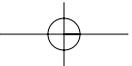
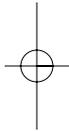
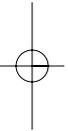
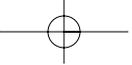


S E C T I O N 1

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# Understanding the forces



# C H A P T E R O N E

## What is horizontal hostility?

*“Define your terms, and I will speak with you.”*

—Voltaire

### **Defining horizontal hostility**

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A literature search on aggression in the workplace produces a potpourri of titles: interactive workplace trauma, anger, horizontal hostility, bullying, verbal abuse, and horizontal or lateral violence. These terms are then discussed within a variety of relationships: nurse-to-doctor, patient-to-nurse, and nurse-to-nurse. Although the literature provides a better understanding of the presence and effect of negative emotions in healthcare settings, the lack of a universal term makes it quite a challenge to integrate the research into one cohesive picture. The following are just some of the definitions used in literature on the subject:

**Horizontal violence:** “Sabotage directed at coworkers who are on the same level within an organization’s hierarchy” (Dunn 2003).

**Verbal abuse:** “Communication perceived by a person to be a harsh, condemnatory attack, either professional or personal. Language intended to cause distress to a target” (Buback 2004).

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The majority of research on aggression in nursing has come from Australia and Great Britain. In these countries, the term “bullying” is used to describe workplace aggression. The definition of bullying shares three elements that come from racial and sexual harassment law. “First, bullying is defined in terms of its effect on the recipient—not the intention of the bully. Secondly, there must be a negative effect on the victim. Thirdly, the bullying behavior must be persistent” (Quine 1999). Bullying is a broad term and includes aggression from superiors, subordinates, and peers in the workplace.

**Bullying:** “The persistent, demeaning and downgrading of humans through vicious words and cruel acts that gradually undermine confidence and self-esteem” (Adams 1997).

The terms “horizontal violence” and “horizontal hostility” are used to portray aggressive behavior between individuals *on the same power level*, such as nurse-to-nurse and manager-to-manager. Research on anger, aggression, bullying, and verbal abuse is relevant because these behaviors are all ways in which hostility expresses itself. In this book, I will use the term “horizontal hostility,” using key points as defined by Gerald Farrell, RN, PhD (see below) and congruent with the elements of harassment law listed above.

**Horizontal hostility:** A consistent pattern of behavior designed to control, diminish, or devalue a peer (or group) that creates a risk to health and/or safety (Farrell 2005).

### ***Overt and covert behaviors***

Horizontal hostility can be physical or verbal. In nursing, verbal aggression is

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more prevalent. It can include any form of mistreatment, spoken or unspoken, that leaves a person feeling personally or professionally attacked, devalued, or humiliated (Farrell 2005). It can be either overt or covert. Since studies show that the majority of our communication is nonverbal, covert behaviors have the biggest impact.

**Overt:** Name-calling, bickering, fault-finding, backstabbing, criticism, intimidation, gossip, shouting, blaming, using put-downs, raising eyebrows, etc.

**Covert:** Unfair assignments, sarcasm, eye-rolling, ignoring, making faces behind someone's back, refusing to help, sighing, whining, refusing to work with someone, sabotage, isolation, exclusion, fabrication, etc.

The following is an example of overt hostility experienced by a fellow nurse:

*"I am used to being in a charge nurse position and am now working with recovering patients from the cath lab. The hostility here is thinly veiled. I come into work and say something like, 'Nice day today,' and the charge replies, 'What's that supposed to mean?'*

*We have really sick patients just fresh out of the cath lab. When the charge nurse told me she was going to take a break, I asked her a few questions so I would have the information I needed to cover. I asked, 'Does 212 have a sheath in?' and the charge nurse said, 'What do you want to know for?' I try to ignore her and just do my job.*

*When she came back from break I told her all that had happened in her absence—for example, that I taped down the IV in 214. Coldly, she responded, 'What did you do that for?' It's a constant, negative, put-you-down undercurrent that never ends."*

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### Is horizontal hostility intentional?

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*For more than an hour, Bethany has been recounting examples of horizontal hostility over a 14-year career, which brought her to three different states and through major depression. At the end of the interview, I ask her, “Do you think the nurses knew what they were doing? Were their actions intentional?”*

*She bristles and responds almost indignantly, “Their actions were very intentional. They knew exactly what they were doing!”*

*I press further, “But were their actions conscious? Do you think those nurses were aware of the pain they were causing you?”*

*Bethany pauses and her face softens. “No, they were clueless to the effect of their actions. They never looked past [their actions] to see how another person would feel. What got me was how a person could hate someone they didn’t even know.”*

The above scenario has occurred with dozens of nurses whom I have counseled. The intent of backstabbing, intimidation, fault-finding, etc., is to alienate, attack, or punish a coworker. In every case I have handled, the perpetrators did not realize the effects of their actions. Many believed that they were superior because they were upholding a standard of quality patient care. Only through education, which began by confronting the behavior, did nurses begin to comprehend the full extent of their actions. And when a nurse did “get it,” the behavior stopped immediately.

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It is difficult to even admit that we could be hurting each other in a profession that has its fundamental roots in caring. Uncovering and discussing horizontal hostility is about as easy as a family acknowledging how damaging it is to live with alcoholism. It is embarrassing and is so remotely removed from our idea of the perfect nurse that we shudder to think that it may be true. In addition, there is an unspoken fear, warranted or not, that acknowledging the problem will make it worse. However, if nursing is to survive, we need an immediate intervention. This intervention starts with listening to the voices in the room—the researchers who have uncovered this behavior, and the nurses who are experiencing the hostility.

### Tales from the front line

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*“Our communication is fraught with indirect aggression, bickering, and fault-finding. It is disheartening to experience the underhanded and devastating ways that nurses attack each other. These rifts divide us and lead us to injure one another.”*

—Laura Gasparis Vonfrolio, RN, PhD

There is nothing as powerful as a story. Stories put the truth out into the world—once a story is shared, you cannot call it back. Stories are a means of truth-telling. If we have had a similar experience, a story resonates with us at the deepest level, and there is comfort and validation as we realize that others share our experience.

At the “Horizontal Violence in the Workplace” conference held by the Oregon chapter of the American Psychiatric Nurses Association in October 2005, I asked participants whether they would be willing to share their stories about hostility in

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the workplace. I collected a list of names and phone numbers of interested nurses and arranged convenient times to speak to each one by phone. As I listened to the first story, I was shocked at the intensity of aggression the nurse had experienced and by the fact that the continuous verbal abuse had resulted in a suicide attempt. From hospitals and academia to outpatient clinic settings, nurses shared with me their poignant experiences with horizontal hostility. I have incorporated many of these stories, and others I have heard throughout my career, into this book (these quotes appear in italics):

*“This is what the group of nurses would do to me: I never sat down for 12 hours. It was horrendous. All I know is that if a group works together for long enough, they keep the others outside.”*

*“The smallest thing would trigger retaliation. [The charge nurse’s] refusal to speak was the worst. Once she went 27 days without speaking.”*

*“It was the looks [the preceptor] gave me, like I was stupid. In my whole three months of orientation, I can’t think of a single time anyone ever complimented me.”*

*“The orientation nurse was ultimately fired. She started drinking and felt attacked all the time. Everything was her fault, all the time.”*

As nurses shared their experiences with me, two common themes emerged. First, every single participant was gravely concerned about maintaining anonymity for fear of being identified. Even if the violence had happened ten years ago and had been resolved by the abuser leaving the workplace, *all nurses feared retaliation*. The workplace was still viewed as dangerous, and nurses continued to feel

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vulnerable. Secondly, no matter what the situation, the stories clearly brought up a lot of emotional pain that was difficult to acknowledge. Like those suffering from post-traumatic stress disorder (PTSD), participants appeared to be reliving their hurt all over again. The air was still thick with feelings of loss and betrayal after the conversations were finished. As stories were coaxed from each nurse, the courage required to tell their stories became obvious. Even to be a witness to another's story was upsetting:

*“Survivors have to look the other way . . . or go along with the crowd to survive. You have to take the party line even if you don't believe it.”*

Research shows that these stories are not isolated events and that the effects of these negative emotions have a serious impact. “Horizontal hostility drains nurses of vitality and undermines institutional attempts to create a satisfied nursing workforce” (Thomas 2003).

### Prevalence

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On an international level, one in three nurses plans to leave his or her position because of horizontal hostility (McMillan 1995). In 1996, a survey was conducted of more than 1,100 employees of a National Health Service Community Trust in England, which included 396 nurses. The bullied staff reported lower job satisfaction, higher job stress, greater depression and anxiety, and greater intent to leave their job. The bully was a superior in 54% of cases, a peer in 34%, and a subordinate 12% of the time. Thirty percent of respondents in the study stated that they were subjected to aggression “on a daily or near daily basis” (Farrell 1999).

A study in the United Kingdom of 4,500 nurses showed that one in six nurses

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reported that they had experienced workplace mistreatment in the past year and that 33% were intending to leave the workplace because of verbal abuse. Mistreatment by peers accounted for 41% of verbal abuse (Gilmour and Hamlin 2003).

Studies in the United States indicate that 90%–97% of nurses experience verbal abuse from physicians (Manderino and Berkey 1997). Some speculate that verbal abuse by physicians contributes significantly to horizontal hostility because nurses pass their anger and frustration with physicians onto other coworkers.

Nurses often cite verbal abuse from peers and supervisors as a reason for leaving their jobs. “Researchers report that verbal abuse contributes to 16%–24% of staff turnover and 25%–42% of nurse administrator turnover” (Braun et al. 1991; Cox 1991; Hilton et al. 1994). In the U.S., “the turnover rate is 33%–37% for clinical practicing nurses and 55%–61% for newly registered nurses. Approximately 60% of newly registered nurses leave their first position within six months because of some form of lateral violence” (Griffin 2004).

In addition, nurses who report the greatest degree of conflict with other nurses also report the highest rates of burnout (Hillhouse and Adler 1997). In 2001, Dr. Linda Aiken of the University of Pennsylvania’s Center for Health Outcomes and Policy Research released a study that examined reports from 43,329 nurses from the United States, Canada, England, Scotland, and Germany. The study found that nurse dissatisfaction was high in all of those countries except for Germany. Burnout and dissatisfaction were reported by 43% of U.S. nurses, and 27.7% planned to leave the profession within a year (Aiken 2001). In a nursing shortage, these statistics are especially foreboding and demand that every nurse, on

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every level, accept the challenge of ending nurse-to-nurse hostility and creating a new culture.

Note that horizontal hostility is not limited to females. “We saw many instances of [horizontal hostility] in our sample of male RNs. They too made disparaging remarks about colleagues. They too experienced frequent verbal attacks by co-workers. One male nurse spoke of being ‘wounded with words.’ Another said, ‘She purposely attacked me, embarrassing me in front of others, humiliating me, trying to make me look incompetent’ ”(Thomas 2003).

As a front-line manager, I have witnessed horizontal hostility on numerous occasions. One nurse would constantly write up other nurses, rather than speaking to those particular nurses directly. It was not unusual for me to come into the office in the morning and find three incident reports in my box written on the same person. Problems arose because new hires and resident nurses found it difficult to fit into a “clique.” Comments like “I hate to follow *her*” were common. The longer the nurses had worked together, the harder it was for others to join their group. Nurses would constantly put down each other by making snide comments, and new nurses struggled to be perfect, knowing that every mistake would be seen as a direct reflection of their competence. Much to my chagrin, the practice of horizontal hostility was quite common on the unit.

Of all the types of aggression that nurses encounter (patient-to-nurse, nurse-to-visitor, doctor-to-nurse, and nurse-to-nurse), nurses report that the **most distressing type of aggression to deal with is nurse-to-nurse aggression** (Farrell 1999). Such intrapersonal conflicts rob us of our energy, deflect our interests

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from patient care, and prevent us from unifying in order to obtain the resources we need to do our jobs. The consequences of horizontal hostility can be felt on all levels: individual, professional, and organizational.

### Impact

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#### ***Individual impact***

*“In the societies of the highly industrialized western world, the workplace is the only remaining battlefield where people can ‘kill’ each other without running the risk of being taken to court.”*

—*Namie and Namie, The Bully at Work*

The effects of a hostile work environment cannot be minimized. Research shows that verbal abuse significantly affects the work environment by decreasing morale, increasing job dissatisfaction, and creating hostility (Manderino and Berkey 1997; Aiken 2001). Bullied staff report a decreased sense of relaxation and well-being at work, increased mistrust, low self-esteem, and lack of support from both staff and superiors (Cook et al. 2001).

Victims of horizontal hostility experience a wide range of emotional, social, psychological, and physical consequences. For example, the medical community recognizes several physical ailments as being triggered or aggravated by stress: irritable bowel syndrome, migraines, hypertension, allergies and asthma, arthritis, and fibromyalgia. Emotional-psychological damage can be less obvious and can include poor concentration and forgetfulness, loss of sleep or fatigue, indecisiveness, anxiety and nightmares, and obsessive thinking about a bully (Namie and Namie 2000).

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At the October 2005 conference on horizontal violence, Gerald Farrell, RN, PhD, summarized some of the known effects of verbal abuse:

### Emotional

- Anger, irritability
- Decreased self-esteem, self-doubt
- Lack of motivation and feelings of failure from being unable to meet personal expectations

### Social

- Strained relationships with partner and friends (One-third to one-half of relationships between partners and family members worsen after someone *simply witnesses* bullying)
- Low interpersonal support/absence of emotional support

### Psychological

- Depression
- PTSD—50% continue to suffer from stress five years after the incident
- Burnout—depersonalization, lack of control
- Maladaptive responses—substance abuse, overeating

### Physical

- Decreased immune response or resistance to infection
- Cardiac arrhythmias (increased risk of heart attack due to continuously circulating catecholamines)

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Seasoned nurses may recall that 20 years ago, new grads were treated as they often are today—harshly, as though they were being hazed to earn membership into the group. But many nurses do not remember horizontal hostility to the extent that it exists now. Little research documents when this behavior escalated and spread from new grads to staff nurses. Informal conversations seem to point to the late 1990s, when managed care and hospital mergers restructured the healthcare setting. No one realized the impact these changes would have on people (Weinberg 2003). The financial gains promised were never delivered because no one took into account the most critical factor of all—human factors. For example, feelings of identity were threatened, and feelings of fear and loss resulted in serious culture conflicts. During this time period, between two thirds and three fourths of all industries, including hospitals, failed to meet their predicted economic gains because the impact of mergers on culture was overlooked (Cartwright and Cooper 1993; Marks and Mirvis 1992). Culture, researchers have found, is critical.

### ***Organizational impact***

*“It is imperative that healthcare organizations re-examine workplace concerns with the goal of creating environments that support nurses in their endeavors to provide quality care.”*

*—Sofield and Salmond (2003)*

Nothing is as destructive to an organization as a toxic work environment. Horizontal hostility creates such an environment by producing feelings of inferiority, anger, powerlessness, and frustration, which are counterproductive when working in a group. Emotional issues will incapacitate even the greatest of initiatives. Horizontal hostility “is a self-serving, non-productive response that perpet-

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uates an escalating cycle of resentment and retaliation” (O’Hare and O’Hare 2004), and research shows that the interpersonal conflict it causes has a direct negative impact on intragroup conflict and work satisfaction (Cox 2003). Indeed, interpersonal conflicts affect teamwork, patient safety, and quality of care (Leppa 1996).

The emotional and physical health of employees is a product of the work environment and a key factor in group dynamics. When horizontal hostility enters the picture, it detrimentally affects the environment by producing a host of physical ailments that result in a loss of time from work (absenteeism, time off with worker’s compensation, family medical leave of absences) and reduced productivity while at work. These responses affect not only the organization’s bottom line but also the efficiency of the entire facility.

The invisible thread that weaves us together is the quality of our relationships. High-quality relationships are reflected in cohesiveness or solidarity—employees who are “all on the same page” and who function with a clear vision of the organization’s goals. Researchers have also noted a direct link between high rates of group cohesion and work satisfaction and a lower turnover rate in acute care settings (Amos et al. 2005). Clearly, the “hallway conversations” that result from such cohesion often give us the critical information and support we need as we do our jobs. Now more than ever, streamlining processes and procedures in hospitals is critical to patient safety and financial efficiency.

### ***The financial impact***

*“The effects of nursing stress have potentially enormous financial and human costs.”*

—Hillhouse and Adler (1997)

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“Nursing leaders are becoming more aware of the costs and consequences of hostility among nurses to the healthcare system and to individual nurses” (Arle 2004). Some economic effects, such as high turnover rates, are obvious. Significant literature also validates the effects of stress and burnout on nurses (Aiken et al. 2002). For example, when positions need to be filled due to sick calls, compensation claims, and family medical leave of absences, overtime and agency costs accrue. An Australian study published in 1999 in the *Journal of Advanced Nursing* showed that 34% of nurses who experienced bullying took off more than 50 sick days in a year (Farrell 1999). In addition, the high cost of replacing nurses during a nursing shortage demands that we become aware of the reasons nurses are leaving.

Other economic costs are more difficult to quantify—e.g., the cost of decreased productivity as well as increased mistakes. In the same Australian study, 25% of nurses reported decreased productivity, and 27% reported impaired ability to perform their tasks. Studies confirm that verbal abuse causes a decrease in morale and an increase in errors and staff turnover.

### **Retention during a nursing shortage**

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As the nursing shortage becomes more critical, the reputation of hospitals and of specific units within those hospitals will become more important. Students in their clinical practicums will assess the quality of relationships and decide where they want to work based on their student experiences. Both new grads and floating inter-department nurses will choose to work on nursing units where they feel valued and supported, so creating a healthy work environment will give facilities a proven competitive advantage.

## WHAT IS HORIZONTAL HOSTILITY?

The nursing shortage projections are well documented and well known. According to the U.S. Bureau of Labor Statistics, more than one million new and replacement nurses will be needed by 2012. But even as we head toward the worst nursing shortage in history, the total number of RNs is growing at the slowest rate in 20 years, further compounding the problem. Forty percent of nursing schools are turning away students due to lack of faculty, and the mean nurse faculty age is 51 years old. Universities cannot compete with the high salaries that an advanced-prepared nurse can earn in the private sector, so the pool of nurses with master's and doctorate degrees will continue to decrease, resulting in a shortage of educators (American Association of Colleges of Nursing).

Ultimately, the shortage comes down to what each of us can control on our own level. As managers, directors, CNOs, and educators, we must make it a priority to learn why nurses are leaving our profession.

*A root cause analysis performed after an episode of over-sedation revealed that the nurse was upset about an interaction with a coworker. Tearfully she stammered to the charge nurse, "I know I shouldn't have let [my coworker] get to me, but he did, and I just wasn't thinking clearly. I felt so humiliated, so belittled."*

*The nurse had inadvertently programmed the PCA to deliver 10 times the ordered dose of morphine. The patient was found unresponsive, with an oxygen saturation of 50%, and was transferred to the ICU. Two days later, a brain scan still showed areas of hypoxia, and the patient still could not put thoughts together clearly.*

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*The nurse transferred to another department within the month. In her department exit interview, the nurse told the manager that she “had always wanted to work on the other unit and wanted to take advantage of the opportunity to transfer.”*

### Summary

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Of all types of aggression a nurse experiences, peer-to-peer hostility is the most hurtful (Farrell 1999). Studying this issue had been hampered by the lack of a universally accepted definition, as well as by a lack of awareness by staff nurses and leaders that the problem exists. Tales from the front line are consistent with the research and demonstrate the tremendous personal, professional, and organizational impact of this behavior.

Nurses who experience the highest degree of conflict also report the highest degree of burnout (Hillhouse and Adler 1997). The effects of a hostile environment are reflected in poor patient and employee satisfaction scores and, ultimately, in the reputation of the hospital or academic setting. New nurses will be drawn to healthy environments; it is therefore imperative that we acknowledge that horizontal hostility is a serious problem and learn strategies to intervene.

## WHAT IS HORIZONTAL HOSTILITY?

### Bibliography

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Adams, A. 1997. *Bullying at work—how to confront and overcome it*. London: Virago Press.

Aiken, L. et al. 2001. Nurses' reports on hospital care in five countries. *Health Affairs* 20(3): 43–53.

Aiken, L. et al. 2002. Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction. *Journal of the American Medical Association* 288: 1987–1993.

American Association of Colleges of Nursing. Nursing Shortage Fact Sheet. [www.aacn.nche.edu/Media/shortageresource.htm](http://www.aacn.nche.edu/Media/shortageresource.htm).

Amos, M., H. Hu, and C. Herrick. 2005. The impact of team building on communication and job satisfaction of nursing staff. *Journal for Nurses in Staff Development* 21(1).

Arle, L. 2004. Horizontal caring in nursing and a narrative community experience. Unpublished thesis for Masters in Nursing. Washington State University, Washington.

Braun, K., et al. 1991. Verbal abuse of nurses and non-nurses. *Nursing Management* 22(30): 72–76.

## CHAPTER ONE

Buback, D. 2004. Home Study Program: Assertiveness training to prevent verbal abuse in the OR. *AORN Journal* 79(1): 148–164.

Cartwright, S., and C. Cooper. 1993. The psychological impact of merger and acquisition on the individual: A study of building society managers. *Human Relations* 46(3): 327–348.

Cook, J. et al. 2001. Exploring the impact of physician verbal abuse on perioperative nurses. *AORN Journal* 74(3): 317–330.

Cox, H. 1991. Verbal abuse nationwide, Part II: Impact and modifications. *Nursing Management* 22(3): 66–69.

Cox, K. 2003. The Effects of Intrapersonal, Intragroup, and Intergroup Conflict on Team Performance Effectiveness and Work Satisfaction. *Nursing Administration Quarterly*, 27(2).

Dunn, H. 2003. Horizontal violence among nurses in the operating room. *AORN Journal* 78(6).

Farrell, G. 1999. Aggression in clinical settings: nurses' views—a follow-up study. *Journal of Advanced Nursing* 29(3): 532–541.

Farrell, G. 2005. “Issues in Nursing: Violence in the Workplace” conference. Tualatin, Oregon. Sponsored by the Oregon Chapter of the American Psychiatric Nurses Association.

## WHAT IS HORIZONTAL HOSTILITY?

Gilmour, D., and L. Hamlin. 2003. Bullying and harassment in perioperative settings. *British Journal of Perioperative Nursing* 13(2): 79–85.

Griffin, M. 2004. Teaching cognitive rehearsal as a shield for lateral violence: an intervention for newly licensed nurses. *The Journal of Continuing Education in Nursing* 35(6).

Hillhouse, J., and C. Adler. 1997. Investigating stress effect patterns in hospital staff nurses: results of a cluster analysis. *Social Science and Medicine* 45(12): 1781–1788.

Hilton, P., J. Kottke and D. Pfahler. 1994. Verbal abuse in nursing: How serious is it? *Nursing Management* 25(5): 90.

Leppa, C. 1996. Nurse relationships and work group disruption. *Journal of Nursing Administration* 26(10): 23–27.

Manderino, M., and N. Berkey. 1997. Verbal abuse of staff nurses by physicians. *Journal of Professional Nursing* 13(1): 48–55.

Marks, M., and P. Mirvis. 1992. Rebuilding after the merger: Dealing with survivor sickness. *Organizational Dynamics* 21(2):18–33.

McMillan, I. 1995. Losing control. *Nursing Times* 91(15): 40–43.

Namie, G., and R. Namie. 2000. *The Bully at Work: What You Can Do to Stop the Hurt and Reclaim Your Dignity on the Job*. Naperville, IL: Sourcebooks, Inc.

## CHAPTER ONE

O'Hare, M., and J. O'Hare. 2004. Don't perpetuate horizontal violence. *Nursing Spectrum*.

Quine, L. 1999. Workplace bullying in NHS community trust: Staff questionnaire survey. *British Medical Journal* 318: 228–232.

Sofield, L., and S. Salmond. 2003. Workplace Violence: A Focus on Verbal Abuse and Intent to Leave the Organization. *Orthopaedic Nursing* 22(4): 274–283.

Thomas, S. 2003. "Horizontal Hostility": Nurses against themselves: How to resolve this threat to retention. *Journal of Advanced Nursing* 103(10).

Weinberg, D. 2003. *Code green: Money driven hospitals and the dismantling of nursing*. Ithaca, NY: Cornell University Press.