involved using mediation to foster a healthier work environment and manage conflict among staff members. Gerardi maintained because of the many advances in healthcare, organizations have had to advance quickly, resulting in an increase in poor communication among healthcare workers. This led to stressful interpersonal conflicts, role confusion among staff, and unclear policies and procedures. The act of mediation would allow staff to identify the significant issues and to determine what is needed to resolve conflict.

Need for This Study

Rowell (2007) discussed the role of gender with regard to lateral violence stating the occurrence of lateral violence in nursing may be the result of nursing being a predominately female profession. The gender theory, introduced by Sandra Bem (1981) as a cognitive theory, explains how individuals become socialized according to gender roles and how sex-linked characteristics are perpetuated to the members of society. The theory can be applied because women have not felt empowered enough for the role they play and they have not been socialized to appreciate themselves. Women are socialized to be nurturers and at the same time to suppress anger. This suppressed anger may come to a forefront when nurses feel frustrated because of the perception of power inequality. This perception results in nurses venting their frustrations laterally or on those with less power (Rowell, 2007).

According to Stevenson, Randle, and Grayling (2006) the results of their study

showed male nurses experienced significantly more bullying in the form of sexual harassment than their female colleagues did. Despite the small sample size of male nurses, the type of harassment was significant mainly because of the unsuitable treatment. Even though male nurses may experience advantages because they are a minority, there are barriers to being truly accepted in what has been deemed as a female oriented profession.

Summary

The literature shows lateral violence has harmful and costly effects on the discipline of nursing (Becher & Visovsky, 2012; Rosenstein & O'Daniel, 2005; Sheridan-Leos, 2008). Some of the harmful effects identified include lack of retaining nurses and high rate of turnover, decrease in productivity, poor quality of patient care, and negative physical and psychological effects on nurses. Much documented evidence discussing lateral violence indicated a clear need for the profession as a whole to overcome these harmful behaviors (Becher & Visovsky, 2012; Rosenstein & O'Daniel, 2005; Sheridan-Leos, 2008). The results of this study will hopefully contribute to the body of knowledge by helping to understand the phenomenon of lateral violence from the perspective of the male nurse. The study may improve understanding of nurse-to-nurse interactions in actual and potential situations of lateral violence through interviews of male nurses working within the setting where these situations occur.

Researchers have explored the concept of lateral violence and defined bullying in the nursing profession, and the causes and the reasons are still being explored (Becher & Visovsky, 2012; Croft & Cash, 2012; Martin, 2008). The scholarly discussions of lateral

violence in nursing have also provided substantial evidence of its harmful effect on nurses who have experienced it and on patients within the facilities where these behaviors occur (Dehue et al., 2012). Significant research and articles about the need for interventions to eradicate lateral violence in nursing exist (Becher & Visovsky, 2012; Rosenstein & Sheridan-Leos, 2008); however, little significant or substantial information on the perceptions about lateral violence among male nurses can be found. This research will contribute to the body of scholarly literature by exploring the perceptions of male nurses on lateral violence in nursing.

Chapter 3: Research Method

Introduction

The purpose of this study was to explore the perceptions of male nurses of lateral violence, or nurse-to-nurse bullying, and its impact on the nursing profession. This chapter describes the research design and rationale, methodology, instrumentation, participants and data collection. This chapter also includes the data analysis plan, trustworthiness issues, and ethical procedures. I also discuss my role as researcher and personal and professional relationships with the participants how issues with biases or conflicts of interest were addressed.

Research Design and Rationale

The research question for this study was "What is the lived experience of a small group of male nurses with regard to lateral violence in nursing?" I used a phenomenological approach to answer this question and explore male nurses' perceptions of lateral violence in nursing. The goal of qualitative, phenomenological research is to describe a lived experience of a phenomenon. Qualitative research has been used in the nursing field to explain related concepts and identify and describe experiences and phenomena helping to develop nursing knowledge and practice (Pope & Mays, 2008). Nursing professionals use qualitative research to develop concepts in patient care to improve many concepts in nursing practice. Using qualitative research in nursing provides a level of sensitivity to the lived experiences of nurses (Pope & Mays, 2008). In this study, a small sample of male nurses' perceptions of lateral violence in nursing was explored with a qualitative analysis of narrative data.

There are three considerations in choosing a suitable approach to conducting research: the nature of the problem to be explored, the personal experience of the researcher and the intended research audience (Creswell, 2007). I chose phenomenological research because it helped in describing the lived experience of male nurses as well as exploring a single phenomenon—the perceptions of male nurses about lateral violence in nursing. I explored the perceptions of male nurses through individual qualitative interviews following vignettes that depict situations occurring in a clinical setting among nurses. Interviews from a phenomenological perspective allows researchers to reflect and gather data holistically (Englander, 2012). Vignettes are useful in qualitative research because they can be used to elicit norms within a culture, which in this study were male nurses working in a clinical nurse setting.

Interpretive phenomenological analysis (IPA) is also used in healthcare research (Pringle, Drummond, McLafferty, & Hendry, 2011). This approach has roots in psychology and recognizes the role of the analyst in understanding the experiences of the participants (Smith, Flower, & Larkin, 2009). IPA offers an in-depth account of the individual experience and can help to understand the experiences of the participants, which allows for a greater understanding of the experiences occurring in healthcare. By understanding meanings and experiences, nurses can positively improve the behaviors and lifestyle of healthcare workers (Pringle et al., 2011). Additionally, an inductive or bottom up approach means that the themes identified are strongly linked to the data collected. The data collected by the interviews allow for themes to be extracted which may not resemble the researcher or any theoretical interest. By using an inductive

approach, I did not test any preformulated hypothesis, but I had the ability to discover the truth about the perspective of male nurses through listening and learning about their perception of lateral violence in nursing. Exploratory or content driven data analysis was used, and specific codes or analytical categories were derived from the data.

By using the approach of clearing my mind of judgment, I recalled my personal and professional nursing experiences over the past 20 years to not allow any preconceptions to influence my research. I identified significant statements from the participants and clustered them into themes. This allowed for constructing a composite description of the meaning of the experiences of the male nurses. This phenomenological study may be used as a diagnostic research tool to evaluate the problem of lateral violence in nursing and may contribute to positive social change in the nursing profession.

Role of the Researcher

Qualitative research allowed me to be the primary tool for data collection (Creswell, 2014; Leech & Onwuegbuzie, 2011). The role of the qualitative researcher also has challenges with establishing a rapport with subjects, listening to stressful human experiences, and researching sensitive topics (Dickson-Swift, James, Kippen, & Liamputtong, 2007). But the relationship between the researcher and the subjects is important and will set the tone for how the research is conducted (Dwyer & Buckle, 2009). The researcher should be aware of the experiences and meanings of the subjects while being aware of biases that may impact the study. Being a member of the group being studied may help the researcher gain acceptance from the participants, and the

participants might be more willing to share their experiences. However, the researcher might make assumptions about the study based on personal experiences and have difficulty separating their views from those of the subjects. The results of the interviews might be guided by the experiences of the researcher and not necessarily the participants (Dwyer & Buckle, 2009). I kept a reflective journal during the entire research process. In this journal, I stipulated justification and reasoning for specific decisions and judgments that were made, as well as personal challenges that I encountered during the research process (see Cope, 2014; Houghton, Casey, Shaw, & Murphy, 2013).

I used the vignettes (see Appendix B) to provide the subjects with examples of typical scenarios occurring in the workplace environments of nurses. I conducted audio-recorded interviews. I had the interviews transcribed, and then I read, organized, and coded the data. I inductively identified classifications and themes from the research data. I analyzed the data using manual coding to interpret the findings and report them.

Methodology

This section includes participant selection, how the study population was identified, and the criteria for selecting participants. I also discuss the sample size and the rationale for the number of participants selected. The process of identifying and recruiting the participants is also discussed as well as the relationship between saturation and sample size.

Population

The participants of the study were male nurses from hospital and long-term care settings. These nurses varied in years of experience to get a whole perception of the

phenomenon. The qualification included licensed practical nurses, registered nurses, and nurse practitioners.

Sampling Strategy

I used criterion sampling for this study. This type of sampling allows the researcher to seek out participants with characteristics that are relevant. The interviews were inclusive of nurses with various credentials from both hospital and long-term care settings. This was done to provide participants with a broad range of experiences in nursing practice. The participants were provided with a demographic questionnaire (Appendix A).

The sampling strategy was also considered in relation to data saturation. Data saturation is achieved when there is enough information to replicate the study, and further coding is no longer feasible (Mason, 2010). The number of interviews in a qualitative study needed to reach data saturation is based on interview questions structured to facilitate the researcher asking multiple participants the same questions; otherwise data saturation will not be achieved (Bernard, 2012).

Procedures for Recruiting Participants

The participants included 10 males currently working at two healthcare centers in New York. I am not employed by either of the facilities included in the study. These nurses were solicited on a voluntary basis through advertisements for the study. The nurses were solicited through the facility intranet with an online poster. I made a formal written request to the administration to solicit volunteers for this research study. I requested the procedure to obtain permission from the facilities' institutional review

board to conduct my research. These facilities were chosen based on the convenience of their location in proximity to where I live and because they are large facilities, which allowed for a sufficient number of subjects. A thorough explanation of the purpose of the study was provided to the participants in addition to an informed consent form outlining the voluntary nature of the study and addressing any ethical concerns.

Instrumentation

I used vignettes to gather responses from participants, which required validating their usefulness for this study. Vignettes are short stories about a hypothetical person, traditionally used in research (quantitative or qualitative) on sensitive topics in the developed world. Vignettes are useful in self-assessments such as ability to perform work duties (Gupta et al., 2009). Vignettes can be validated by using careful wording, translation, focus groups, and cognitive debriefing to improve research surveys, which leads to response consistency (Gupta, Kristensen, & Pozzoli, 2009). The consistency of responses indicates that the subjects use the same response categories for their assessments of a topic and that participants understood the domain levels represented in each vignette (Gupta et al., 2009). I did not find any recommendation for the number of vignettes to be used in a qualitative study. In this study, the vignettes, hypothetical situations typically occurring in the workplace among nurses, allowed the participants to have a typical picture of an incidence of lateral violence to answer the interview questions consistently (see Appendix B). The vignettes were constructed based on articles from the literature review as well as from personal experience. Though there can be some variation in interpretation of the vignettes based on age, education, and gender (Gupta et

al., 2009), this had no impact on the current study. My study involved only male nurses of various ages and educational preparation.

Previous research has supported the appropriateness of using vignettes. For example, Van Soest, Delaney, Harmon, Kapteyn, and Smith (2007) validated using anchoring vignettes for subjective threshold scales by using vignettes and self-assessments of drinking behaviors of students. Anchoring vignettes corrects for issues of cross cultural and interpersonal comparisons in research when ordinal response categories are used (Van Soest et al., 2007). According to Van Soest et al., using vignettes was helpful in reducing the problem of different thresholds that different participants have in answering qualitative questions using a subjective scale. Van Soest et al. determined that there was response consistency with the participants' use of the same threshold in answering questions about themselves as they used in answering questions about the vignettes.

The male nurses in my study were asked to assess their objective realities—things that exist independent of perceptions (Andrews, 2012)—in terms of whether they had experienced lateral violence in the work place and to assess whether they perceived the scenarios presented in the vignettes to be lateral violence. The same vignettes were used in all interviews. The participants were provided with copies of the vignettes to read. Following the reading of the vignette, audio recorded interviews were conducted, which lasted about one hour after obtaining the consent of the participant.

Participants and Data Collection Procedures

In this section I discuss the process for recruiting study participants, data

collection procedures, and how the data were recorded. The participant debriefing process is also described.

Data Collection

The participants were male nurses who were recruited from two long-term care facilities. These participants took part in interviews after they reviewed a series of vignettes (Appendix B). The interviews were audio recorded and then transcribed.

When planning the data collection process for a qualitative research study, it is important to determine a suitable number of participants (Crouch & McKenzie, 2006). The appropriate sample size is achieved when additional participants do not provide added insight to the study, which refers to data saturation (Crouch & McKenzie, 2006). To ensure saturation has occurred, it was important to go beyond the point of saturation to make sure no new major concepts emerge in the next couple of interviews.

Debriefing Procedures

The participants were thanked for taking part in the study. A verbal conversation was held between each participant and me during which I provided an opportunity for the participants to ask questions. I also shared information related to the study purpose with the participants. The participants were provided with a debriefing statement to take with them at the conclusion of the study. This debriefing statement included the study title, my contact information for follow up questions, an expression of gratitude for taking part in the study, the purpose and the aim of the study, an opportunity to withdraw consent from the study or the using their audiotaping, and an offer to provide them with study results.

Data Analysis Plan

The data collected was analyzed using manual coding. I looked for themes using a word analysis approach, which seeks to describe patterns across qualitative data. IPA is associated with a phenomenological epistemology and it allows the researcher to gain an understanding of the everyday experience of individuals in detail to address the research question (Braun & Clark, 2006). I attempted to use themes to capture important information related to the research question through patterned responses obtained from the data. According to Braun and Clark (2006), researcher judgment is necessary to determine what a theme is; and they go on further to say that the key to a theme is not necessarily dependent on quantifiable measures but rather the ability to capture important ideas related to the overall research question.

I also used an apriori approach because although there is essentially no literature on the male perspective of lateral violence in nursing, there is much literature on lateral violence in nursing in general. Themes such as bullying, high stress, burnout, and pressure have been identified in research on lateral violence in nursing (Calkin, 2013).

Critical Analysis of the Vignette Methodology

Atzmuler and Steiner (2010) defined vignette as "a short, carefully constructed description of a person, object, or situation, representing a systematic combination of characteristics" (p. 128). According to Bradley and Aguinis (2014), vignettes may be presented in written format but can also include images, videos, and other media. Bradley and Aguinis (2014) discussed the experimental method as a means of addressing the validity of research that uses vignettes. The experimental method studies involve

presenting the study participants with vignettes carefully constructed and realistic scenarios which assess attitudes, behaviors, and intentions of the participants. Bradley and Aguinis (2014) described one type of experimental method as paper people studies which involve presenting participants with vignettes typically in written form and then asking participants to make explicit decisions, judgments, and choices or express behavioral preferences. According to Bradley and Aguinis (2014), the experimental method is a useful way to address internal versus external validity. The article by Bradley and Aguinis (2014) provided evidence that major journals in the field have published at least some articles relied on experimental method.

According to Hughes and Huby (2012), the critical analysis of the vignette methodology is guided by the following key questions: Was the vignette developed and intended as indicated? The vignettes need to be carefully developed for the context of the study, delivered by the interviewer, and received by the participant so the feasibility of the approach is assessed. The interpretation of the vignettes by the participants were determined during the interviews. The verbatim transcripts of the audio-recordings of the interviews were analyzed, and the resulting data was managed using manual coding. The codes were created to capture the way the participants respond to the vignettes.

The vignettes should achieve the intended objectives. The participants should be comfortable enough to discuss their personal experiences. The quantity and the quality of the data will be considered during the interpretation of the data (Hughes & Huby, 2012).

Issues of Trustworthiness

According to Noble and Smith (2015), it is important to evaluate the quality of the

research to ensure the findings can be used. The findings of this study may be used to improve nursing practice by improving relationships between nurses to make them less adversarial, and ultimately to have a positive impact on care delivery.

Credibility

According to Onwuegbuzie and Leech (2007), the importance of validity in qualitative research has long been accepted as being important among qualitative researchers. Qualitative studies take place in a real social world and because of this there can be real consequences in the lives of people. Qualitative research should allow us to have a reasonable view of what happens, what is believed and what is interpreted about particular situations. The researchers who render accounts of these situations must be held to standards of credibility (Onwuegbuzie & Leech, 2007).

Todres and Holloway (2010) maintain researchers using the phenomenological approach, as well as the grounded theory approach; seek to collect the data from the participant perspective and to analyze the data to ensure the findings are not influenced by preconceived ideas. This process increases the trustworthiness of the findings because the participants are involved in data analysis. Researchers using grounded theory or phenomenology seek to explore the experience of the individual in the context of the worlds in which they live (Todres & Holloway, 2010).

According to Bowen (2008), the term theoretical saturation in qualitative research is used typically in the grounded theory approach. The theoretical saturation of data refers to the point where sampling of data by the researcher will not lead to any more new information relevant to the research question. The researcher will see similar instances

emerging allowing for empirical confidence the category is saturated and the researcher is allowed to stop sampling at this point (Bowen, 2008).

Transferability

According to Polit and Beck (2010), the term transferability is an indication of the degree to which the qualitative research results can be transferred or generalized to other settings or contexts. This is primarily the responsibility of the researcher, and the researcher can improve the transferability process by thoroughly describing the research context as well as the assumptions central to the research. I applied the concept of thick description. Polit and Beck (2010) defined thick description as "rich, thorough descriptive information about the research setting, study participants, and observed transactions and processes. Readers can make good judgments about the proximal similarity of study contexts and their own environments only if researchers provide high-quality descriptive information" (p. 1453). According to Polit and Beck (2010), to ensure transferability through using thick description, the researcher must provide the most thorough description of the study as possible.

Dependability

According to Wargo (2013), in qualitative research, the validity findings can be improved by using triangulation and audit trails. Triangulation refers to checking the integrity of the inferences drawn by the researcher. By using audiotapes for interviewing there is less distraction as would occur in note taking. Audiotaping also allows for opportunities to ask more probing questions as well as to seek clarification or elaboration of a response. The audiotapes may also be transcribed and returned to the participants for

their review and approval. This process is referred to as member check or validation. Collaboration with an outside evaluator or external auditor during the process of data analysis is also an option to ensure reliability. The auditing process involves an independent third-party examiner to review the audit trail of the researcher (Wargo, 2013).

Confirmability

According to Thomas and Magilvy (2011), confirmability is similar to objectivity in qualitative research. Confirmability occurs when dependability, transferability, and credibility have all been established. Objectivity is difficult to achieve because the tests, questionnaires, and in the case of this study, vignettes are designed by humans allowing for possible researcher bias. One of the key criteria for confirmability is the extent to which the researcher can admit their biases, which may impact the researchers report. Triangulation reduces the effect of researcher bias. It is important for the researcher to admit to any assumptions or predispositions underpinning the decisions or methods used for the study. It is also important to recognize any shortcoming in the study and the potential effects or impact (Tracy, 2010).

Ethical Procedures

Agreements to Gain Access to Participants or Data

Permission to conduct the study from the facilities was obtained including necessary institutional review board approvals. Any ethical concerns related to recruitment material and process were addressed. According to Kirk (2007), some important ethical issues to consider in conducting qualitative research include power

relations, informed consent and confidentiality. I made a point to focus on anonymity as well. To address confidentiality, no personal information will be revealed without consent of the participant. If the participant discloses situations involving direct harm to a patient or to a colleague, personal information will be requested. The autonomy of the participants was respected in light of the sensitive issue related to lateral violence in nursing. The participants were be informed of how data is collected and how it will be used, particular focus to be placed on how the research will benefit nursing practice, improve patient outcomes and health policy relating to nursing practice. The participants were also informed that they may choose not to take part in the study at any time.

Summary

The purpose of this chapter was to describe the method used in the study. The sample selection and data analysis plan were described including how the data connects to the research question, and how the data was coded. The chapter describes the procedure used in interviewing the participants and analyzing the data. The procedure to ensure the participants and data were ethically obtained was addressed. Issues of confidentiality in the study were discussed as well storage and data dissemination, data access and a timeframe when the data will be destroyed. The issues of trustworthiness of my study were discussed including credibility and strategies used to establish credibility. Transferability, reliability, and confirmability were also addressed in this chapter.

Chapter 4: Results

Introduction

The goal of this research study was to investigate male nurse perceptions of lateral violence in the field of nursing. I explored how male nurses understand the phenomenon of lateral violence in nursing, if and how it impacts them, and what solutions there are to this phenomenon. The phenomenological approach was used for this study because it is concerned with the way a phenomenon appears to individuals in a specific situation. I explored how male nurses perceive lateral violence in nursing through semi structured interviews and vignettes. I used vignettes to present a realistic representation of a typical situation that may be interpreted as lateral violence. They were taken from situations that I have witnessed in my 20-year nursing career and from nursing journals and other literature pertaining to lateral violence in nursing. All vignettes are composites rather than exact replications of real events. I used three vignettes, which will be described in the Data Collection section. Thus, I used an open inductive approach to the collection and analysis of data to generate rich and detailed descriptions of what these male nurses had observed and experienced regarding lateral violence in nursing.

Phenomenology is one of the fundamental principles of IPA. IPA is a popular methodological framework used in qualitative psychology (Pietkiewicz & Smith, 2012). The purpose is to make sense of the life experiences of the subjects, as people engage in interpreting the people, objects, and events in their world (Taylor, 1985). The main objective in IPA is to gain a full appreciation of the subjects' account of a situation (Pietkiewicz & Smith, 2012). IPA studies will usually have a small sample size with the

goal being to gain a detailed account of the subjects' perceptions of the phenomenon being studied.

IPA researchers should focus more on the depth of the study to help illuminate the human experience (Turpin et al., 1997). The participants of my study were purposely selected to enable me to interview a specific population for whom the research problem has significance and relevance. The representation of male nurses in the workforce has remained steady at 11% over the past 5 years (Center for Interdisciplinary Health Workforce Studies, 2017). Because the total number of subjects for whom this study is relevant is small, I established boundaries for sample size at a total of 10 male nurses. Additionally, the recommendation for an IPA study is six to eight participants (Turpin et al., 1997). My study included 10 participants ranging in age from 26-60. The variation in responses based on age led to me include two more than the recommended number to gain a more detailed study with regard to the population of nurses working in the long-term care setting.

Setting

There were several issues during the scheduling and conducting of my interviews. One of the original facilities had been sold and was under new ownership, and I was unable to obtain a partner's agreement. I had to submit a Change in Procedures form to request the use of a different facility for my study. I also had to submit a subsequent Change in Procedures form because I had submitted the incorrect name and address of the new facility. Once the Walden University Institutional Review Board approved these changes (approval no. 0353328), I proceeded with my data collection.

Accommodating the work schedules of the nurses was also an important effort. The nurses I interviewed worked either the 7:00 A.M to 300 P.M. or 3:00 P.M to 11:00 P.M. shifts. Most of the interviews were granted to me during breaks of the nurses' shifts. P6 met me at the facility on his day off, and P7 and P9 granted me the interviews just prior to the start of their shifts. The nurses were cooperative and eager to participate in the study; however, the responsibility of completing their work within their shifts made scheduling difficult. We had to be mindful of the time, which forced me to have to keep the questions and responses on track to complete the interviews within an hour. Three of the nurses were supervisors and were paged overhead a couple of times, causing interruptions in the interviews. Another issue I encountered was a Department of Health Survey, which occurred at one of the facilities. I was asked by administration to conduct my study at the completion of the survey. This caused me to have a 2-week delay in my data collection.

Both facilities allowed me to conduct my interviews in a quiet space where we were free from disturbance, with the exception of the overhead paging. The nurses assured me that the paging was not a distraction to participation in the interview. The nurses were able to speak with me privately. To ensure each interview was captured accurately, I used a handheld digital recorder. I also gave each participant a copy of the vignettes so that they could read them, and they were encouraged to ask for clarification if needed.

Demographics

Table 1 describes the participants in terms of their age, highest level of education,

current practice setting, area of specialty and years of practice. There are several levels of educational preparation for the participants of the study:

- Postsecondary nondegree award: These programs require at least 1 year of full-time equivalent coursework and awards a diploma or certificate of completion as a licensed practical or vocational nurse (LPN/LVN). These programs lead to a certificate or other award, but not a degree. The certificate is awarded by the educational institution and is the result of completing formal post-secondary education. Certification is issued by a professional organization or certifying body.
- Associates in nursing: Associate programs are a step between a high school diploma and bachelor's degree. An associate degree in nursing refers to a number of different 2-year degrees: associate of nursing (AN), associate degree in nursing (ADN), associate of science in nursing (ASN), Associate of applied science in nursing (AASN). The difference between these degrees is relatively minor and pertains to additional coursework outside of core nursing courses.
- Bachelor's of Science in Nursing: The Bachelor of Science in Nursing (BSN, BScN), also known in some countries as a Bachelor of Nursing (BN) or Bachelor of Science (BS) with a major in nursing, is an academic degree in the science and principles of nursing, granted by an accredited tertiary education provider. The course of study is typically 3 or 4 years.

Table 1

Characteristics of Participants

Participants	Age	Highest level of education	Current practice setting	Area of practice or specialty	Years of practice
P1	28	Postsecondary nondegree	Long term care	Geriatrics	4
P2	46	Bachelors of science in nursing	Long term care (also works in a hospital)	Psychiatric	10
P3	26	Postsecondary non-degree	Long term care	Orthopedics & rehabilitation	5
P4	31	Postsecondary nondegree	Long term care	Geriatrics	12
P5	36	Bachelors of science in nursing	Long term care (also works in homecare)	Subacute rehabilitation	5
P6	60	Bachelors of science in nursing	Long term care	Geriatrics	28
P7	30	Postsecondary nondegree	Long term care	Geriatrics	2
P8	31	Postsecondary nondegree	Long term care	Subacute rehabilitation	8
P9	36	Associates in nursing	Long term care	Infection control & education	4
P10	52	Associates in nursing	Long term care	Wound care	20

Data Collection

I collected data from the 10 participants over a month in the form of semi structured interviews. I obtained consent from each nurse prior to the interviews. I discussed and reviewed the purpose of the study as well as the possible risks of taking part in the study. The participants verbalized understanding and signed the consent forms prior to the interviews. The participants were given copies of the consent forms. The participants were also given copies of the vignettes and instructed at which point of the interview they were to read them. The interviews averaged about 30 minutes to an hour in length.

After determining whether the participants were familiar with the term *lateral*

violence in nursing, I provided them with the definition according to Thobaben (2007),

> Horizontal violence is hostile, aggressive, and harmful behavior by a nurse or group of nurses toward a coworker or group of nurses via attitudes, actions, words, and/or other behaviors. It controls, humiliates, denigrates, or injures the dignity of the nurse(s). It indicates a lack of mutual respect and value for the worth of the nurse and denies another's fundamental human rights. It also has been described as intergroup conflict, interpersonal conflict, and bullying. (p. 82)

The data collection took place in a conference room of each of the facilities. The interviews were conducted behind closed doors to assure privacy. The interviews were recorded using an Olympus-WS-100 64 MB Digital Voice Recorder with USB Interface.

Data Analysis

I carried a journal in which I took notes of the nurses' interviews. I also made notes of my personal thoughts during the interviews. I was careful in my notes and interviewing to be objective and not disclose my personal feelings or experiences of my career as a nurse. After each interview and prior to sending the interviews to be transcribed, I listened to the recording and made notes of points that I may have missed during the interview. The interviews were then uploaded from the recorder to a password-protected computer. Turnaround time from the transcriber was approximately 1 to 2 weeks, after which they were returned. The transcribed interview files were uploaded to a password-protected computer.

Generating Themes

I carefully read through the transcripts to try to gain an overall understanding of

each interview. To reinforce my coding strategy, I listened to the recorded interviews of the participants while reading their transcripts. My goal was to try to get a sense of each interview before breaking it down into parts. As I read through the data, I attempted to identify trends and recurring patterns that reflected what the subjects felt most strongly about considering events occurring in a typical workday as a nurse. It is important to identify salient themes, recurring ideas or language, and patterns of the ideas of participants (De Vos, 2005). I clustered the recurring patterns into generative themes and commonalities of the participants. I examined each participant's form of expression, and I attempted to derive broader meanings, interpretations and significances in the form of general themes common to all of the participants.

I generated themes with an awareness of participants' particularities and generalizations and found that the ideas expressed by one participant helped me to understand and make sense of what came next from another participant. I was also able to structure questions better after gaining the perspective of the various participants. One of the goals of data analysis is to make meaning from participant responses that can help understand other participants' responses (Falmagne, 2006). I took notice of how one participant's expressions fit into a chosen theme, while another might have indicated a divergence from the theme. Individual theme content varied throughout the interview process, which will be reflected in the data of Chapter 5. To create order out of the different patterns and commonalities of participant expressions, I used coding.

Coding of Themes

A transcriber was hired, who numbered each change of narrative between the

participants and myself. This allowed me to have a clearer presentation of data when the themes were described. I then followed the theme analysis process as described by DeCuir-Gunby, Marshall, and McCulloch (2011). Analyzing the data from the interviews is a multistep endeavor to make sense of the interviews, and codes can be developed apriori from existing theory or concepts or they can emerge from raw data (DeCuir-Gunby et al., 2011). I used both theory-driven and data-driven codes by incorporating the nurse as wounded healer theory (Conti-O'Hare, 2002), as well as research from existing data on lateral violence in nursing. The nurse as a wounded healer theory (Conti-O'Hare, 2002) has been used in prior nursing research (Almost et al., 2010) to provide insight into why lateral violence occurs.

Open coding. The first stage was open coding, which entailed reading and rereading the data to have an idea of how patterns could be clustered and coded. I read through the interviews several times and then started to create labels for chunks of data that summarize what I saw happening. This based on the meaning that emerged from the data. I recorded examples of participants' words and established properties of each code. This involved naming the identified patterns or categories of expression, breaking them down into discreet parts, examining them, comparing them for similarities and differences, and questioning the phenomena that are reflected in them (see De Vos, 2005). I highlighted the clustered patterns or themes and then named each them depending on its focus or subject matter and marked the name down in the text above the highlighted narrative (see Strauss & Corbin, as cited in De Vos, 2005). The statements made by the subjects were compared as I went along so that similar phenomena could be

given the same name. The name given to each theme or category is the one that seems most logically related to the data it represented.

Axial coding. The next procedure was axial coding. Axial coding consists of identifying and determining relationships among the open codes. This involved looking for links and connections between the themes so that related themes could be merged into clusters. Axial coding involves searching for categories of meaning that have internal convergence and external divergence (De Vos, 2005). The categories or themes should be internally consistent but distinct from one another (De Vos, 2005). I then clustered the highlighted themes in the different participants' interviews that were similar and moved them to a new document. The instances of identified patterns, trends, and themes were noted from the transcripts of the participants, and they gave deeper meanings to my understanding of the text of the interviews. This allowed me to critically evaluate the apparent patterns and search for explanations for the data.

Selective coding. The next step in the coding process was selective coding. This allowed me to figure out the core variable that includes all the data. Selective coding was the final process whereby all themes from the document of the combined participants' themes were divided into a selected number that comprised the final presentation. In the process, "families" of themes were created with the subthemes and categories (De Vos, 2005).

Evidence of Trustworthiness

I explored the data collected from each interview to understand the experience of each participant. I submitted a copy of my first recorded interview to my committee for

feedback. I was able to use the questions of each subsequent interview to more deeply explore the experiences that each nurse shared. The interviews were anonymous, increasing the credibility of the data. I was able to gain a sense of how each nurse viewed his role as well as the responsibilities in the context of the work environment. I was able to check my interpretations by reflecting participants' responses back to them for clarification. I also made sure to give a clear definition of the concept of lateral violence in nursing if they were unfamiliar with the phenomenon. I explored the responses to the vignettes as a way of gaining an understanding of their perceptions of the situations occurring in each vignette. All the interviews were recorded and transcribed verbatim by a professional transcriber. I thoroughly checked the transcriptions against the recordings. The files were labeled with times and dates along with other identifying data of P1-P10. All the data were kept confidential throughout the entire process, as was described in Chapter 3.

To establish confirmability, I took notes using track changes in the Microsoft Word program in addition to the notes that I took within my own private journal. The interview process was challenging because of the sensitive topic, but participants were interested in the topic of lateral violence, and more than half of them expressed being grateful that the topic was being studied. Several participants expressed looking forward to reading the completed study. To establish dependability, I use direct quotes from the participants in the Data Analysis section. To establish transferability, the participants were encouraged to express the experiences of their daily-lived experiences in such a way that the reader could understand the scene that encompasses this research study. The

participants were encouraged to respond within the context of their social and cultural environments as male nurses.

Results

The research question of the study was "What is the lived experience of a small group of male nurses with regard to lateral violence in nursing?" I tabulated the themes and described them in the Table 2. Five major themes emerged from participant interviews.

Table 2

Generating Themes

Themes	Frequency	Meaning	Evidence
Unfamiliarity with the term lateral violence:	27	The participants were not familiar with the actual term lateral violence, however all but one participant admits to having experienced it. All participants admit to witnessing lateral violence.	*"Like, I wasn't even sure what it meant."* P1 *"No, I'm not familiar with lateral violence in nursing. I'm familiar with bullying through school but medically specified, I'm not familiar with that."* P7
Impact of lateral violence on the field of nursing:	22	Lateral violence is ultimately detrimental to patient care.	*" At the end of the day, it's the patient that is going to suffer."* P2 *"If you're going to be violent to each other, how are you going to take care of your patients?"* P6
Perpetuation of lateral violence:	20	Lateral violence is the result of a lack of communication between nurses and also it is perpetuated when nurses are stressed.	*"Because burnout you know, it's a real thing."* P3 *"Nurses fight each other instead of helping each other."* P5 *"Stress is number one, some people don't know how to handle stress."* P8
Gender bias in nursing:	20	Male nurses experience gender bias because they are a minority in the field of nursing.	*"I mean you're a guy. And they would definitely ask you to do extra work, even if you can't, they're gonna be looking for you."* P3 *"It's common to male nurses because the fact that you are a male, with that masculine structure, they think you can do everything."* P5 *"When you say nurse, people assume it's a woman right off the bat."* P7
How to decrease the incidence of lateral violence in nursing:	17	Education about lateral violence is essential to diffusing the phenomenon. There should be more of a team oriented approach among nurses. The nurses all felt that situations should be escalated to administration.	*"I think training and familiarizing everyone and letting them know to be aware of this. Be on the look out for this, maybe people don't do it intentionally."* P7 *"The key is to educate people when we hire them. We need to inform them of what they might expect in nursing."* P10

Theme 1: Unfamiliarity with Term Lateral Violence

This theme speaks to the familiarity of the nurses with the phenomenon of lateral violence. Most of the participants were not familiar with the term lateral violence itself. Interestingly however, all except one participant had experienced lateral violence, and all reported witnessing lateral violence. The description given by the nurses of the term lateral violence encompassed a wide range of behaviors ranging from covert, to more overt forms of negative behaviors among nursing colleagues. P1 described the term lateral violence as being situations where there was not a fair distribution of work among the nurses. He stated that in his experience, there is a tendency for a nurse who is willing to go above and beyond just so a "patient doesn't suffer," to be taken advantage of. P1 stated that he had definitely witnessed lateral violence among his colleague. He describes working in a correctional facility where all of the nurses pretty much shared the same job duties, however there was one nurse who was unfairly given most of the work to do.

P2 also stated that he had never heard the term lateral violence, however, when I compared the term lateral violence in nursing to the term bullying in nursing, he was able to give his perception stating, that it could be both verbal and physical. He stated that while he had never actually witnessed physical violence, he could see how some of the situations that he witnessed had the potential to escalate to physical violence. P3 stated that he had in fact heard the term lateral violence but he wanted more clarification of its meaning. He stated that he had experienced lateral violence, and he described an example of lateral violence where a nurse would leave a very heavy medication pass for him coming on to the next shift. A medication pass involves a nurse preparing, administering

and recording prescribed medications to patients. He stated that this was done to inconvenience him, perhaps for some personal reason.

Some of the male nurses in the study made a distinction between lateral violence as described in the definition given by Thobaben (2007), and what they termed straight aggression. P3 shared an incidence where he witnessed what he described as one nurse "yoke up" another nurse in an act of what he considered to be "straight aggression". P3 stated, "And the one time I did see actual workplace violence, I mean that was different. That wasn't a 'nurses eat their young' situation, that was a superior had said something very demeaning to the nurse in question and he responded by taking him by the neck." According to P1 when discussing Vignette 2, "It's definitely more physical - than mental and this seems definitely across the line more."

P5 who works as a nurse supervisor stated that this is a phenomenon that actually began for him in nursing school where he first heard the term 'nurses eat their young'. He stated that there is a need for education regarding the phenomenon of lateral violence because of how unfamiliar people are regarding the topic. He indicated that the issue has been pushed aside, and there should be more open dialogue regarding lateral violence in nursing.

In sum, while the technical terminology describing lateral violence was unknown, they knew the concept. They exemplified lateral violence in the form of unfair distribution of work, exploitation of physical strength with heavy lifting assignments, discrimination based on male gender such as stereotyping of sexual orientation, spreading false rumors and defamation of character, as well as questioning their ability to provide

competent patient care.

Theme 2: Impact of Lateral Violence on the Field of Nursing

This theme describes the affect that lateral violence has on the discipline of nursing. According to the nurses the negative impact of lateral violence definitely results in detriment to patient care, however the nurses described the negative impact on themselves as well. Some of the sentiments expressed by these nurses include, feelings of inferiority, dissatisfaction with the profession of nursing overall, burnout, and being so negatively impacted emotionally that they do not feel like caring for their patients.

P4 stated that lateral violence is a very prevalent problem in nursing, and he knew of a nurse who had left the field because she was experiencing a lot of negative behaviors from her colleagues. He also states that because of these types of behaviors, burnout becomes very prevalent. According to P3, lateral violence is a major problem because of the potential for it to escalate beyond just being peer to peer, to affecting the patients that are cared for by nurses engaging in this particular behavior. The examples given by P3 is that there may be a delay in the nurses picking up orders, as well as a delay in the overall care of the patient. P3 also stated that since working as a nurse, he has become less satisfied with the profession, however he can't determine if he is dissatisfied with being a nurse, or if it was that particular facility that causes him to feel frustrated.

According to P4, the perpetuation of this phenomenon has resulted in an inferiority complex regarding his ability to function effectively as a nurse. P8 shared a similar view, when referring to Vignette 2. He stated that the actions of the preceptor would have caused him to question his abilities as a nurse. P8 also stated that

experiencing lateral violence could result in the nurses being so emotionally affected by experiencing lateral violence that they do not feel like taking care of their patients.

Theme 3: Perpetuation of Lateral Violence

This theme discusses factors that may foster or perpetuate the phenomenon of lateral violence. According to most of the participants, the phenomenon of lateral violence is perpetuated when there is a lack of communication, and when the nurses are overly stressed. The nurses also described other ways that lateral violence is perpetuated such as, newer nurses receiving unfair assignments, or assignments for which they are not sufficiently trained. Other ways that these behaviors are perpetuated is by inappropriate communication with these nurses, such as being reprimanded in front of their colleagues. The nurses also described being unfairly targeted for having a higher level of educational preparation and being assigned management or supervisory roles over nurses who may have more experience but lack the educational preparation.

P3 stated that if there were more effective communication among the nurses, there would be less incidents of lateral violence in nursing. He referred to the situation in Vignette 2 as direct aggression precipitated by ineffective coping mechanisms by nurses in stressful situations. He pointed out that the lateral violence occurring in this particular scenario could possibly result in harm to the patient, which would reflect badly on both nurses in the situation. P3 also perceived that nurses with seniority would usually get preferential treatment, indicating that the newer nurses may receive unfair assignments because of their newness.

P5 stated that he quickly became familiar with the meaning of this term while

working his first job as a professional nurse. He stated that he was often "called out" and reprimanded in front of his other colleagues by a nurse supervisor. He stated that communication and dialogue between himself and this particular nurse would have been a much more effective way of handling his being a novice nurse. P5 when referring to the situation in Vignette 2 stated that he as a nurse in training would have voiced his feeling of being disrespected. During the interview, he states that he has never seen this type of treatment among colleagues in any other profession. He wonders if it has something to do with the history of nursing and he states that in his career, he has continued to see lateral violence being perpetuated in the field of nursing. P10 who is a nursing supervisor and an educator states that he was 'bullied' as a new nurse and felt that no one was giving him a chance to grow. He stated that an older female nurse took him under her wings and essentially trained him to be a nurse.

P7 was the only nurse who stated that he had not experienced lateral violence, but he had witnessed it. When asked what he felt was the cause of such a phenomenon being perpetuated in the field of nursing, he stated that there are nurses who have a great deal of experience, but they do not have the educational preparation that some of the newer nurses have. According to P7, this breeds resentment because the nurses with more experience may have the capability of functioning with more expertise, however they have supervisors who have positions based on educational preparation and not necessarily experience.

Theme 4: Gender Bias is Prevalent in the Field of Nursing

This theme discusses how lateral violence is uniquely experienced by male

nurses. This was a theme that emerged as a result of the data because the participants felt that male nurses are treated differently than female nurses. Some of the experiences described by these nurses were comparable to those experienced by female nurses based upon literature describing lateral violence in nursing. However, these nurses also described situations that were unique to the male gender. Some of these situations included the typical stereotype of feeling exploited for their physical strength, however a few of the nurses described the assumption that nurses are female, P8 discussed the misuse of the female gender pronouns of 'she' or 'her' when describing nurses. P5 stated that these biases took place in both the educational and practice settings. As a student nurses he was sometimes denied clinical experience such as maternity or OBGYN assignments because of his gender. P3 stated that he was told that men should not be nurses.

Vignette 3 described an experience of a male nurse who was not only given very heavy assignments with more acutely ill patients, but was also assigned more physical tasks based upon his gender. This was the one vignette that all of the participants said that they could relate to, or had in fact experienced very similar situations. P1 states that he had personally experienced this type of bias of being assigned heavier patients when he worked as a certified nursing assistant. He stated that he did not think that it was fair that all the weight should be put on him just because he was a male.

P4 stated that he had not worked with a lot of other male nurses, and he felt that there are definitely instances where male nurses are targets of lateral violence. He shared an example where he worked with a female nurse who he perceived to have a strong

dislike for male nurses. He stated that she referred to them as incompetent, and she made accusations of him that were not true. When referring to Vignette 3, P3 stated that he has experienced similar situations at essentially every placed that he has worked as a nurse.

P3 also reiterates that he feels that it is inappropriate to assign nursing tasks based on gender. He stated that when he is called away to do heavy lifting, he then gets behind in completing his own assignment. P5 also expressed how common the situation in Vignette 3 is. He stated that by virtue of the masculine stature and structure, they are very often called to perform physical acts. P5 also reiterates the fact that being called away to do these physical acts comes at the expense of being able to complete his own workload. P6 and P10 did not feel that being asked to perform extra tasks of lifting patients was a problem unless they were not able to do their own work. P6 who is also a nursing supervisor stated that he considered it to be a chivalrous act to help nurse out who need his help.

P8 spoke to the prevalence of gender bias stating that as soon as someone refers to a nurse, the assumption is that it is a female. He also says that he has had instances where patients are not too comfortable with receiving care from male nurses. According to P10, male nurses are looked at as if they may not be appropriate for the profession; he stated that in his experience, he has had to remain calm when he hears disparaging comments about men in nursing. P7 when asked about gender bias stated that he felt that female nurses are more ‘catty’ and this is a reason for gender bias in nursing, he stated that as a male he himself has no issues with being a nurse and therefore does not allow gender bias affect him or his ability to function as a nurse.

Theme 5: How to Decrease the Incidence of Lateral Violence in Nursing

This theme describes the ways in which some of the nurses discussed eradicating the problem of lateral violence in nursing. Most of the nurses stated that education and team approach are essential to diffusing the phenomenon of lateral violence in nursing. Some of the more experienced nurses advocated the nurses who experienced lateral violence should escalate their concerns to administration. The newer, less experienced nurses did not feel as comfortable reporting situations of lateral violence. The nurses also stressed the importance of communication. P5 stated that he believes in speaking his mind regarding unfair treatment. This has essentially been a coping mechanism for him, and has allowed him to have a viable and more satisfying nursing career. P7 stated that nurses, especially those in a supervisory role should be more authoritative in their roles. He stated that nurses should not tolerate being disrespected. His comment on Vignette 1 was that basically, the nurse supervisor should have demanded more respect from her staff and that and acts of defiance should be handled with disciplinary actions such as writing the nurses up. P8 suggested that training nurses about how to recognize situations of lateral violence, and teaching nurses the best way to diffuse these situations when they occur would be very helpful. According to P8 the first step to diffusing lateral violence in nursing would be to admit that this phenomenon is a definite problem in nursing. P9 stated that new nurses need to feel more supported; they need to be encouraged to speak up if they are having these problems. He said that by taking time and listening to these nurses, they cannot only be educated, but they will also be empowered to function effectively. P10 also discussed the need for support within the profession of nursing. He

also stated that his pride in being a nurse as well as a supervisor motivated him to want to help other nurses.

Reactions to the Vignettes

The participants collectively related to the experiences of the nurses in the vignette scenarios and considered them to be accurate examples of lateral violence. There were varying views of the situation in the first vignette which describes Jones R.N., who is a newly experienced, bachelors prepared nurse. She is put in charge of a unit of nurses, some of whom are more experienced than her and experienced resentment as a result. P2, P6, P9 and P10 who worked in a supervisory role felt that Jones R.N. should have taken a more authoritative role in managing her staff, and if this didn't resolve the situation, they felt it would need to be escalated to administration. The participants with less experience stated that they would basically take on the extra work without complaining.

The second vignette described a new graduate nurse, Susan, being spoken to harshly by her preceptor, and the preceptor putting a hand up to the face of the new nurse. This elicited a strong reaction from some of the participants. P1 felt that this was a more physical form of lateral violence and P4 described he scenario as straight aggression. P5 alluded to the fact that this particular scenario could have escalated to a more violent situation.

The third vignette described a situation where a male nurse was the subject. This particular nurse Tyson, was given more difficult assignments with more critically ill patients, in addition to being constantly called to assist with lifting heavy patients. The nurses all related to this scenario, P3 and P5 chuckled in regard to how familiar they were

with the scenario. Although they all related to the scenario, the older nurses did not feel as strongly about the situation, particularly about being asked to lift patients. The younger nurses felt that this was unfair, and it is a situation that is ingrained in the culture of nursing. P8 stated that the expectation is that all nurses be required to lift 50 pounds and there was therefore no need to call upon male staff to assist with lifting. P3 stated that this has been his experience in every facility where he has worked in his career in nursing. P6 however considered it to be an act of chivalry to assist with lifting, as long as it did not interfere with the ability to complete his assigned tasks. P10 took this situation as a compliment, to be called upon because of, as he described his 'big muscles'.

Discuss Discrepant Cases

Two of the nurses maintained that as a male nurse, there is an expectation that by virtue of their gender, they are to be called upon to perform more physical labor than their female counterparts. P6 stated, "I guess because I'm a holder of ancient chivalry I wouldn't want to see a woman lifting something heavy, so I would always be called on, and I look at it as a blessing to be useful to be helpful, and in fact that's part of the real need for male nurses in the industry, to help with those types of entities. So guys when they come in should come in with that understanding that really these are women, and that really the things they are asked to do is not things that their upper body strength can't handle. So you shouldn't feel anyway about helping them of course it's going to set you back but that's part of the deal." P10 stated, "Yes, it is lateral violence, but the staff comes to you to ask for your help because you are a male, to lift heavy patients because you have muscles. Look at your biceps you are big. Yes this is lateral violence but the

person who is coming to you doesn't look at it that way. Also you as a male nurse don't look at it as violence, sometimes we look at it as a compliment, we strong, we big."

These two participants happened to be the two oldest nurses; perhaps this had an impact on their views regarding being asked to perform more physical tasks as a nurse. They were of a different generation than the younger male nurses who took it as a personal affront to be asked to perform tasks based on gender.

Summary

Generative themes in this chapter indicated that participants responded to the interviews, as well as the vignettes by expressing five themes. The themes that emerged from the data, along with sub-themes, have all been substantiated with supporting quotes from the recorded interviews. This indicated that these interviews allowed the participants to express themselves in meaningful ways.

Each participant's interview reflected in distinct ways their thoughts on lateral violence in nursing, whether or not he experienced it, as well as ideas on how it can be diffused or rectified. In generating themes, I also noticed trends of perceptions in ideas that were similar to all participants. The themes were identified and analyzed without discarding the particular life circumstances, or unique social context of each participant.

My open coding was based on the raw data of the participant's interviews. I found myself interpreting the thematic data as I was compiling different themes. In this way I began a simultaneous process of analysis and interpretation. For clarification I will analyze the findings of the study in the discussion section of chapter 5. My study is based on Conti-O'Hare's (2002) theory of the nurse as wounded healer. The participants in my

study reiterated these ideas, along with others, which are described in the Data Analysis section. In Chapter 5 the purpose of the study and implications of the findings are organized within the conceptual framework. Recommendations for further research and practice are discussed in Chapter 5, along with implications for social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to explore the lived experiences of male nurses and their self-reported perceptions of lateral violence in nursing. I used vignettes designed to simulate potential occurrences of lateral violence followed by interview questions, which allowed the subjects to verbalize their perceptions of lateral violence in nursing. The respondents' descriptions of behaviors, values, and feelings reflected a concern about lateral violence in their respective workplaces as well as their opinions on the etiology and possible solutions for this phenomenon. Participant responses reflected their perceptions of the gravity as well as the implications of lateral violence in the nursing workplace. Qualitative analysis of the coded data revealed five major themes that indicated that lateral violence results in detriment to patient care and results in stress and burnout among nurses. The results also indicated that a lack of communication among nursing staff perpetuates the phenomenon of lateral violence.

Interpretation of the Findings

The findings of this study both confirmed the problems of lateral violence in nursing and extended empirical knowledge about the perception of male nurses on the issue of lateral violence in nursing. Nursing is a caring profession (Cherniss, 2016). The literature review for this study indicated that lateral violence, or the action of nurses responding negatively toward their colleagues, is a problem in nursing (Janzekovich, 2016). This study confirmed that lateral violence does exist within the nursing workplace based on the perception of male nurses.

Unfamiliarity with Lateral Violence

Lateral violence has been described by multiple researchers (Almost, 2006; Becher & Visovsky, 2012; Brown, 2010; McNamara, 2010; Simons & Mawn, 2010). My research on this topic required a clear definition of the concept of lateral violence in nursing to the participants i to conduct the interviews. This reinforced the belief that there is an educational deficit when it comes to the phenomenon of lateral violence in nursing. This point was made by several participants in this study, as responses indicated that most of the participants were not familiar with the term *lateral violence*. However, all except one participant reported having experienced lateral violence, and all reported having witnessed lateral violence. Analysis of the collected data revealed that many of the causes of lateral violence in nursing are rooted in lack of education about the phenomenon as well as poor communication. Thus, there are gaps in knowledge lateral violence in nursing, which indicates the need of more support from management for nurses experiencing lateral violence (Morrow, 2009).

Impact of Lateral Violence on Nursing

Lateral violence is important to nursing because it impacts patient safety and job satisfaction. This was represented in the existing literature on lateral violence in nursing (Maddalena, Kearney, & Adams, 2012; Simon & Mawn, 2010). A number of researchers on the topic have found lateral violence in nursing to significantly impact job performance and patient care (Sanley, Dulaney, & Martin, 2009); Townsend, 2012). A review of the responses from the participants in this study confirmed that not only was there a potential for harm to the patients, but they also described the harmful impact on

themselves as well. The participants described high levels of stress associated with these negative behaviors.

The participants responses suggested the need for more education on the prevalence of lateral violence in nursing and the harmful impact that it has on nurses. This increased education may allow researchers to explore the etiology of lateral violence within the discipline of nursing. It may also help to understand the history of lateral violence, how it evolved and why, and how to prevent nurses from perpetuating this phenomenon. One of the main problems from lateral violence is the financial impact with having to replace and train new staff to make up for nursing shortages. This was discussed in the current literature on lateral violence in nursing by researchers who reported the cost analysis of turnover in nursing (Becher & Visovsky, 2012; & Blair, 2013). This was reinforced by the participants, who discussed wanting to leave their current positions and possibly the field of nursing.

Perpetuation of Lateral Violence

Based on participant responses, although the phenomenon of lateral violence is prevalent in nursing, there is a knowledge deficit in discussions about it. The participants expressed sentiments that new graduate nurses were often targets for lateral violence. This is supported by previous research that has indicated that lateral violence is more prevalent among newly graduated nurses than the more experienced nurses (Griffin, 2011). Further supporting this claim, a couple of the participants referenced the phrase "nurses eat their young," which comes from the pervasive act of lateral violence in nursing (Egues & Leinung, 2013). Nearly 60% of newly graduated nurses resign within

the first few months of employment because of lateral violence issues (Embree & White, 2010). The possible root causes of this phenomenon are multifactorial, and the problem of a lack of communication was the third highest occurring theme in the study. The current study confirmed that lateral violence is perpetuated when there is a lack of communication. Based on the responses in the study, not only is communication between the nursing staff imperative, but there is a need to have strong communication between administration and staff as well.

Gender Bias in Nursing

Another important theme that emerged was the prevalence of gender bias against male nurses. The history of men in nursing involved an exclusive male representation prior to the 1800s (Yullyzar, 2014). However, nursing is seen as a feminine profession, with male nurses stating that they have experienced feelings of isolation and self-doubt because of this (Kirk, 2012). This idea is reinforced by the responses of the male nurses in this study who stated that they were unfairly targeted for certain duties such as lifting patients. They also perceived favoritism toward female nurses because of the profession being predominantly female. All of these factors play a role in the perpetuation of lateral violence in nursing.

Other research has supported participant responses regarding lateral violence. For example, Hegney et al. (2012) stated that there is evidence to support male nurses being exposed to workplace violence more often than female nurses. Stevenson et al. (2006) also indicated that male nurses have experienced significantly more bullying in the form of sexual harassment than their female colleagues. In another study by Dumont et al.

(2012), compared to females, male nurses had experienced a higher frequency of the behaviors of lateral violence. The gender breakdown of the respondents in the were 879 females and 50 males.

How to Decrease Lateral Violence in Nursing

The findings of this study regarding the best interventions for lateral violence varied based on the level of experience of the nurses in the study. The more seasoned nurses felt more comfortable either speaking up for themselves or escalating the situation to administration. This was not the case with the newer nurses who were less inclined to be vocal about these incidences. For instance, new graduate nurses have stated that they were targets of lateral violence because of their lack of experience and feelings of being overwhelmed with responsibilities beyond what they were able to handle (Sheridan-Leos, 2008). Interventions for lateral violence include mediation, which may foster a healthier work environment by managing conflicts among nursing colleagues (Gerardi, 2004). Because several of the participants discussed the need for more effective communication diffuse this problem, mediation may well be an effective intervention.

Results Related to the Theoretical Framework

The theoretical framework used for this study was the theory of the nurse as the wounded healer (Conti-O'Hare, 2002). There is a psychological distress component to lateral violence in nursing, and there is a need for identification of interventions to break the cycle of lateral violence occurring on nursing. The theory of nurse as the wounded healer describes negative psychological outcomes of previously sustained traumas experienced by nurses, which will continue if these experiences are not addressed.

Engaging in steps of reflection helps nurses to assign and understand meaning to their past trauma, which will allow the nurses to eventually transform and transcend these traumas and change their perspectives. This study confirmed that psychological distress as an outcome of lateral violence in nursing may present in many forms, particularly in stress and burnout. Burnout, increased pressure, high stress, and bullying have been identified in research on lateral violence in nursing (Calkin, 2013). This stress can be characterized as a form of discomfort or a negative shift away from the nurses' baseline level of comfort. Psychological distress that is associated with lateral violence may result in an inability to effectively cope and may result in a negative change in the nurses' emotional status and ultimately a communication of discomfort and harm (Conti-O'Hare, 2002). This idea was confirmed in the study as the nurses discussed feelings of being stressed and experiencing burnout as a direct result of experiencing lateral violence.

Trauma is a psychological phenomenon, so trauma resulting from lateral violence is subjective. The subjects in this study had varying perceptions of what they considered to be lateral violence. Some of the nurses verbalized that their perception was that lateral violence consisted of physical violence as opposed to verbal or emotional abuse. Based on the theory of the nurse as the wounded healer, nurses may not recognize the harm that occurs as a result of a previous traumatic event and therefore, discussing these events may be painful if they have not been appropriately resolved. The tendency for nurses as professionals is to strive to live up to an image of perfection, and to be able to care for others without being affected by issues that may have a negative impact on them. The responses of the nurses in this study provide their personal meanings of their professional

encounters and interactions with colleagues. The self-reflection by these nurses may help them to understand the problems that stem from unresolved previous traumatic events. The personal reflections of the nurses also assist the reader to understand the pressures of the task of caring for patients, which is compounded when lateral violence occurs.

Applying the theory of the nurse as wounded healer is useful in identifying, guiding, and diffusing incidents of lateral violence, so it was useful as the framework for this study to describe psychological distress and identify potential interventions focused on addressing lateral violence rather than reporting perpetrators. The focus on the perpetrator may cause a more defensive position on the part of the nurse and may in fact escalate the situation. This study revealed that addressing lateral violence from the viewpoint of the victims increases the potential of improving nurse satisfaction as well as retention to both the job and the profession overall. The nurses stating their gratitude that this phenomenon was being discussed suggests the potential for nurse satisfaction. This will hopefully have a positive impact on patient outcomes in addition to job satisfaction and retention of nurses. The responses from the nurses in my study included references to stress and burnout, so there may be a link between lateral violence in nursing and psychological stress.

Limitations of the Study

The 10 male nurses who participated in this study were selected based on their gender and current employment as nurses. The limitations of the study included that the study was conducted in two long-term care setting facilities, and therefore the transferability of the small sample in this study cannot be expanded to other nursing

employment settings or healthcare facilities. The fact that the nurses admitted to not being familiar with the phrase "lateral violence in nursing" and the definition had to be given to them was a relevant finding. After the definition was clarified, all but one of the nurses indicated that they had experienced lateral violence, but they did not have a name for what they experienced. This was relevant because of the importance of transparency in my study. I wanted to assure that there was no informational bias when explaining the phenomenon to the nurse. My attempt to minimize this limitation was to provide each nurse with a uniform definition of lateral violence in nursing. I considered this to be a limitation because of the possibility of a misinterpretation of the meaning of the phenomenon of lateral violence, as it pertains specifically to nursing. My hope was that the subjects would respond to the interview questions with their focus being on the impact of lateral violence in nursing as opposed to the phenomenon occurring in other disciplines, other settings or other situations.

Other limitations of this study were related to data collection and analysis procedures. According to Smith et al. (2009), a certain level of proficiency is expected when conducting interviews in order to obtain the depth of responses necessary for IPA studies. This was my first attempt with conducting an IPA study, and I was the sole researcher. I may have missed the identification of certain themes within the collected data, or I may have failed to ask relevant questions during the interview that would have elucidated a certain response. My own experiences with nursing may have influenced my interpretations of the nurse's responses. Although I wrote extensive notes, and kept a journal as well, there may be feelings that I was unaware of throughout my analysis.

Demographic information beyond what was shared was not collected and may have implications beyond what the nurses reported. Aside from their gender, age, years of experience and education, demographics such as socioeconomic status or ethnicity were not incorporated.

Recommendations

The results of the study indicate a lack of awareness and concern for behaviors associated with lateral violence as being problematic. As these behaviors have an impact on patient care and job satisfaction (Sanner-Stiehr & Ward-Smith, 2017), this is especially relevant and important. This potential lack of awareness or concern merits further investigation. In addition, findings suggest that the perpetuation of lateral violence in nursing is multifactorial, and further investigation into the potential contributing factor of gender bias in nursing to lateral violence is needed. Future investigation should address a range of factors such as barriers to reporting of these incidents, identifying nurses who are experiencing ineffective coping as a result of experiencing lateral violence, the overall impact that it has on patient care, and the financial burden that this phenomenon may have on healthcare in general because of the need to recruit, hire and train new nurses in order to fill the void of the nurses leaving the profession. All of these are factors that may perpetuate lateral violence in nursing, and future investigations should address them with consideration for the complexity of the phenomenon.

Recommendations for further research in education and practice, as well as strategies to address lateral violence in nursing include research on management education. This should increase competencies in managing lateral violence and gender

discrimination toward male nurses. There is a need to address the stereotype of male nurses as 'muscle' in educational preparation and nursing practice; this was a frequently occurring theme among the responses of the subjects in this study. Increasing the accountability of administration and senior management to mitigate lateral violence in nursing, as well as in male nurse discrimination is necessary. Internal organizational committees are needed to enforce compliance of policies developed to diffuse lateral violence in nursing. As well, workplace education is needed on how gender discrimination in nursing may contribute to lateral violence.

Implications

Lateral violence among nurses persists as a prevalent problem, contributing to psychological distress, staff turnover, and attrition (Ceravolo, Schwarz, Foltz-Ramos, & Castner, 2012). The potential impact for positive social change at the individual level is two-part. The first part focuses on new male and female nurses who are vulnerable due to their inexperience, and are therefore at particular risk for being targets of lateral violence, and experiencing its negative outcomes (Ceravolo et al., 2012). The second part focuses on the population for this study, which is exclusively composed of male nurses. Historically society has held the perception of gender specific professions (Kronsberg, Bouret, & Brett, 2018). Men have increased from 7% of the U.S. nursing workforce in 2006 to 9.6% in 2013 (Bureau's Industry and Occupation Statistics, 2013). There is a rise in the increase of male nurses and although it is slow, it is present. According to Kronsberg et al. (2018), the United States is expected to experience an increase in the shortage of nurses in the near future as a result of health care reform, aging baby

boomers, and an insufficient number of nursing school graduates.

The potential impact for positive social change at the organization level involves the need for more nurses to care for the aging population, and an increase in the need to manage chronic care conditions. This will increase the demand for quality nursing care and the need to explore opportunities to recruit and retain men in nursing to address the pending shortage of nurses (Snavely, 2016). There is a need to promote gender diversity in nursing in order to mirror the culture and population for who nurses care for (Kronsberg et al., 2018). The perceptions and shared experiences of the male nurses in this study may provide insight into the need to eradicate the phenomenon of lateral violence in nursing. These nurses stated that better communication as well as education regarding lateral violence in nursing would have a positive impact on the field of nursing overall.

The potential impact for positive social change at the societal and policy level should address civility in a system value that will focus on improvement in safety in healthcare settings. According to the Joint Commission, Division of Health Care Improvement (2016), the connection between civility, patient care, and workplace safety is not a new concept and was addressed in 2003 by the Institute of Medicine report entitled “Keeping Patients Safe: Transforming the Work Environment of Nurse”. This report stated that “workplace incivility that is expressed as bullying behavior is at epidemic levels” (Institute of Medicine, 2003, p. 1). The Joint Commission (2016) recommended the development and implementation of specific policies and procedures that address bullying among nurses, reduction of the fear of retaliation, responding to

individuals who witness bullying, and initiating disciplinary action for these occurrences. Another recommendation by the Joint Commission (2016) was to solicit input from an inter-professional team that includes representation of nursing and medical teams, other employees and administrators. I feel that psychologists would be an essential addition to this inter-professional team because of the emotional and psychological impact that lateral violence has on nurses.

The potential increased level of awareness may decrease the impact of lateral violence in nursing. Clarification is needed about the effect that teaching and learning about lateral violence may have in diminishing the disruptive behavior that results from lateral violence. Rectifying lateral violence in nursing may potentially combat the nursing shortage, help retain newly registered nurses and recruit additional nurses into the workforce. The responses of the nurses in my study serve as an exemplification of the need for interventions to diffuse lateral violence in the field of nursing.

It is important to address implications specifically for nursing schools. The nursing school faculty should be focused on reducing incidences of lateral violence and preparing students to manage this phenomenon. Curriculum content should address integrating lateral violence content into simulation experiences. This may be helpful in facilitating knowledge into clinical experiences. Students should be trained to adhere to policy and practice codes of conduct that serve as guides for both students and faculty. As role models, faculty should be cognizant of their own behaviors. Nursing faculty should role model appropriate communication, facilitate a courteous and respectful academic environment, and develop nurses capable of identifying and appropriately responding to

lateral violence.

Conclusion

Lateral violence and the behaviors associated with this phenomenon have a very negative impact on the field of nursing. Throughout the past 30 years, the topic has been formally discussed in the field of nursing, no definitive resolution to this problem has emerged, and the underlying problem of lateral violence in nursing remains a constant problem (Privitera, 2010). This study explored the lived experiences of male nurses working in a nursing home setting, and their perceptions of lateral violence in the profession of nursing. All but one of the subjects in the study admitted to experiencing lateral violence, and all of the nurses admitted to having witnessed incidents of lateral violence at some point in their nursing career. Behaviors such as unfair workloads, verbally abusive communications, difficult patient care assignments and gender bias were reported by these nurses. The nurses in this study recognized that lateral violence is not an isolated phenomenon that can be separated from the influences of the work environment. Some of the influences include the effects of stress, inappropriate staffing, the level of experience, and the gender of the nurse. Alternate interventions, as well as additional explanations are needed to constructively manage behaviors that are damaging to the patients and nurses involved in these events. The results of the study indicated that decreasing the incidents of lateral violence is a priority in the field of nursing. By diminishing lateral violence and enhancing a more respectful workplace culture, it can be inferred that there will be an improvement in job satisfaction, a decrease in the incidents of stress and burnout, greater retention of nursing staff and an improvement of patient

outcomes overall. Studies such as this one will hopefully not only bring awareness to the issue of lateral violence and its accompanying consequences in nursing but will also help nurses to perceive the nursing profession as one of central importance to health care. Nurses must reject the notion that it is appropriate to perpetuate the culture of nurses eating their young. They must feel empowered to shift the consciousness of nurses within the field to eradicate these negative and abusive behaviors. Once scholars understand all this, effective interventions can be developed to diffuse and eventually eradicate lateral violence in nursing.

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Appendix A: Demographic Questionnaire

Completion of this questionnaire is significant for the study. All records will remain confidential. Please check or fill in the appropriate line.

Age_____

Educational Background (please check the highest level of earned academic degree)

_____High school graduate

_____College graduate (Diploma nurse)

_____College graduate (2-year degree)

_____College graduate (4-year degree)

_____Master's Degree

_____Doctoral Degree

Current Practice Setting

_____Long Term Care

_____Hospital

Area of Practice or Specialty_____

Years of Practice_____

Appendix B: Interview Guide and Vignettes

I will begin the interview process by asking the subject

1. What is your definition of lateral violence?
2. Do you think that lateral violence is a problem in nursing, and if so, please explain why?
3. Have you yourself ever experienced, or do you know of a colleague who has been impacted by lateral violence? Was that colleague male or female?

I will then ask the nurse to read the vignettes. After each vignette I will ask the following question:

1. Is this an example of lateral violence? Can you explain why or why not?
2. If you were the nurse in the scenario, how would you handle the situation?

Jones R.N. has just been awarded a bachelors degree in nursing which qualified her for a promotion to the position of charge nurse on her 40 bed medical surgical unit. Her colleagues with whom she has worked for a little less than a year have expressed that Jones R.N. did not have the experience that would be required to manage the duties associated with this position and feel that it is unfair that she was promoted based upon education preparation rather than experience. Jones R.N. subsequently encountered experiences of her staff being openly defiant, leaving her with orders which were not carried out and abusing break time. Jones R.N. felt that ultimately the responsibility for running the unit rested on her shoulders and therefore she decided to pick up the slack causing her to leave work late. She, in turn was written up by nursing administration after one month in the position for abuse of overtime.

Renee is a new graduate nurse she is assigned to work with a preceptor for the next six weeks of her orientation. She asks her preceptor, Susan, a question pertaining directly to care of the patient she was assigned to. Susan puts her hand near Renee's

face, gesturing for her to "Stop," and says in a loud voice, "I told you the answer to that this morning. Why are you bothering me again?" Renee thinks that she is in danger of not being prepared to perform the duties that are expected of her once her orientation is over. She does not feel that she has received the proper support from the staff.

Tyson RN is hired to be a Go Where You're Needed (GWYN) nurse at a long term care facility. He is a relatively experienced nurse requiring minimal supervision. After working in the facility for approximately two weeks he noticed that in addition to being assigned to the most acutely ill patient, he is very often called to assist the other staff with lifting heavy patients and transporting patients which interferes with his ability to complete his own assignment. When Tyson mentions this to the supervising nurse, he is accused of not being a team player. He is told that he is a man and should be expected to assist his colleagues with heavy lifting and GWYN nurses should be expected to receive the most difficult assignments because they are floating to the different units.