

Preventing workplace incivility, lateral violence and bullying between nurses. A narrative literature review

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Abstract. *Introduction:* according to available literature workplace incivility, lateral violence and bullying among nurses are widely diffused. Their negative consequences and the outcomes on nurses and healthcare organizations have been well described. However, real pro-active and reactive actions to manage these issues, seem to be poorly recognized and investigated. *Aim:* to summarize the results of international studies regarding the prevention of individual and collective reactions towards workplace incivility, lateral violence, and bullying between nurses. *Methods:* a narrative literature review was performed. *Results:* 7 original papers were included in this review. The implementation of zero tolerance policies and passive dissemination of information about these phenomena showed to be clearly ineffective. *Conclusions:* The limited number of evidence based studies and the typologies of interventions (mainly educational rather than team building programs and assertive communication) show inadequate effectiveness plus a lacking in the scientific evidence-based support. The need to find out innovative and “creative” solutions to face these problems has been suggested by different authors.

Key words: workplace incivility, lateral violence, bullying, nurses, prevention, reaction, solution

Introduction

The professional world of nursing is affected by specific kind of internal conflicts, exerted among peers, which has been widely reported in scientific literature (1-5). These conflicts can vary through an ideal continuum in terms of intensity, frequency and severity, ranging from workplace incivility (WI) to bullying (or mobbing, according to a most “European term”), passing through lateral violence (LV) (6).

Incivility is defined as “a low intensity deviant behavior with the ambiguous intent to damage the target, breaking the norm of mutual respect in the workplace. Uncivil behaviors are rude and discourteous, revealing the lack of respect towards the others” (7, 8).

Even if workplace incivility represents just the precursor, the workplace violence phenomena show up only when harassment and LV begin to emerge. Harassment are described as abusive behaviors with a systematic intent to damage the target (9) and they are essentially based on gender, sexual, racial, and disability differences (4, 10, 11). Lateral violence are consistent behavioral patterns planned with the aim to control, belittle or devalue a group of peers. These verbal or physical behaviors produces a risk for the health and/or the safety of healthcare interventions delivery. The verbal behavior is the most common and includes every kind of professional or personal mistreatment (12).

The definitions of LV are quite different among the authors. However, the main expressions of LV are

referred to open or covert hostility, criticism, sabotage, damage, internal conflicts, looking for a scapegoat (13, 14).

LV can occur as isolate incidents, without gradient of power among the involved persons (eg. the interaction takes place in a shared culture environment) (11, 15).

Viceversa, bullying can occur also among peers, towards superiors or subordinates (vertical or hierarchical violence) (16), as a kind of deliberate and repetitive behavior able to affect negatively the health and economic wellness of the victim.

Bullying is made of recurrent and persistent negative actions towards one or more individuals involving an unbalanced power, creating a hostile work environment (17).

Personal consequences of incivility, LV and bullying targets are related to the psycho-physical and professional spheres. Up to 75% of the victims reported disturbs (18), ranging from irritability and insomnia to psycho-somatic symptoms, till post-traumatic stress disorders (PTSD) and in some cases, also suicide contemplation (19-25).

The professional impact exerted by these phenomena is also notable. The literature reports moderate correlations between LV and quality of patients' care ($r=-0.469$; $p<0.01$), and mistakes/adverse events ($r=0.442$; $p<0.01$) (3). A percentage's range from 11.3% (26) to 30.5% (20) of nurses experiencing LV, decided to quit their job role and rates increase up to 34% for whom planning to leave nursing profession definitively (1).

Similar (or worse) conditions are also reported when bullying among nurses takes place. When bullying events increase, the intent to leave the organization increase too ($r=0.51$; $p<0.001$) (27), since a clear negative correlation exists also with the work satisfaction levels ($r -0.46$) (28). Vessey et al. found that 78.5% of a nurses' team with a length of service lower than 5 years resigned to search another job position, due to bullying victimization (4).

These kinds of phenomena have been brought to the attention of the worldwide nurses' scientific community. Their diffusion, the consequences and the outcomes on nurses and healthcare organizations have been widely described. However, at this moment, the

concrete proactive and reactive solutions seem to be scarcely explored and studied (29).

Aim

For all the above mentioned reasons, the aim of this paper is to find out and summarize the results of international studies about preventive actions, individual and collective reactions against workplace incivility, lateral violence and bullying among nurses.

Methods

A systematic review of scientific literature available was conducted on three different databases: PubMed-Medline, CINAHL and Embase. The keywords were: "lateral", "horizontal", "nursing", "violence" "incivility", "hostility", "bullying", "mobbing". The research was limited to Italian and English written papers. Inclusion criteria were: original quantitative research, systematic reviews and meta-analysis papers. Literature related to workplace violence in academic settings and qualitative studies was excluded.

Results

After the double and not pertinent records removal, 7 publications were relevant for this review. Major topics were then divided as follows: preventive measures, appropriate targets' reaction to bullying events, nurse managers' contribution, healthy work environment, professional association and scientific societies' contribution.

Preventive measures

As of today, the adopted strategies to prevent WI, LV and bullying are summarized in table 1 (29).

As a recent literature review highlighted, the amount of policies or procedures and their level of evidence, appear to be insufficient to counteract bullying and LV in the workplace environment (30).

However, several ideas to find and try further solutions, emerged from those attempted efforts: be-

Table 1. Strategies to prevent workplace incivility, lateral violence and bullying in nurses' professional community

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- To increase the awareness of these phenomena among nurses, managers, and administrators
 - To perform informative and educative campaigns to implement prevention
 - To provide nurses with assertive communication and conflict management skills to face bullying
 - Leadership style centered on authentic relationships
 - Zero tolerance strategies towards every kind of abuse
 - Healthcare workers conduct codes defining accepted and not accepted behaviours, disrupting behaviours, and the management processes of inadequate behaviours
 - In some cases, appropriate legislation
-

havioral changes encouraging a culture supporting anti-LV policies; major involvement of management; implementation of policies and environments, whereas their single application is ineffective (30). Currently, there are clear evidences of inefficacy related to the implementation of 'zero tolerance' policies and passive dissemination of information (30).

A summary of published studies about pro-active interventions related to WI, LV and bullying among nurses is reported in table 2.

The scarce number of studies suitable for this review (only 7) and the typologies of interventions (mainly educative interventions, and only partially, team building programs and assertive communication) seems to confirm the results of Coursey et al. in their review: the lack of evidence of effectiveness (30).

The measured outcomes essentially are: the nurses' turnover (31-33) (which is, anyway, sensitive to other factors besides the workplace violence), the rate of bullying (32-36) (usually rather stable) and the direct confrontation between target and perpetrator (34).

Some authors have redefined the concept of nurse's "professional behavior" in order to recover inside the basis of "being a professional", the "natural antidotes" to bullying and LV (37).

The antecedents (behaviors or events preceding the concept manifestation) of nurses' professional behavior are: ability of compassion, human dignity, values and beliefs, emotive intelligence, self-awareness, reflection, regulation, and confidence (37). The critical

attributes are: mutual respect, harmony in actions and convictions, motivation and collaboration. The consequences, that is the events occurring in presence of the concepts are: words and language reflecting care, respect and clinical competence, effective communication, professional attire, respectful behaviors, effective relationships with patients and colleagues, self-regulation, and responsibilities (37). Obviously, these characteristics are poles apart when compared with those emerging from the perpetrators of abuses.

In the professionals, emotive intelligence seems to be an element requiring improvements, helping to create "resonant" leadership, capable to mitigate conflicts, promoting interpersonal relationship inside and outside groups, and building a work climate suitable to reach cure and care objectives.

Emotive intelligence is made of four dimensions: self-awareness, self-management, social skills (empathy), and management of relationships (interpersonal abilities) (38).

The awareness of own and other people's emotions, the highly stressing setting where the framework and the relationships develop, represent the starting point to attempt the mitigation and the governance of stressors, preventing and wittingly managing the emerging conflicts (39).

Regardless personal attitude towards emotive intelligence, this life-skill can be exerted and increased from anyone (39).

Some authors propose to focus the efforts towards solutions linked to schools of thoughts as the "Peace & Power", made up elements of reflection and action (praxis), education to emancipation, and the building of (sense of) community (40).

This philosophy uses the perpetrators' anger and frustration to make them more aware about the consequences of their actions on the others and create new modalities to live in community. On the other hand, "Peace & Power" offers to the victims of LV a frame of thought to transform the rage in a "call to the change" and give a voice to people without it, through an environment where hierarchical structures are removed, favoring the chance to have a say with the respect of all the different points of view (40).

Olender-Russo has proposed to face the problem of bullying inside nursing, building a culture of "recip-

Table 2. Synthesis of proactive and reactive actions against negative interactions among nurses, and their outcomes

| Authors (year) | Sample/Setting | Typology of negative interactions | Proactive actions | Reactive actions | Outcomes |
|--------------------------------------|---|-----------------------------------|---|------------------|--|
| Spence Laschinger et al. (2012) (36) | 755 nurses respondents in the 1st survey, and 573 in the 2nd survey, among 32 wards in Nova Scotia, and 19 wards in Ontario (Canada). | Workplace Incivility | Structural empowerment and working relationships improvement program (Civility, Respect and Engagement at Work - CREW program) in 8 wards, with 33 wards as control (no program). | NR | Not statistically significant variations between the intervention and control groups, before and after the interventions, related to the levels of WI among peers. Improvement recorded in the intervention group related to the trust levels in management, the total empowerment, and in the levels of WI from the supervisors. |
| Barrett et al. (2009) (63) | 145 hospital nurses from ICU, ED, surgical ward and operating room, Rhode Island (USA). | Lateral Violence | Team building and cohesion intervention. | NR | Significant improvement in cohesion scores and nurse to nurse interactions, after the team building intervention. |
| Ceravolo et al. (2012) (32) | 4000 nurses and 1100 nursing students in 5 US hospitals. | Lateral Violence | Educational workshops to implement assertive communication and LV awareness. | NR | Verbal abuses lowered from 90% (634) to 70% (370). Turnover and vacant roles at 8.9% in the 1st survey, and reduction to 6% and to 3% respectively, after the 2nd survey. |
| Dimarino TJ. (2011) (33) | Surgical outpatient setting, in an US hospital. Number of nurses NR. | Lateral Violence | Application of a code of conduct and precise definition of acceptable and unacceptable behaviors; zero tolerance policy for LV; educative session in LV, and consequences for personnel, patients and organization. | NR | In 2010, no turn-over reported, and no reports of LV. |
| Embree et al. (2013) (31) | 135 nurses in pre-survey; 48 respondents (35%). 143 in post-survey; 35 respondents (24%). Setting: an US hospital. | Lateral Violence | Education about LV, and cognitive trials. | NR | 7.84% of voluntary turnover in the year before the intervention; 1.42% in the following year, and 0% in the subsequent. |
| Griffin M. (2004) (34) | 26 neo-graduate nurses. (US). | Lateral Violence | 2-hours educative intervention about theory and methods of reaction to LV, with a special badge reminder card about LV. | NR | 25 nurses (96.1%) have seen LV during their 1st year of work; 12 (47%) were victims of LV. 100% of LV victims faced the perpetrator. 22 respondents (85%) have not used the reminder card because the lesson contents were well recalled. |
| Rush et al. (2014) (35) | 245 nurses from British Columbia (Canada). | Bullying | Formal transition program for neo-graduate nurses. | NR | Similar rates of bullying between nurses who participated to the program and not participated (39%). In the nurses who participated to the program the rates of access to needed support were 90% among non-victims of bullying and 69% among victims. In nurses that have not participated to the program the proportions were 64% and 38%, respectively. |

Legend: ED – Emergency Department; ICU – Intensive Care Unit; LV – Lateral Violence; NR – Not Reported

rocal treatment with regard” (41). According to this author, this aim is feasible using the Felgen’s IE2E formula for the long-lasting changes (41). This formula considers 4 elements that are necessary and crucial to succeed: Inspiration (II), Infrastructure (I2), Education (E1), Evidence (E2) (41). However, there are no current experiences proving the effectiveness of this method to fight bullying.

Moreover, a recent editorial suggests the need to find “creative” solution to face LV in nursing (42), indicating how this “game” has just began, plus the lack of effective answers to these phenomena.

Appropriate targets’ reaction to bullying events

Several institutions and authors have promoted guidelines and suggestions about appropriate behaviors to adopt in presence of workplace violence.

The Royal College of Nursing published a special guideline to face workplace bullying, listing all the necessary sequential approaches to undertake, and offering some options of behavior to adopt in case of bullying: to talk about the events with others; to draft a written report about the suffered incidents; to con-

sult a delegate of professional association; direct approach with the bully (often resolving); to follow the local procedures of abuse reporting and conciliation/contradictory (19).

The main individual techniques to react to bullying episodes are summarized in Table 3.

Nurse managers’ contribution

Obviously, the solutions of WI and its subsequent phenomena should involve organizational leadership elements and the promotion of civil behavior models (43).

The starting point is to detect the presence of bullying or harassment, turn-over indexes, work satisfaction levels, absenteeism rates, groups cohesion and perform general surveys on work environment climate (44).

Nursing literature showed that ‘junior’ nurses are often the target of negative interactions by other colleagues. A survey performed among nurses with clinical leadership roles, found a scattered opinion about an “adverse” relationship between educational and clinical practice. Nurses’ perception of education appears to

Table 3. Personal techniques to counteract bullying (25)

| Techniques | Behaviors |
|----------------------------|---|
| Verbal | Express own feelings to the perpetrator, saying him/her to stop the bullying Appease the person Understand the perpetrator’s anger Calm attitude Provide memories in a careful way Face to face communication (not isolate) Mirror behavior of the perpetrator Talking about the incidents to a colleague Talking about the incidents with the perpetrator’s boss Talking about the incidents with the human resources department Talking about the incidents with the delegates of professional associations |
| Non-verbal techniques | Maintaining an eye-contact with the perpetrator Taking a physical distance from the perpetrator Adequate use of the touch Using surrounding space limitation to calm the person Change the conversation argument to focus elsewhere the undesired attention |
| Writing about the incident | Take a registration of data and hour of the incidents Mail to the perpetrators and ask to stop his/her negative behaviors Take copies of mails and written memories, for safety reasons |

be distant from their daily professional reality with a lack of shared aims and change educational curricula too slowly (45). Some of the educational strategies to improve the civility culture among nurses' students are: assertive communication, team collaboration, leadership skills, civility education and patients' safety culture. Ultimately, some proposed interventions to improve the civility in clinical contexts are: appropriate codes of conduct, promotion of positive roles, meetings to share and learn the civility culture, education to mediation and conflict resolution (45).

Rocker underlined the need of early intervention in case of bullying episodes by the nursing front-line managers, turning on appropriate resources to solve the conflict situations following the anti-bullying and anti-harassment policies (46).

Managers should also take in account the fear from staff nurses to get involved in the resolution process because their perception of power unbalance and the potential re-victimization dread (46).

One of the most difficult challenge is to create an environment allowing people to speak and report about negative acts, without the worry about retaliation (44).

Healthy work environment

The American Association of Critical Care Nurses (AACN) (47) and the Registered Nurses Association Ontario (RNAO) (48), with proactive aims towards WI, LV and bullying, have developed the concept of "Healthy Work Environment". This concept is mainly based on the maintenance of an adequate work climate as a favorable environment aiming for high levels of effectiveness policies. These organizational goals should be reached through the strengthening of the team spirit, the flexibility as a value in operative and organizational settings always in development and the mutual inter and intra professional respect. In this sense, the "Silence kills" report is a concrete declaration of intents (49).

Healthy Work Environment project is founded on 4 key elements: minimize the barriers to delivery of care; design and implementing of technologies; focus on care directed to the patient; supporting "brand new" nurses (50).

In healthy work environments, the disruptive behaviors should receive special attention through adequate educational and pragmatic interventions. Some educational interventions are: improvement of basic communicative skills, increasing the desire of an effective communication, introduction of policies/procedures against disruptive behaviors (zero tolerance), and adequate interaction with the perpetrators (51).

Professional association and scientific societies' contribution

Since the problem of WI, LV and bullying emerged inside the scientific community, a lot of associations and professional governmental institutions, (mainly in US) have published dedicated position statements, among which, the most relevant was drafted by the Joint Commission (52).

In these documents, the various kind of negative interactions and abuses among nurses are defined, the research results are summarized, the consequences on persons and organizations are described (if management does not take in charge these problems) and potential solutions are suggested (53-59). Moreover, the authors indicate which individual behaviors are the most appropriate and suggest different organizational answers (culture of respect, empowerment, early reporting of every kind of abuse, and zero tolerance policies). Lastly, educational interventions to sensitize the personnel and the search of innovative solutions are recommended (54-58).

The Royal College of Nursing (UK) published a special booklet, describing all the manifestations of workplace violence, including harassment and bullying, a list of behaviors to manage the conflicts, plus the possible actions to follow in case of victimization (19). Similarly, American Nurses Association (ANA) has published a document (59) plus a "tip card" to promptly recognize abuses and adopt individual strategies to manage the event (60).

Discussion

Despite the interest earned from this topic in the worldwide nursing literature, with a remarkable number of papers published from different countries, the

contributions to prevention and resolution, appear to be still scarce and poorly effective (29).

The peculiar nature of relationships inside the workplace environments -unicity, complexity, dynamicity- does not promote the elaboration of standardized strategies. Probably this is one of the main reasons why there is still a lot of work ahead.

Together with the searching of effective solutions, it seems to be not realistic to hope in a complete eradication of these kinds of problems. Nonetheless it's necessary to provide a wide diffusion of information about this issue, to increase the awareness and inspire reflections for a cultural change in terms of cooperation and mutual respect inside the workplaces (40).

Concerning the ethical aspects of this issue, the disruptive behaviors are stigmatized in The Code of Ethics for Nurses, where they are defined as "non-ethical" (61). Moreover, every nurse has the individual responsibility to not get involved with these kinds of behaviors (61). Lastly, The Code of Ethics for Nurses recommend the nurse managers to promote improvement processes to correct the disruptive behaviors (61).

Conclusion

The searching of effective (preventive and reactive) solutions to WI, LV and bullying still remains open. The cultural change, able to free nurses from the passive acceptance of antiquated and mean rules (e.g. professional rites of passage), seems to be a way walked by many institutions. This approach has the aim to change the nurses' vision about the logics underlying lateral violence, felt as a normal condition to deal with. After all, the high rates of nurses playing the double role of victims and perpetrators of abuses, confirm the great strength of this system's cultural background (62) and the inability of individuals to break this chain by means of they have been socialized.

We believe that retrieve data about these phenomena by the local organizations is urgent and a priority in order to avoid any further delay in the implementation of preventive measures.

However, for some institutions, the emerging data about LV and bullying among nursing teams represents an indicator of failure of the system's soft components.

Moreover, if become public, these results could be interpreted as an element of "poor image", undermining the trust of patients (and other types of clients) in the organization efficacy.

Nevertheless, we think that immediate interventions to be implemented are to diffuse the awareness of phenomena, and educate nurses about the slightest individual tools to be adopted. This typology of actions can be simultaneously performed within the healthcare organizations and in the university nursing courses. The cultural change should start immediately, involving all nurses at every level, nursing student as well, through the providing of adequate communicative skills to deal with the abuses, and to build a collaborative and respectful work environment.

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