NEOPHYTE NURSES AND LATERAL VIOLENCE: THE LIVED EXPERIENCE

by

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ABSTRACT

The aim of this qualitative phenomenological study was to gain an understanding of the lived experience of neophyte nurses who encountered lateral violence (LV) during their first year of nursing practice. Ten neophyte nurses were interviewed to ascertain their description of the LV experience, how they defined LV, and what they perceived nurse educators could do to better prepare nursing students for this phenomenon. Phenomenology framed the conceptual foundation and the presence of oppression within nursing provided a theoretical framework. Data analyses implemented Colaizzi's Method. Emergent themes were identified as follows: (1) lack of empathy from more experienced nurses toward neophyte nurses, (2) personal expectations of nursing related to cognitive dissonance, (3) inability of neophyte nurses to practice professional autonomy, and (4) presence of cognitive dissonance related to oppression in the nursing profession. The importance of the results included implications for nurse educators to include LV as part of the nursing curriculum. The importance for nursing practice included the need for empowerment of the nursing population in order to promote healthy relationships among the nursing profession.

DEDICATION

To my family without whom none of this would have been possible, thank you for allowing me to achieve this monumental goal. To Mark and Justin, you kept me grounded and made me laugh when I felt like crying. To the best dissertation committee, a doctoral student could have ever obtained, you are amazing.

In loving memory of my father, James G. Sewell, he would have been so very proud. This is for you, Dad.

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CHAPTER I:

INTRODUCTION

Neophyte nurses (new graduates; 12 months or less experience as a practicing nurse) carry an increased risk for lateral violence (LV) events to occur during the first year of nursing practice (Baltimore, 2006; Clark, Athen, & Marcy, 2013; Griffin, 2004; Roberts, 2015; Sauer, 2012, Weaver, 2013). This increased risk is related to inexperience and lack of self-confidence of the neophyte nurse during the transition from nursing student into practicing nurse (Griffin, 2004; Kramer, 1974; Weaver, 2013). Although the occurrence of LV is present within many occupations, the nursing profession carries the highest risk for an LV event to occur (Baltimore, 2006; Becher & Visovsky, 2012; Carter, 1999; Farrell, 2001; Moore, Leachy, Sublett & Lanig, 2013; Pelllico, Brewer & Kovner, 2009, & Simons & Mawn, 2010).

The profession of nursing has long cultivated the idea of neophyte nurses being initiated into the nursing profession through a type of hazing. The quoted adage "nurses eat their young" (Meissner, 1999) illustrates how nursing culture has tolerated, even sanctioned, these behaviors as traditions for well over three decades (Baltimore, 2006; Farrell, 1999; Roberts, 1983; Sauer, 2012). Actions of initiation are exercised through verbal and nonverbal behaviors administered by more confident and often more experienced nurses. The impact of an LV event on neophyte nurses is pernicious, demonstrated by the fact that one in every three neophyte nurses leave the profession within the first six months of practice (Booth, 2011).

The inability to accurately name the phenomenon of LV contributes to the endurance of this phenomenon within the nursing profession. Lateral violence has a myriad of definitions and

descriptions found throughout the literature and is synonymous with terms such as horizontal violence, bullying, harassment, incivility, and workplace violence (Alspach, 2007; American Nurses Association [ANA], 2015; Baltimore, 2006; Griffin, 2004: Taylor, 2016). Terms of lateral and horizontal violence are used interchangeably and are described as abusive behaviors occurring between nurses of the same level (the absence of a superior role) within the professional hierarchy (Baltimore, 2006; Griffin, 2004; Taylor, 2016).

Any behaviors that are intended to humiliate the targeted nurse by inflicting psychological distress on the intended target (demonstrated by lack of acceptance and nonsupport), as well as creating distress among the nurses who witness the event (Griffin, 2004; Taylor, 2016). Furthermore, actions may be surreptitious, making it difficult for the neophyte nurse to recognize behaviors or actions as that of an LV occurrence (Taylor, 2016). Also, behaviors of the perpetrator may be conducted at an unconscious or non-intentional level, contributing to denial that the action was that of LV (Sauer, 2012). When actions are difficult to identify due to a lack of understanding of the phenomenon of LV, or a lack of awareness that the actions they are experiencing are those of LV, underreporting occurs (Taylor, 2016). Underreporting of a LV events renders administrators powerless to change or eradicate LV within the working environment (Taylor, 2016).

Neophyte nurses are less aware of the cultural norms of the nursing profession, due to inexperience, and lack of security and confidence in their role as practicing nurses, which contributes to the vulnerability to experience an LV event (Berry, Gillespie, Fisher, Gormley, & Haynes, 2016; Griffin, 2004; McKenna, Smith, Poole, & Cloverdale, 2003). Experiences of LV are described throughout the relevant literature as feelings of humiliation and inadequacy which can lead to low self-esteem and possible abdication of the profession by the targeted nurse, most

frequently, a neophyte nurse (Berry et al., 2016; Booth, 2011; Sauer, 2012; Taylor, 2016). When nurses witness an LV event there is an increase in personal stress related to fear that they may also become a target of the perpetrator (Blair, 2013; Booth, 2011; Roberts, 2015). The focus of LV within this study includes the following: deliberate, damaging behaviors that are demonstrated within the working environment by experienced nurses toward neophyte nurses, with the intent to discredit or humiliate the intended recipient (Becher et al., 2012; Booth, 2011). The literature describes that neophyte nurses report they experience LV from more experienced nurses daily. Examples are described as patient assignment manipulations, assignment of higher patient acuity, inadequate or incorrect information regarding patient care, and an increased patient load (Edwards & O'Connell 2007; Gaffney, DeMarco, Hofmeyer, Vessey & Budin, 2012; Griffin, 2004; Johnson & Rae, 2009). Behaviors of LV vary from rolling of the eyes to deliberately withholding pertinent patient information from the neophyte nurses charged with the patient's care (Berry et al., 2016; Vessey, DeMarco, & DiFazio, 2011).

The complacency of the nursing culture lends to an acceptance of virulent personal interactions between neophyte and more experienced nurses as acceptable behavior and is considered a rite of passage or initiation by fire. Lateral violence is extremely distressing for a profession that considers itself to be caring and compassionate. These distressing effects are demonstrated as these actions that interrupt healthy working environments and impedes safe delivery of patient care (Hockley, 2002; Hutchinson, Jackson, Vickers, & Wilkes, 2006; Jackson, Clare, & Mannix, 2002).

Bullying is classified as repeated offensive and inappropriate behaviors conducted across a time continuum within the workplace, with the intent of undermining an individual's right to dignity (Quine, 2001; Taskforce on the Prevention of Workplace Bullying, 2001). Incivility

refers to behaviors that intend to harm the targeted nurse’s mutual respect (Andersson & Pearson, 1999). Other actions include rude, disruptive, and intimidating behaviors (Brown & Middaugh, 2009; Clark, 2013; Clark & Athen, 2011). Behaviors reflective of bullying and incivility are conveyed through covert or overt actions and are intended to wreak havoc on the targeted neophyte nurse (Becher & Visovsky, 2012; Griffin, 2004).

Covert actions are difficult to identify especially for neophyte nurses. Because of the difficulty to identify, these actions often go unreported and can even escalate into overt LV behaviors (Griffin, 2004). Covert actions are less obvious behaviors. Covert actions included eye-rolling, nonverbal innuendos, and exclusion of a neophyte nurse from a discussion or activity. When covert actions were dismissed as simple misunderstandings by the perpetrator, the targeted neophyte nurse may overlook these behaviors when encountered in the future allowing the cycle of LV to continue unchecked (Griffin, 2004). Covert actions are demonstrated through verbal affronts, failure of the experienced nurse to provide support to the neophyte nurse, belittling, and gossiping about the neophyte nurse (Griffin, 2004). When experienced nurses fail failed to respect the personal privacy of a neophyte nurse, the working environment becomes unhealthy for nurses as well as patients (Griffin, 2004; Rowe & Sherlock, 2005).

Overt actions that sabotaged the neophyte nurses included withholding pertinent information regarding patient care and deliberately ignoring the neophyte nurses when they were engaged with them in conversation (Thomas, 2010). Overt behaviors are more obvious than covert behaviors and have been linked to disruption of patient care, medical errors, increased absenteeism, and difficulty of the targeted nurse to concentrate when performing nursing duties (Lim & Berstein, 2014). When organizations failed to enforce a zero-tolerance policy for LV behaviors within the workplace the perception became a panoptic acceptance for all healthcare

team members (Vessey et al., 2011). Furthermore, failure to report an event leads to a false sense of acceptance of these disruptive and toxic behaviors within the working environment.

Background

The phenomenon of LV has been addressed within the nursing literature for more than three decades with little to no resolution (Bartholomew, 2006; Farrell, 1999; Meissner, 1999; Quine, 2001; Roberts, 1983, 2000; Rowe & Sherlock, 2005; Sauer, 2012). The literature provided a narrative that included the perception of the nursing profession was one of subservience (Roberts, 2000, 2015). Struggles faced by Florence Nightingale in the development of nursing programs did little to remove the stigma of nursing being inferior to the medical (male physicians) profession (Bostridge, 2008). Oppression issues surfaced within the confines of the profession as frustration and dissatisfaction evolved into behaviors of LV, demonstrated by the way Florence Nightingale treated nursing students. It was reported that Nightingale showed nursing students disrespect and animosity, resulting in the retention of only 25 of the original 60 nursing students (Bostridge, 2008).

The early 1900s brought nursing programs under the authority of nurses, removing physicians as primary directors for nursing education. While negative workplace behaviors were present throughout the evolution of nursing, these behaviors were not referred to as LV until the 1980s. The struggle to understand negative nursing behaviors toward peers resulted in Roberts' attempt to name the phenomenon as that of LV (Roberts, 1983). Also, Roberts (1983), describes a link between hierarchical and patriarchal structures within nursing and medicine as a major contributing factor for the occurrence of LV (Roberts, 1983).

Along with the shift in the type of leadership in academic nursing programs, written ethical guidelines for nurses and a more detailed definition of the obligations of a practicing

nurse were published (Epstein & Turner, 2015). It is interesting to note that as early as 1926, the American Nurses Association (ANA) published a code of ethics addressing the ethical behavior of nurses (ANA, 1926). This code included directions about how professional nurses should behave toward one another, as well as, toward patients and physicians. The code included that ethical, professional, and congenial behaviors, as well as, integrity, was expected of all nursing students and practicing nurses (ANA, 1926).

Nursing programs throughout the 1900s remained focused on obedience to the profession, loyalty, and character development (Reverby, 1987). As recently as the 1950s nursing students continued to receive training that included total submission of them into the profession. Programs required students to reside within the hospital throughout their training and discouraged nursing students from marriage or starting a family until training was completed (Melosh, 1982).

The 1980s ushered theories of oppression as a possible explanation for nurse-on-nurse violence (Roberts, 1983). The suggestion of nursing as an oppressed culture remained a logical inference. Since the evolution of nursing, the structural design impressed that nurses serve and support physicians who held positions of power (Brunt, 2011). Power accompanies knowledge and persons in more powerful positions were considered the most valuable people (Matheson & Bobay, 2007).

Lateral violence impacts the nursing profession negatively through issues of nurse retention and recruitment. Lateral violence has been linked to an increase in absenteeism and retention issues in both neophyte nurses and experienced nurses (Booth, 2011; Calkin, 2013; Griffin, 2004). Retention efforts related to issues of LV continue to impact the nursing shortage. Evidenced by, the fact that of every three neophyte nurses, one will abandon the profession

within the first six months of entering practice (Booth, 2011), greatly impacting the future of the nursing reserve. Furthermore, 57% (nearly three out of every five) of nurses abandon the profession within the first 24 months (Calkin, 2013). Resulting in a devastating impact on the future of nursing.

Lateral violence remains a major concern for neophyte nurses across all practice settings, largely related to inexperience, marginalization, and feelings of inferiority in a new working environment (Griffin, 2004; Stanley, Dulaney, & Martin, 2007; Roberts, 2000; Woelfe & McCaffrey, 2007). The irony that LV continues to flourish within a profession that strives to be compassionate, caring, and merciful is concerning. Even more alarming is the complacency with which professional nursing culture has allowed the phenomenon of LV to prevail (McKenna, Smith, Poole, & Coverdale 2003; Woelfle & McCaffrey, 2007).

Problem Statement

Nursing programs saturate nursing students with an educational foundation and the knowledgeable skillsets that are necessary to produce competent and skillful nurses (Maben, Latter & Clark, 2006). However, academe has fallen short when preparing student nurses for the reality of nursing practice and the truth about LV. This lack of education, unfortunately, places neophyte nurses at an increased risk of leaving the profession after an LV event occurs (Hutchinson et al., 2006; Kramer, 1974). Lack of awareness of the occurrence of LV can affect the neophyte nurse’s ability to develop healthy working relationships with physicians, experienced nurses, nursing peers, and other healthcare professionals. The development of professional socialization (such as the development of the nurse’s professional identity) is imperative for the neophyte nurse’s successful transition into the profession (Farrell, 2001; Kramer, 1974; Longo & Hain, 2014).

Purpose of the Study

The purpose of this qualitative, phenomenological study was to gain an understanding of the lived experience of neophyte nurses who encountered LV during their first year of nursing practice. Specifically, understanding how neophyte nurses describe covert and overt actions of LV from more experienced nurses during the period of transition from nursing student to a practicing nurse. How did their LV experience affect the ability of the neophyte nurse in the development of a professional relationship with a more experienced nurse? Did the experience of LV impact neophyte nurse's intention to leave the profession? The knowledge gained may aid academia in better preparation of nursing students in identifying behaviors of LV and prompt retention of neophyte nurses within the profession.

Significance of the Study

The significance of this study may aid the retention rate of neophyte nurses and build the nursing population pool, so nurses are better prepared for the increased healthcare needs of the largest aging populations to date. In addition, creating educational programs that are inclusive of LV knowledge, may provide future nurses with the tools to deflect and defuse unacceptable LV behaviors when encountered. Empowerment of neophyte nurses may result in a healthy work environment that supports acceptance, mentoring, and cooperation to ensure patients receive optimal health benefits through nursing. Nursing students, neophyte nurses, and experienced nurses must understand how to accurately identify LV when it occurs.

Significance to Nursing Education

The development of programs that educate nursing students on the phenomenon of LV can blunt the effects of LV in the neophyte nurse through the reduction of reality shock upon entering the nursing culture. Neophyte nurses are submerged into the nursing culture and often

find themselves struggling with this transition. When an event of LV occurs, many neophyte nurses abandon the profession altogether (Griffin, 2004), instead of understanding the acculturation process of the nursing culture, even the unacceptable nursing behaviors. Preparing nursing students in LV will provide them with the tools needed to successfully transition to practicing nurses. Understanding covert and overt behaviors when subjected to these actions by more experienced nurses, may reduce the number of neophyte nurses leaving the profession.

Significance to Nursing Profession

The goal of the nursing profession to recruit and retain competent, skillful, and professional nurses who deliver patient care within a caring and healing environment. The need to build a healthy population of nurses can deflect the projected forthcoming nursing crisis. Increasing an adequate number of practicing nurses remains one solution to improve and promote a safer patient care environment, reduction of risk to multiple patient populations, and prevention of nursing burnout (Embree, Bruner. & White, 2013). With a healthy quantity in the nursing population, job satisfaction may increase, burnout may be reduced, and nurses may have adequate time to recharge before returning to work. As a result, patient errors may be reduced, preventing readmissions and untoward outcomes.

Retention rates impact both current and projected nursing populations through fatigue, exhaustion, and burnout (Embree et al., 2013; Griffin, 2004). Failure to retain competent and experienced nurses contributes to fatigue and burnout of the entire nursing population. When nurses are fatigued, burned out, or dissatisfied with their job there is an increase in nursing errors and a decrease in the quality of patient care (Becher & Visovsky, 2012; Hutchinson et al., 2006; Roberts, 2015).

Furthermore, when retention is compromised, neophyte nurses spend less time orientating and are pushed into practice before they feel confident, which may further impair the successful development of interpersonal and professional relationships with peers (Simons & Mawn, 2010). The placement of neophyte nurses into the practice setting before acculturation has occurred, further impacts their self-confidence and leaves them vulnerable to an LV event and abandonment of the profession. Furthermore, placing neophyte nurses into the practice setting before adaption to the transition may increase the risk for patient safety as demonstrated by medication errors, patient injuries from falls, and delayed procedures and treatments (Becher & Visovsky, 2012; Blair, 2013; Hutchinson et al., 2006; Embree, et al., 2013; Littlejohn, 2012; Roberts, 2015).

Nursing programs report an increase in the number of student enrollment and an increased number in students graduating from accredited programs (American Association of Colleges of Nursing [AACN], 2007), which seems to contradict the projected nursing shortage. What do nurse curriculums need to include to encompass empirical knowledge that changes the future for nursing and provides preparation for the recognition of and reaction to the phenomenon of LV? Can providing future nurses with the tools and skills to neutralize negative workplace behaviors, such as LV, build better working relationships and safer patient environments (Center for American Nurses, 2008)?

The nursing profession has experienced a nursing shortage for years, so why is it so alarming now? The increased demand for nurses is multifaceted. A more intense look identified several factors. First, the largest aging population seeking healthcare presents the need for facilities that address aging issues as well as respite care. Second, many experienced nurses are reaching retirement age at a time when the patient care population is expanding exponentially.

Third, the Affordable Care Act has offered new populations a direct line to healthcare. This created greater demands for facilities and nursing professionals needed to address healthcare issues, specific to unique populations and cultures (Nursing Solutions Incorporated [NSI], 2013; The Affordable Care Act, 2010).

Research Questions

To attain a more in-depth understanding of the lived experience of neophyte nurses' exposure to LV within the first year of nursing practice the following questions will be addressed. These research questions allowed the researcher to demonstrate through data collection and analysis the consistency, dependability, credibility, and trustworthiness of information on this specific phenomenon (Merleau-Ponty, 1962). The following questions are designed to address significant areas of the phenomenon of LV experienced by neophyte nurses within the first year of nursing.

1. What is the lived experience of LV in neophyte nurses?
2. How do neophyte nurses describe LV?
3. What content areas do neophyte nurses perceive that nurse educators could include for aiding in preparation to recognize and respond to LV?

Theoretical Foundation

Oppression within nursing includes the exercise of authority or power by a burdensome, cruel, or unjust manner (Dong & Temple, 2011). Oppression becomes a logical inference within the nursing profession, largely related to the design of the medical hierarchal structure (Griffin, 2004; Roberts, 1983). Lateral violence behaviors are present when feelings of powerlessness exist. These behaviors are demonstrated through covert or overt actions from more experienced nurses toward less experienced nurses after perceived oppressive struggles from administrators

or physicians have occurred within the nursing environment (Sheridan-Leos, 2008). Behaviors of LV are an attempt by more experienced nurses to take power from neophyte nurses (Lachman, 2014; Weaver, 2013).

The Relationship of Oppression to LV in Nursing

Historically, nursing practice was developed and patterned from a paternalistic structure within healthcare. Nurses served many roles including patient advocates, physician assistants, caregivers, and service providers for daily living needs including housekeeping duties within the patient environment (Jasmine, 2009; Jinks & Bradley, 2003). Nursing was founded and supported by physicians to be a submissive occupation for women which provided support and service to men in positions of authority (Watson, 1999). Since nursing is considered a submissive profession some nurses reported feeling a definite division of power and in return felt powerless to improve their status. These feelings of powerlessness were turned inward and surfaced as hostilities toward one another (Becher & Visovsky, 2012).

The existence of oppression among nursing can result in internalized feelings of low self-esteem, especially for neophyte nurses (Weaver, 2013). Furthermore, when nurses experience feelings of powerlessness within the working environment, feelings of low self-esteem surface (Griffin, 2004). These emotions of low self-esteem can be internalized and may result in behaviors of LV expressed toward peers through overt or covert actions (Stanley et al., 2007). Neophyte nurses are easy targets of negative comments, criticism, and misplaced blame (Weaver, 2013). Oppression theory shares a direct link to self-loathing and animosity for fellow nurses and contributes to the high risk of LV (Farrell, 2001). When LV is present, the dominant members can suppress less powerful members into complete submission. This convinces the

menial subjects to embrace the thoughts and beliefs of the dominant leader (Freire, 2000; Matheson & Bobay, 2007).

Currently, the nursing profession remains predominantly female, with only nine percent of nurses being male (NSI, 2016). The introduction of oppressed group behavior in the nursing profession is a logical inference. When nurses are oppressed, feelings of powerlessness often result in internalized frustrations. These feelings of frustration increase the stress within the working environment and often result in behaviors of LV toward perceived inferior (commonly neophyte) nurses (Mitchell, Ahmed, & Szabo, 2014).

Neophyte nurses arrive in the practice setting armed with the educational and foundational knowledge required to provide competent patient care; however, the sheer lack of experience, personal insecurity, lack of confidence, and professional identity place them in an oppressed position (Griffin, 2004). Lateral violence comes into play when more experienced nurses assume the role of the group's dominant player (because of the power of experience and knowledge working in the profession) over less experienced nurses. Societal acceptance of views and actions of experienced nurses provides support that allows oppression to remain unchallenged (Matheson & Bobay, 2007). Oppression theory posits that survival skills must be developed. There is a demand that neophyte nurses must assimilate the characteristics of the more dominant role (oppressor) as a survival technique (Freire, 1970; Matheson & Bobay, 2007). This assimilation is imperative to the development of successful socialization and healthy professional relationships (Kramer, 1974).

Oppression affects the nursing profession by decreasing retention. Oppression theory predicts that turnover and burnout will result when oppressive behaviors go unchecked (Longo & Hain, 2014). Behaviors of LV can cause prolonged stress, which is a contributing factor in

decreased job satisfaction, decreased patient care and the intent of the targeted nurse to leave the profession (Weaver, 2013). The intent to leave the profession is implemented when self-esteem becomes so low that oppressed nurses feel unable to continue practicing nursing, given the existing conditions (Becher, 2012; Matheson & Bobay, 2007). The continuation of oppressive actions within the working environment can produce a division and disharmony among all nurses (Woelfle & McCaffrey, 2007).

Nature of the Study

The application of a conceptual framework within a research study allowed me to organize themes and ideas in a way that can be easily applied to data collection for empirical confirmation (Creswell, 2013). The phenomenological approach within this study will serve as a conceptual framework as well as a methodology (Creswell, 2013). Phenomenology consists of both a philosophical evolution and an innovative approach to researching the lived experience of subjects. Phenomenology takes an in-depth look at a specific phenomenon--in this study LV--and what LV means to humans (neophyte nurses) who experience that event. This phenomenological study explored and examined the lived experience of individuals through a descriptive tapestry of their recounting of events, feelings, and thoughts pertaining to LV (Creswell, 2013).

A qualitative approach views the human experience as the key to understanding the phenomenon of the study (Langdridge, 2007; Merleau-Ponty, 1962). Gaining knowledge of the LV experience through the verbal account of the neophyte nurse, who has less than 12 months experience as a practicing nurse, allowed a glimpse of how LV is perceived or experienced.

As a qualitative phenomenological researcher, I believe this is the most relevant method of application to apply when exploring a phenomenon of pedagogical importance (van Manen,

1999). When studying a phenomenon to gain an understanding of the experience through the perception of a specific group of people who share the phenomenon, this allowed me insight into how that experience shaped and formed thoughts, beliefs, and behaviors (Langdridge, 2007). Phenomenology has the capability of delving into the core of the phenomena to expand on the crucial points of the lived experience through the subject's eyes and feelings (van Manen, 1999).

Utilizing a phenomenological study, I was encouraged to focus on the ontological aspect of the phenomena. Discussing the phenomena of LV allowed me to understand how this experience shaped the personal emotions of neophyte nurses. Allowing participants to verbalize how the phenomenon changed their views, values, and beliefs permitted the lived experience of LV to have meaning through confirmation or discarding of beliefs.

When neophyte nurses experience LV within the first 12 months of nursing practice yet undeveloped personal beliefs and behaviors are affected. The struggle to acclimate to the practice environment requires social and professional identity development. Any occurrence that shapes philosophy, values, beliefs, or behaviors may have an impact on the lived experience for the neophyte nurse. Understanding the phenomenon of LV and how that phenomenon alters values and beliefs of neophyte nurses deserves a social and scientific approach (van Manen, 1990).

I desired to conduct an engaged phenomenological research, which required me to be well versed for phenomenological text. This provided me the ability to identify didactic phenomenological material which enriched the study (van Manen, 1990). Questions asked using medical vocabulary and English as the first language allowed participants to feel comfortable conversing with me (Benner, 1994). Understanding the neophyte nurse's verbal delivery, as well as the verbal content enhanced translation once I was educated in the phenomenological importance (van Manen, 1999).

Definitions

Bullying--Bullying is described as a continuation of personal attacks by a perpetrator intended to damage self-worth, confidence (Moustaka & Constantinidis, 2010), professional reputation, and status of the targeted nurse (Edwards & O'Connell, 2007). Actions of bullying are unrelenting offensive repeated behaviors (Dehue, Bolman, Vollink, & Pouwelse, 2012), abusive, intimidating, malicious (Hutchinson, Vickers, Jackson, & Wilkes, 2006), or insulting, abuses of power (either actual or perceived) (Zaph & Gross, 2001). These actions are intended to threaten, humiliate, or control the recipient (ANA, 2015; Edwards & O'Connell, 2007).

Examples of bullying behaviors include the following: gossiping about the targeted nurse, (Stokowski, 2010), sabotage of the intended target, and hostile comments made to the targeted nurse in front of peers, patients, and patient's family members (ANA, 2015). Additional examples include excessive criticism about the nurse's performance, organizational skills, and time management (Rowe & Sherlock, 2005), scapegoating (Ayakdas & Arslantas, 2018), and unrelenting berating (Simons & Mawn, 2010).

Covert behaviors--Covert actions are defined as concealed, hidden, secret, and disguised actions (Merriam-Webster.com, 2018). This type of behavior is difficult to identify and often dismissed by both the perpetrator and the target as innocent banter (Duffey, 1995; Embree et al., 2013; Farrell, 2001; Griffin, 2004).

Examples of covert behaviors include eye-rolling, sighing, and isolation of the targeted nurse (Bartholomew, 2014). The deliberate withholding of pertinent information and sharing personal and private information from the targeted nurse (Taylor, 2016) are representative of covert actions demonstrated within the profession.

Experienced nurse--A nurse who holds a current nursing license, is actively practicing in a professional role, and has 12 months or more of clinical experience.

Incivility--Incivility is a term used interchangeably with LV (Farrell, 2001). In addition to behaviors mentioned above, incivility includes psychological harassment that seeks to interrupt normal workplace environments (Felblinger, 2008). Behaviors may be overt or covert. An attempt to emotionally control the target remains the intent of the perpetrator (Farrell, 2001).

Lateral violence (LV)--Behaviors that are unwelcomed by the recipient (Brunt, 2011) consist of unwanted abusive or hostile covert and overt actions (Griffin, 2004) toward the targeted nurse (Becher & Visovsky, 2012; Thobaben, 2007). LV can comprise multiple incidences or may be exercised in a single isolated incident that is void of a power gradient between individuals involved (Duffy, 1995; Rainford, Wood, McMullen, & Philipsen, 2015). Terms used interchangeably throughout the literature include bullying, incivilities, workplace aggression, covert or overt behaviors, and incivilities among peers (Lim & Bernstein, 2014; Vessey et al., 2011).

Examples of LV include the following: criticizing a peer, blaming the targeted nurse falsely, withholding information from the targeted nurse that impedes optimal patient outcomes or interrupts the nursing practice, and breach of confidentiality (Embree et al., 2010; Griffin, 2004; Sanner-Stiehr & Ward-Smith, 2016).

Neophyte nurse--Neophyte nurse is defined as a graduate nurse from an accredited nursing program, who holds a current nursing license, and is currently working in the nursing profession. A neophyte nurse has less than 12 months of experience as a practicing nurse.

Overt behaviors--Overt actions are defined as open to view or knowledge; not concealed or secret (Merriam-Webster.com, 2018). Actions include clear, obvious, and damaging behaviors (Griffin, 2004) witnessed by employees, patients, and patients' families.

Examples include verbal outbursts from experienced nurses toward neophyte nurses, refusal of experienced nurses to answer questions asked by neophyte nurses, exhibiting uncooperative attitudes during a routine daily activity, condescending language, and voice intonation (Geradi & Connell, 2007; Hickson, Pichert-Webb, & Gabbe, 2007; The Joint Commission, 2008; Weber, 2004). Falsely accusing targeted nurses of negative outcomes, assigning unrealistic patient loads and refusing assistance to neophyte nurses in need were reported in the literature (Taylor, 2016).

Safe working environment--The professional environment is where patient care is delivered by licensed nurses to achieve optimal patient outcomes. The expectation within the environment includes respect for all persons (ANA, 2015), regardless of their station or status level. Environments that encompass healing and empowerment are declared as healthy (both mentally and physically) working environments (Moore, Leahy, Sublett, & Lanig, 2013). Furthermore, healthy working environments are crucial to the successful transition of neophyte nurses into nursing practice. When the transition of neophyte nurses is not supported, patient outcomes and standards are compromised, often resulting in untoward outcomes in patient care (Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Aiken, Clark, Sloane, Sochalski, & Silber, 2002; Carayon & Gurses, 2008).

Assumptions

I experienced lateral violence in my career, which resulted in a personal conflict of whether to remain in the nursing profession. Therefore, one assumption is that the participants

have remained within the profession. I also assumed that LV remains part of the nursing culture. Time can alter the perception of an experience. I assumed that the lived experience of the LV could be recalled in detail and that the participant would answer truthfully to interview questions. Recall of facts, emotions, and any changes in personal or professional beliefs related to the experience would be conclusive during the first year as related to the occurrence and the effect on the participants.

Scope and Delimitations

The scope of this study was confined to neophyte nurses who had less than 12 months of experience practicing in the profession of nursing and had experienced an LV event from a more experienced nurse. Furthermore, these neophyte nurses experienced LV while transitioning into the role of the professional nurse. The geographic location of this study included a region within the southeast that provided a central hub for several urban healthcare communities. Participants were strictly female. The focus on female neophyte nurses was grounded in the fact that the nursing profession remains predominately female. Oppression appeared within the literature in relation to women, therefore, this study did not attempt to understand how LV impacted male nurses. Educational levels considered in this study included associate and baccalaureate nurses, excluding higher levels of educationally prepared nurses, related to Master of Science in Nursing (MSN) prepared nurses holding positions of management (power).

Conclusion

In conclusion, the occurrence of LV within the nursing profession has existed for over three decades with little to no resolution (Bartholomew, 2006; Farrell, 1997; Meissner, 1999; Quine, 1999, 2001; Roberts, 1983; Rowe & Sherlock, 2005; Sauer, 2012; Woelfle & McCaffery, 2007). The theory of oppression offered a rationale on the way nurses behaved toward one

another. These behaviors included, but not limited to lateral or horizontal violence, incivilities, bullying, and disruptive workplace conducts (Griffin, 2004; McKenna et al., 2003; Vassey, 2010).

Lateral violence is responsible for the abandonment of one in every three neophyte nurses during the first six months of entering practice (Booth, 2011). This contributes to the already existing nursing shortage through an inability to recruit (if the institution has a reputation of LV) and retain skilled and competent nurses. For victims of LV, the physical and psychological damages can be detrimental (Griffin, 2004; Weaver, 2013). Furthermore, LV leads to poor communication among all nurses working in an environment where LV is present. A correlation exists between LV and an increase in medication errors, lack of concentration of the targeted nurse when performing nursing tasks, and decreased competency when providing patient care thus placing patient safety at risk (Blair, 2013; Mitchell, Ahmed, & Szabo, 2014).

In Chapter II, I provide a detailed review of the literature available on LV and the nursing profession. The literature confirmed the presence of LV within the profession for over three decades (Griffin, 2004). This chapter included the search strategy, theoretical foundation, and theory of oppression among the nursing profession.

CHAPTER II:

REVIEW OF LITERATURE

Chapter II further explicates the theory of oppression as it relates to nursing and provides an overview of available research discussing LV in nursing and the concepts surrounding this phenomenon. I discuss terms and definitions of LV as I understand it, how it is defined within the literature, and the theory presented to explain the existence of LV within nursing. Guided by the relevant review of the literature I explicated inappropriate and unacceptable workplace behaviors that demonstrate LV events.

Search Strategy

To better understand how neophyte nurses experience LV within the first year of practice, a comprehensive literature review was undertaken. In addition to reviewed articles, I analyzed publications of American Association of Colleges of Nursing [AACN]; ANA (code of conduct); Ethics, Law, and Policy (Lachman, 2014); The Joint Commission [TJC] policy; and Occupational Safety Health Administration [OSHA] guideline for workplace safety concerning LV.

A search of The University of Alabama Library Scout search as well as (CINAHL), EBSCO, ELSEVIER, InfoTrac, Google Scholar, and ProQuest was conducted. Sixty-four articles related to LV from three decades were retrieved. This period covered the introduction of oppression as it first appeared in the nursing profession (Roberts, 1983) and concluded with articles that examined nurse’s perceptions of bullying and LV (Butler, Prentiss, & Benamor, 2018). Most articles reviewed originated within the United States (US); however, some studies

were conducted abroad (Dickie-Clark, 1996; Duffey & Sperry, 2012; Hallman, 2000; Hockley, 2002; Langdridge, 2007; Marks, 1988; Merleau-Ponty, 1962; van Manen, 1990; Watson, 1999).

Key terms of the literature search included lateral violence, bullying, incivilities, "eating their young" (Meissner, 1999), rites of passage, horizontal violence, aggression, and nurse on nurse violence; however, as the search continued additional terms were included. Those terms oppression within nursing, interpersonal conflict, workplace aggression, and toxic work environments.

Theoretical Foundation: Oppression Theory

The introduction of Paulo Freire's model of oppression first appeared in 1970 as he observed the behaviors of Brazilians being dominated by Europeans (Mathenson & Bobay, 2007). Although Freire did not introduce oppression for the nursing discipline, the application of his work applies. The five dimensions of oppression were introduced as (1) assimilation, (2) marginalization, (3) self-hatred and low self-esteem, (4) submissive-aggressive syndrome, and (5) horizontal violence (Freire, 1970). Characteristics of oppressed populations surface when aggressive and dominant group(s) within the specific culture can subjugate their personal views as the right views for the group, rejecting any view of the less dominant members (Freire, 1970).

As the members of the oppressed group assimilate the views and values of the oppressor, marginalization occurs and oppressed members begin to feel powerless (Freire, 1970). When environments are rich in overt and latent rewards and punishments members of the oppressed group desire the power that the dominant group is perceived to possess (Rainford, Wood, McMullen, & Philipsen, 2015). Oppression leads to feelings of powerlessness, self-loathing, self-hatred and low self-esteem (Freire, 1970). Submissive-aggression syndrome develops when members of oppressed groups are unable to express personal feelings or emotions associated

with oppression, for fear of retaliation from the oppressor (Freire, 1970). Therefore, feelings and frustrations of the oppressed often surface through behaviors of LV directed toward peers in the same level of oppression. These behaviors of LV perpetuate the cycle of oppression and allow unacceptable behaviors to remain a part of the nursing culture. The existence of LV further indicates that nurses lack autonomy and therefore need to be governed by those with authoritative characteristics (such as nurse managers or physicians) (Freire, 1970).

Oppression Theory in Nursing

The practice and duties of the nursing profession are under constant scrutiny as nurses are continually monitored, evaluated, and reported through governing boards. Nurses are expected to provide patient care, per physician orders, amid a corporate framework, within a time-oriented, stressful, and ever-evolving environment (Hutchinson et al., 2006). Nurses report they feel marginalized or assimilate marginalization because of the view of nursing as a subservient role to medical hierarchy, and the belief that the needs of self will always follow the needs of others such as (patients, physicians & family members) (Chu & Evans, 2016; Duchscher & Cowin, 2004; Farrell, 2001). Furthermore, societal perception indicates that the caring role (nursing) will always be subordinate to the curing role (physicians) (Mark, 1988).

Oppression theory was introduced to explain behaviors in nursing as early as 1980, when Roberts observed oppressive group behaviors (OGB), among nurses in the workplace (Roberts, 1980; Vessey et al., 2011). Currently, the nursing profession remains under the control of hospital administrators, physicians, and the governing board of nursing (Rainford et al., 2017), further sanctioning the oppressed culture of the nursing profession. Lateral violence is the outward expression of the inward frustration of nurses, as they acknowledge their lack of power and diminished autonomy (Rainford et al., 2015).

Women are an oppressed population, this is largely related to societal views that nursing is a subservient role and women have held that position in the hierarchical design throughout history (Chu & Evans, 2016). Currently, the nursing profession is predominantly female, and nursing has historically been considered a women's profession, rating alongside childcare and secretarial work (Kanter, 1979). The design of the medical hierarchical structure (by males), has left the predominantly female nursing profession struggling with the desire of acquiring autonomy for self, and for the profession (Becher & Visovsky, 2012; Murry, 2018; Vessey et al., 2011). 9% of the current nursing workforce is male, which further contributes to the inference that nursing has been and always will be a female-dominated women's profession (NSI, 2013). Furthermore, nursing professionals report they feel more like servants, than professionals (Rainford et al., 2015).

When nurses (as an oppressed group) internalize values, beliefs, and practices of a dominant group (hospital administrators, physicians, or nurse managers), suppression of personal values is enforced. This suppression is reported to result in feelings of self-loathing, and low self-esteem emerges (Blair, 2013; Chu & Evans, 2016). Power imbalances from oppression result in (a) low self-esteem, self-loathing, and self-hatred; (b) internalized feelings of anger; and (c) passive-aggressive behaviors and marginalization of self (Bartholomew, 2006). Internalized feelings of anger, suppression, and dismissal are linked to job dissatisfaction, which allows behaviors of bullying, incivility, horizontal or lateral violence to come the surface, often targeted toward neophyte nurses (Embree, et al., 2013; Griffin, 2004).

Neophyte nurses remain the nursing population with the highest risk of experiencing an LV event, due to lack of experience of organization norms, lack of self-confidence, and insecurities (Feng & Tsai, 2012; Sanner-Stiehr & Ward-Smith, 2016; Weaver, 2013). Because

neophyte nurses lack an understanding of the working culture within nursing, they often find it difficult to accurately identify LV behaviors, especially covert actions (Moore et al., 2013). Also, neophyte nurses enter the nursing profession with ideation of what they perceive nursing to be, only to be faced with what nursing is. The reality of nursing is filled with organizational demands for neophyte nurses to accept workloads equal to experienced nurses and to complete technical skills and tasks rapidly and efficiently, further complicating their transition into practice (Pellico et al., 2009; Weaver, 2013).

Review of Literature

Articles retrieved were widespread across numerous nursing specialties. Studies included pragmatic intervention for nursing students, nursing faculty, and neophyte nurses. However, the search strategy did not produce a single article with research focused on the lived experience of LV among neophyte nurses within the first year of nursing practice.

The depth of oppression in nursing may prevent neophyte nurses from recognizing LV and researchers from investigating the phenomenon related to the lack of reporting of LV behaviors. Because neophyte nurses are unable to identify actions of LV, underreporting of these behaviors makes it difficult to assess the degree to which it occurs, the damage it causes to the targeted nurse, and the devastation it leaves upon the nursing profession.

Interventions for Neophyte Nurses

Studies focus on interventions that promote self-evaluation to assist in professional growth and personal development. Neophyte nurses need to develop personal strength through proposed interventions and skilled communication, as well as, effective decision-making (Longo & Hain, 2014). When neophyte nurses are provided skills that assist in self-reflection and self-awareness, they may become empowered in their professional practice, which results in more

efficient patient care delivery, and a greater understanding of the patients they care for (Taylor, 2016). Interventions found throughout literature include empowerment, self-efficacy, and self-awareness.

Empowerment. Empowerment includes the resources, tools, and environments required to build confidence and competence in neophyte nurses for a successful transition into nursing practice (Shanta & Eliason, 2014). When nursing students are empowered, liberation from the oppressive healthcare hierarchy can occur (Pope, 2008). When students are provided tools and education to manage LV, liberation can become reality (Griffin, 2004). Other examples of empowerment training includes teaching assertiveness techniques, which provides neophyte nurses with the knowledge and power to control situations in which LV is occurring (Stevenson, Randle, & Grayling, 2006). When neophyte nurses develop a meaningful relationship with nursing peers, they feel valued (Clark & Davis-Kenaley, 2010). Furthermore, when nurses experience empowerment they report lower levels of burnout which improves nurse retention rates (O'Brein, 2011).

Self-efficacy. Self-efficacy determines how successful neophyte nurses will conduct their practice based on a personal belief in themselves (Cherry, 2017). Cognitive rehearsal is a proactive intervention designed by Griffin (2004) to build on self-efficacy as a means of role-playing in given situations of LV as it may present in nursing practice (Griffin, 2004; Pope, 2008; Sanner-Stiehr, 2015). Neophyte nurses should develop a healthy personal belief that they can be successful as professional nurse (Murry, 2018).

Self-awareness. The ability of neophyte nurses to self-reflect on the lived experience of LV develops a deeper sense of professional identity (Hakojavri, Salminen, & Suhonen, 2014). Through self-awareness, neophyte nurses gain a better understanding as to why they behave the

way they do within certain settings (Rasheed, 2015). Application of self-awareness aids neophyte nurses in the ability to build nurse/patient relationships (Rasheed, 2015). Tools used to develop self-awareness include journal writing, reflection on self-action, and seeking peer feedback (Gessler & Ferron, 2012). Self-awareness allows neophyte nurses to maximize personal strengths and minimize personal weaknesses through peer and patient interactions (Arnold & Boggs, 2015).

Systemic Factors

Systemic factors include circumstances in which the neophyte nurses has little to no control regarding the working environment. While there are boundaries in place to control some components, these boundaries are based on organizational guidelines to control cost, with little to no input from nurses concerning workloads, shift duration (hours), and staffing.

Workloads. Job demands that neophyte nurses carry the same workload as experienced nurses contribute to poor nursing retention (Lim & Bernstein, 2014). When neophyte nurses feel unprepared to accept a workload that is mandated by institutional administrators, or experience lack of support from experienced nurses when seeking affirmation retention issues arise (Booth, 2011). In addition to unrealistic patient loads and documentation overload, nurses (especially neophyte nurses) state concern over a reduction in the time allotted to assess or address patient needs (Pellico, Brewer, & Kovner, 2009).

Circumstances surrounding workload concerns can result in the shock of the reality of nursing before acculturation into the profession has occurred (Longo & Hain, 2014). Patients with higher acuity who requires complex management of comorbidity conditions are a major concern for neophyte nurses (Weaver, 2013). Citing knowledge deficit, uncertainty, and

inexperience in their role as professional nurses, intent to leave the profession becomes the only action some neophyte nurses consider their only option (Weaver, 2013).

Staffing. The lack of control of daily shift requirements (being moved to another unit to assist with staffing shortages), results in increased stressors for neophyte nurses who struggle with consistency in their work environment (Lim & Bernstein, 2014). Appropriate staffing requires an equal number of competent nurses to assess and deliver patient care (AACN, 2005).

Fears, vulnerability, stress, and apprehension. In two studies, 90% of the nurses confirmed that they experienced LV (Aiken et al., 2002; Embree et al., 2013). Nurses often do not report these experiences due to insecurities about their ability to accurately identify the phenomenon and a lack of universal definition for these actions (Bartholomew, 2014). Nurses note that they do not report medication errors, missed medication dosing, and failure to perform a nursing task, because of fear of being considered incompetent (Taylor, 2016). Furthermore, when nurses raise concerns over lack of time to deliver patient care, they are viewed as complainers by nurse managers (Taylor, 2016).

An apprehension over the possibility of litigation, backlash from patient dissatisfaction, organizational requirements for cost containment, and technical challenges neophyte nurses face in nursing practice (Murry, 2018). When events of LV are reported, fear of retaliation by perpetrators, nursing peers, nurse managers, and organizational management remains a major concern for neophyte nurses (Becher, 2012; Griffin, 2004; McKenna et al., 2003; Murry, 2018).

Significance of LV within the Nursing Profession

Recognizing behaviors of LV as opposed to normal demeanors remains a significant barrier for neophyte nurses as they transition into nursing practice (Murry, 2018). Often LV behaviors are explained away as a rite of passage, baptism by fire, paying your dues, or as nurses

eating their young (Messiner, 1999). These adages support the acceptance of covert and overt behaviors within nursing as a normal and acceptable behaviors and result in a lack of concern or acknowledgement of the need to change the culture of nursing (Clark, Leddy, Drain, & Kaldenberg, 2007; Crick, Ostrov, & Werner, 2006; Griffin, 2004; Hutchinson et al., 2008; Jack, 1999; Kessler, Sector, Chang, & Parr, 2008; Longo, 1996; McKenna, Smith, Poole, & Coverdale, 2003; Quine, 1999; Roberts, 1983; Vassey et al., 2009). When nurse managers perpetuate behaviors of LV, the identification of these behaviors becomes extremely difficult, especially for neophyte nurses (Johnson & Rea, 2009). Lateral violence has no place in the nursing profession. Shifting toward educating nursing students may launch a change for a healthier profession where patient care/compassion includes peer care/compassion.

Significance to the nursing profession. Due to the expansion of the aging patient population, the US is currently faced with an increased need for experienced nurses (Carayon & Gurses, 2008). This aging populace, in need of care, increases nursing demands in long-term facilities and as related to specialized care for comorbidities (Embree et al., 2013). The nursing workload is infused with multidimensional factors that require nurses to perform secretarial and ancillary duties thus reducing time spent providing patient care (Carayon & Gurses, 2008). With a projected nursing shortage of over one million working nurses by 2020, the need to retain current nurses becomes imperative (Embree et al., 2013). Recruitment of skilled, educated, and competent nurses is vital to the health care industry.

When working environments are emotionally charged with LV, one coping method to avoid the perpetrator lies in an increase in absenteeism. This is reported in both experienced and neophyte nurses (Griffin, 2004). In addition to an increase of absenteeism, one out of every three neophyte nurses will abandon the profession within the first six months of nursing practice

because of LV (Booth, 2011; Randle, Stevenson, & Grayling, 2007), and 57% (or three out of every five) leave the profession as a direct consequence of LV within the first 24 months of practice (Calkin, 2013). With the projected nursing shortage reaching an all-time high in 2020, older people with comorbidity health concerns pose a dilemma for nursing and healthcare (Embree et al., 2013). The current nursing population struggles to fill the gap created by the present nursing shortage. Future staffing shortages will be further impacted by higher patient acuity, demand for more long-term facilities, respite care demands, and the largest aging population healthcare has encountered to date (Embree et al., 2013).

When nurses leave the profession, the cost to train and orient their replacement in the southeastern (US) can range between $36,000 and $48,000 (NSI, 2013). However, the real cost goes beyond the monetary expense, with patient care being jeopardized. The strain on the current nursing workforce increases each time a nurse leaves the profession. The nursing shortage means nurses work longer workdays, additional workdays, and have increased patient loads with higher patient acuity (Pellico et al., 2009). For every patient added to an existing patient workload, the increase of patient mortality escalates by 7% (Aiken et al., 2002; Bean, 2017).

As discussed above, retention issues impact both current and projected nursing populations through fatigue, exhaustion, and burnout (Embree et al., 2013; Griffin, 2004). Furthermore, when retention is compromised, neophyte nurses spend less time orientating and are pushed into practice before they feel confident in their role and this may impair the successful development of interpersonal and professional relationships with peers (Simons & Mawn, 2010). Lack of accountability allows LV perpetrators to remain on staff, while energetic, passionate, and dedicated nurses abandon the profession (Taylor, 2016). The need for neophyte nurses rapidly transition into nursing practice (before acculturation has occurred), impacts their

self-confidence and leaves them vulnerable for an LV event to occur (Berry, Gillespie, Fisher, Gormley, & Haynes, 2016; Belcher, 2012; Blair, 2013; Chu & Evans, 2016; Embree et al., 2013; Hutchinson et al., 2006; Littlejohn, 2012; Roberts, 2015).

Individual nursing beliefs, values, attitudes, and behaviors must reflect the pursuit of patient safety (TJC, 2009). The environment in which nurses conduct patient care must promote safety, healing, and respect in the delivery of quality nursing care (AACN, 2005). When LV is allowed in the working environment, the ability of nurses to concentrate and deliver competent and efficient patient care becomes compromised (Griffin, 2004). These compromises are evidenced through reports in delay of patient care delivery, medication errors, missed medication doses, increases in patient injury related to falls, and increases of untoward patient outcomes including frequent hospital readmission (Vassey et al., 2009).

Since the nursing profession carries the highest risk for LV, organizations must be proactive in measures that aid in the prevention of nurses abandoning the profession (Christie & Jones, 2014). When LV exists within working environments the overall mental and physical health of all nurses may become damaged. This is demonstrated by reports of decreased sense of well-being (Sanner-Stiehr & Ward-Smith, 2017; Vessey et al., 2010). Organizations that approach LV by encouraging nurses to toughen up when they experience LV sends a perceived message that LV is an accepted or standard institutional norm (Murry, 2018). Lateral violence further impairs neophyte nurses from seeking validation of the nursing process, building nursing skills, and seeking assistance with time-oriented organization, all of which remain imperative to safe patient care delivery (Griffin, 2004).

Significance to nursing education. The goal of educational inclusion of LV is to increase the knowledge that neophyte nurses can become liberated from oppression and dismiss

the behaviors and beliefs of the dominant group (Griffin, 2004). Education about communication skills specific to the nursing environment should be embraced for nursing students as the first line of defense against LV behaviors and actions (Arnold & Boggs, 2015; Sanner-Stiehr & Ward-Smith, 2016). The boundaries between assertiveness and LV can become hazy if the proper guidance and coaching have not been provided for neophyte nurses (Rad, Mirhaghi, & Shomoossi, 2015). Addressing real-life examples of LV within the clinical environment can better prepare neophyte nurses for a possible occurrence in the future (Bronx, 2015).

Nursing students have experienced acceptance as part of the student body and view themselves as belonging making up the sum of the whole (Dickie-Clark, 1966). The desire to belong to a group remains deeply rooted in the development of a positive self-concept, as evidenced in Erickson's stages of psychosocial development (Erickson, 1998). Transitioning from student to practicing nurse demands their professional standards be challenged through patient acuity, time restrictions, and unrealistic patient workloads (Duchscher & Cowin, 2004). Transition to practice programs (Rush, 2014) has been studied as possible solutions for reducing neophyte nurse's vulnerability of a LV experience. For example, simulation programs student nurses offer a suggested process that will aid neophyte nurses in real- life situations including exposure to an LV event during pre-briefing, simulated experiences, and conclusion discussion following the simulation (Jefferies, 2014). The push for nursing faculty to engage students in realistic examples of LV, as opposed to textbook example is encouraged as a process to acculturate nursing students for real-world nursing practice (Moore, Sublett, Leahy, & Bradley, 2016), and reduction of the reality jolt (Kramer, 1974). Adding real-world experience provides students with a more accurate picture (digital storytelling) of the reality of LV behaviors within the actual nursing profession (Moore, Sublett, Leahy, & Bradley, 2016; Stacey & Hardy, 2010).

Educational programs through clinical experience can assist students in the process of transition from nursing student to practicing nurse and facilitate professional relationships. The benefit of this professional relationship will offer empowerment for neophyte nurses as well as experienced nurses, gained through mentoring neophyte nurses throughout the experience of acculturation into the profession. Furthermore, this acculturation process for nursing students into practicing nurses includes acceptance of the bureaucracy within the healthcare organization. Neophyte nurses report a fear of personal failure at the enormity of the responsibility that comes with caring for an exorbitant number of patients with high acuity during a normal work shift (Gessler & Ferron, 2012), largely related to the low number of patients cared for during clinical rotations. Adaptation to the unit routine (time-oriented tasks) is necessary for the neophyte nurse to feel acclimated to the institution but for neophyte nurses there is little time to assess and meet their patient's needs (Duchscher, 2001; Moustaka & Constantinidis, 2010). Neophyte nurses report dichotomized (little autonomy with great accountability) values of patient care are often conflicted by the institutions demand of clinical expediency and loyal obedience (the mental consensus of doing it how the organization wants it done, which may fall short of the personal beliefs of how it should be done) (Kramer, 1974).

Effects of LV on Individual Nurses

Proficient nursing care is dependent on effective decision-making, clinical judgment, collaboration, professional relationships with nursing peers, and skilled communication (Longo & Hain, 2014). Lateral violence contributes to personal and professional dilemmas for neophyte nurses. These dilemmas include breach of patient dignity, breach of patient safety, clinical errors (including medication errors such as wrong medication, wrong route, wrong dose, and/or wrong

time), and communication violations between healthcare members (Rees, Monrouxe, & McDonald, 2014).

Physical effects of LV. There is an association between LV and impaired physical health for targeted nurses (Etienne, 2014; Felblinger, 2008; Johnson & Rae, 2009; Roberts, 1983). These physical effects of LV on targeted nurses include weight loss or gain, gastrointestinal distress, such as ulcers, diarrhea, ulcerative colitis (Woelfe & McCaffrey, 2007), and gastroesophageal reflux disease (American Psychological Association [APA], 2018). In addition, cardiovascular symptoms, including cardiovascular disease, palpitations, dysautonomia, hypertension (Woelfle & McCaffrey, 2007), and an increased risk of stroke and myocardial infarctions are reported (APA, 2018).

Constant stressors may cause some nurses to develop a weakened immune system. Weakened immune systems can result in the development of autoimmune disorders, such as multiple sclerosis, rheumatoid arthritis, and perhaps Parkinson's disease (Moustaka & Constantinidis, 2010). Women who are exposed to stress may experience other physical changes, such as abnormal menstrual cycles, painful menstruation, infertility, and decreased sexual desire (APA, 2018).

Psychological effects of LV. The psychological perception nurses hold of themselves affects thoughts, emotions, and behaviors within their professional practice. Successful and competent nursing practice requires a positive self-concept (Cowin & Hengstberger-Sims, 2006). Targets of LV are emotionally wounded, potentially making an LV experience equivalent to that of a physical attack (Bartholomew, 2004). Feelings of poor morale and disconnectedness may result from LV events, and some targeted nurses report post-traumatic stress disorder (PTSD) after experiencing LV in the working environment (Berry et al., 2016; Dehue, Bolman, Vollink,

& Pouwelse, 2012). In rare cases nurses admit to thoughts of suicide following an LV experience and unfortunately these feelings have resulted in actual suicidal ideation, actions, plans, and attempts (Bartholomew, 2006; Dehue et al., 2012; Felblinger, 2008).

Other psychological manifestations related to LV include increased levels of anxiety, irritability of unidentified etiology, depression, unstable emotions, significant loss of confidence in their nursing ability, feelings of shame (Yildirim, 2009), and panic attacks (APA, 2018). Periods of sleeplessness and disbelief reported after LV events have been associated with chemical dependency (alcohol, recreational drug use, and sometimes both) as a means of coping (APA, 2018). Furthermore, an increase in emotional exhaustion leading to job dissatisfaction and burnout is reported among targeted nurses, as well as absenteeism from the actual environment where LV occurred and is occurring (Aiken et al., 2002; Baltimore, 2006). Increased absenteeism is a coping mechanism used to avoid the stresses associated with LV (O'Connell, Young, Brooks, Hutchings, & Lofthouse, 2000).

Gaps in the Literature

Lateral violence is present within the nursing profession and has been for over three decades (Roberts, 2015); however, a lack of successful strategies to diffuse the effects has fallen short. Neophyte nurses continue to lack the ability to identify and diffuse LV events when they occur. Several gaps in the literature exist regarding the effect of LV in neophyte nurses. Exploration of the lived experience of LV may contribute to an understanding of why this phenomenon has survived despite suggested interventions. There is scant research available from the neophyte nurses' views, knowledge, and experience of an LV occurrence within the first 12 months of becoming practicing nurses. With a lack of information available on how neophyte

nurses identify, clarify and resolve LV experiences there is much to be gained through a research study into the lived experience of the phenomenon.

There is limited research on the inclusion of educational preparedness or to what benefits may have resulted. Suggested options of Problem-Based Learning (PBL) activities that included both didactic and clinical based scenarios of LV were suggested (Edwards & O'Connell, 2007). Furthermore, the need for formal preparation of nursing students of LV was highly recommended, but at the time of this study no curriculum inclusion was proposed (Luparell, 2011). Articles focused on the cause and effect of LV on nurses, both neophyte and experienced. This study may provide recommendations of inclusion of LV education for nursing curriculums.

The presence of LV within the nursing profession is well documented, occurring for over three decades (Bartholomew, 2006; Berry et al., 2016; Einarsen & Skogstad, 1996; Farrell, 1997; Messiner, 1999; Quine, 1999, 2001; Roberts, 1983; Sauer, 2012; Woelfle & McCaffery, 2007). A review of the literature did not demonstrate that an accurate account of the occurrences of LV and neophyte nurses' abilities to identify the phenomenon further complicates matters. In addition, my literature search was unable to produce a qualitative study that focused on the lived experience of the LV event from the perspective of neophyte nurses during their first 12 months of nursing practice. Furthermore, the transition into professional practice is critical for neophyte nurses largely related to the lack of confidence and lack of experience in nursing practice (Griffin, 2004). Building successful working relationships during this critical transition as well as honing nursing judgment skills are imperative if LV is to be stopped. This fact is often a predictor of achievement of acculturation for the neophyte nurse (Arnold & Boggs, 2015).

Conclusion

The literature reviewed provided evidence that LV is alive and well within the nursing profession and has been for over three decades. The effects of this phenomenon remain highly disturbing, as it impacts nursing populations worldwide. Issues of LV encounters included problems with current nurse retention, but most importantly they compromised patient care (Griffin, 2004). In addition, the effects of LV on targeted nurses remain ominous, with some reporting suicide ideation and even some suicide attempts (Bartholomew, 2006; Dehue et al., 2012; Felblinger, 2008). Physical and psychological effects on targeted nurses, as well as nurses witnessing an event, are well documented (Bartholomew, 2006; Berry et al., 2016; Dehue et al., 2012; Griffin, 2004). The fact that nursing loses one in every three neophyte nurses within the first six months as a direct result of LV (Booth, 2011) requires action to empower or promote resilience for future nursing generations; thus, reducing this statistic.

Allowing neophyte nurses to share their experience may provide the first step to understanding how LV presents in the practice environment, allowing solution development toward eradication. Through a greater understanding of the LV reality for neophyte nurses, nurse educators can view the path needed to prevent the shock of LV and render the phenomenon powerless.

Chapter III introduces the reader to the proposed methodology that was applied to this study. Included in the upcoming chapter, I discuss the process of participant recruitment, data collection, and analysis method. Specifically, the approach used to capture the lived experience of LV through life accounts of neophyte nurses who have undergone an occurrence with LV. The study design consisted of logical progressive steps toward successful examination of the lived experience of LV through neophyte nurse's experiences. This study hopes to achieve an

understanding of how LV is experienced, how neophyte nurses define the phenomenon, and how they perceive nursing education can assist future nurses to be prepared and perhaps to prevent loss of valuable resources to the profession.

CHAPTER III:

METHODOLOGY

Phenomenology framed the conceptual foundation of this study and provided the methodology for this qualitative phenomenological research study (Creswell, 2013). Qualitative phenomenological research studies rely on the subjective narratives from individuals who share in a like experience, seeking common themes and categories, to understand the phenomenon as experienced by a specific population (Creswell, 2014). This methodological approach provided participants a narrative platform so they could share and expand on their personal experience (including feelings, emotions, and behaviors) regarding the specific phenomenon being researched (Creswell, 2014).

The focus was to examine the phenomenon as it occurred in society related to a specific population who have different meanings and contexts when compared to other populations (Creswell, 2014). Lateral violence varies in its meaning to neophyte nurses when compared to LV occurring in other occupations, and a phenomenological approach was the most accurate way to conduct this study (Creswell, 2014). Specific to this study, how neophyte nurses experienced LV and what this experience meant to them and their views about the nursing profession.

The proposed study allowed participants the privilege of telling their story of the lived experience, how they described LV (then and now), and what they perceived nurse educators can do to aid in preparing neophyte nurses to identify and process an LV experience. Creswell states the researcher of a qualitative phenomenological study remains the tool used for the

implementation of the posed research question (Creswell, 2014). This process was conducted through semi-structured interview questions designed and informed from the current literature.

Qualitative designs are malleable and inductive (Maxwell, 2013), meaning individual narratives contain underlying currents that required extraction from me. Exploration through a phenomenological approach allows participants to share their perception of the lived experience (in this case, neophyte nurses) (Creswell, 2014). In addition, phenomenology has the capability of delving into the core of the phenomena to expand on the most severe aspect of the lived experience by understanding what that experience meant to them, and how their experience shaped their values, beliefs, and behaviors (van Manen, 1999).

The lived experience of an LV event is a process. While the experience of LV is occurring, emotional turmoil and feelings of disbelief prevent the individual from understanding what the experience meant to them (van Manen, 1990). Understanding verbal delivery, verbal content, and nonverbal body language as individuals shares their stories, translation of the verbal content will be enhanced, and these studies result in a phenomenological importance (van Manen, 1999).

Research Design

Collecting verbal accounts from targeted neophyte nurses provided insight on how this phenomenon was experienced. This qualitative phenomenological study utilized in-depth, face-to-face (physically or electronically), one-on-one interviews (the researcher and the individual) with neophyte nurses who experienced LV within the first 12 months of entering nursing practice. This qualitative phenomenological study allowed me to step into the world of the participant and understand how the phenomenon shaped and altered personal views and practices following the experience (Corbin & Strauss, 2008; Maxwell, 2013). Understanding how a LV

event was defined in the words of a neophyte nurse, how the experience affected their personal and professional life, and what they perceived nursing programs could do to better prepare future nurses could provide guidance for academic programs.

Participants

The target population consisted of associate or bachelor's degree prepared female nurses who had successfully completed an accredited nursing program, passed NCLEX, and were currently (or did work) working as a nurse in an acute care setting (bedside nursing). Neophyte nurses carry the highest risk for an LV event to occur during the first year of practice (Griffin, 2004). Therefore, participants included nurses who experienced LV from a senior nurse within the first 12 months of entering the work environment.

Preservation of details about the experience (values, beliefs, emotions, and change of attitude toward nursing) were best represented when the occurrence of LV had occurred within the past 24 months or less. Participants were informed that there were no compensation benefits or individual benefits other than the opportunity to share their experience for the purpose of this study.

Access and Recruitment

Snowball sampling was executed for participant recruitment. Snowball or chain sampling is used for individuals who know others who have information-rich experiences in the same phenomenon, and who would add to the study being conducted (Creswell, 2013). This method allowed persons who experienced the phenomenon of LV to be recruited (Maxwell, 2013).

I contacted nursing institutions of several academic nursing programs within the geographic location in the southeast US to gain e-mail or home addresses for possible participants (graduates within the last two years). Information acquired from these institutions

presented the best opportunity for a research invitation. Each potential participant was contacted by phone and invited to participate if study criteria was met. The research invitation was sent through the United States Postal Service, via e-mail, text, or additional modes of communication.

Recruitment was geared to accrue female nurses with a self-report history of an LV event that occurred during their first year of nursing practice. Once initial contact was completed if they were willing to participate in this study an interview was arranged.

Potential participants were given a description of bullying, lateral violence, covert behaviors, overt behaviors, and incivility as described in Chapter I. Discussion followed regarding personal experience if they felt aligned with these descriptions. When it was determined their experience fell into a described category, I obtained their method of communication (US mail or e-mail) for research invitation.

The research invitation stated the inclusion criteria for participants: (1) graduated from an accredited registered nursing program, (2) passed NCLEX-RN exam, (3) currently practicing as a registered nurse (or recently practiced) in an acute care environment, (4) experienced LV from a more experienced nurse during the first 12 months of practice, (5) willing to share their LV experience, and (6) the experience occurred within the last 24 months. Also, initial contact addressed any questions the participant may have had regarding the study. Upon completion of this process, an interview time was scheduled at their convenience.

The information shared through phone calls was noted in field notes and followed up at the scheduled interview session. Participants declined the choice of a pseudonym, so I assigned them one for study anonymity. All pseudonyms implemented within the study were directly correlated to individual narratives. This ensured trustworthiness for this study.

The sample size was expected to range from eight to ten, provided that the data collected from participants reached saturation. Data saturation occurs when the information no longer yields new or differing information (Creswell, 2014). For qualitative studies, the researcher is the instrument of measurement (Creswell, 2016). Therefore, I identified when the study no longer provided new information from participants and concluded that more participants and concluded that additional participants would only result in redundancy or a repetitive pattern (Creswell, 2014, p. 185).

In addition to Creswell's sample size suggestion, Morse (1994) acknowledged that a sample size of at least six should provide data to achieve the aim of the study on a specific phenomenon (p. 225). More data collection does not necessarily provide more information or new information for a study (Mason, 2010). A sample size of ten participants allowed me to reach this conclusion. Also, this number allowed me to explore a diversity of LV experiences as reported through the verbal accounts with participants.

Setting

The setting provided anticipated needs of the participants (refreshments, restroom, privacy and access to a private entrance and exit). Participants were given specific information on the interview site (public institution of major university, library, or conference center), parking, and entrance into the building prior to arrival of the interview setting. I made contact prior to each scheduled interview to alleviate any anxiety or confusion over arrangements. I arrived prior to each scheduled interview to greet and reassure the participant.

Participants were either local (within 60 miles) to the interview site or they chose to be interviewed via telephone. Therefore, none of the participants were required to travel any lengthy distance to be interviewed, nor was I required to travel very far for the purpose of conducting

interviews. None of the participants required reimbursement for travel expenses. Because travel was not implemented by any participant, the use of technological devices was implemented to capture some interview sessions. The technological devices used were cellphones, landlines, and a handheld audio recorder. Face-to-face was the preferred interview method. All interviews were captured via audio recording to ensure that data were accurate, intact, and free from personal biases.

Exclusion Criteria

Exclusion criteria included the following: (1) LV experienced outside the nursing profession or prior to attaining a nursing license (for example nursing as a second-generation professional choice); (2) LV experiences that resulted in legal restriction of disclosure of the experience (for example court ordered monetary reward for negative LV effects); (3) violence from patients, patient family members, and physicians; (4) male nurses, and (5) LV occurring greater than 24 months ago.

Ethical Considerations

Permission from The University of Alabama Institutional Review Board (IRB) was granted prior to data collection. Training required by IRB was completed to ensure the protection of human participants (Creswell,2014). The IRB committee goes beyond federal regulations to ensure research is ethical and safe for participants (Integreview, 2018). This ensured that nurses who experienced LV and met inclusion criteria would be interviewed in an environment that was ethically sound, human subject protection would remain compliant, and respect of human research was maintained (Integreview, 2018).

Participants were reminded that participation was purely voluntary. Furthermore, I reiterated that any participant had the right to refuse to answer any question posed by me

throughout the interview process. I acknowledged that narratives could include emotions that could be draining or distressful. If these emotions resulted in outward displays of distress (crying), I would pause the interview or even suspend the interview process. However, this did not occur in any of the interview sessions, nor did any participant decline to answer any question. I had contact information for a professional licensed counselor available but did not have to provide this to any participant.

The information collected throughout the interview process was uploaded to The University of Alabama (UA) box. Use of UA box provided encrypted and safe storage of data collected, maintained who could access the data, and was readily available for me once analysis began. Furthermore, the key members of my dissertation committee could also access the data. These members included my dissertation chair and dissertation methodologist.

Data Collection and Analysis

The data collected from in-depth interviews via audio recordings and field notes were the sole responsibility of myself. Recordings were then transcribed by a professional scribe and emailed to me. Once recordings were converted to text, I reviewed each transcription a minimum of three times to ensure no discrepancies existed. This process ensured that the data remained intact and pure.

Analyses of data required several steps to ensure that all similarities and differences were identified. The method of analysis proposed by Colaizzi (1978) was implemented as I considered this as the best approach for this study. Colaizzi’s method of analysis is a gradual reduction of the data collected and includes the following steps: (1) familiarization, (2) identifying significant statements, (3) formulating meanings, (4) clustering themes, (5) developing an exhaustive description, (6) producing the fundamental structure, and (7) seeking verification of the

fundamental structure (Morrow, Rodriguez, & King, 2015). Implementing Colaizzi's method allowed me to sift through the transcribed text word for word, allowing identification of themes and correlations (Morrow et al., 2015).

Initial Data Collection

Interviews

Data were collected as I engaged participants through in-depth interviews, using open-ended questions and the application of a constructed interview guide. Introduction of myself, the facility, and the research goal concluded with written and verbal consent of each participant which is included at the bottom of the research invitation. Each interview was recorded on a handheld audio recording device to ensure trustworthiness of each narrative. Furthermore, I kept detailed written observations of what I heard and observed throughout the interview process. Every interview was conducted one-on-one and six of the ten interviews were conducted face-to-face. I re-interviewed six participants for clarification purposes via telephone and a handheld audio recorder. None of the interviews exceeded 60 minutes duration and none resulted in an emotionally charged or negative issue while recounting the experience.

Participants shared their narrative in an unobstructed manner and questions were interjected for clarification purposes only. The application of the research guide kept me focused on the goal of my research and ensured that all participants were probed using the same format. However, not all the research guide questions were asked or answered, unless it became pertinent to the overall research goal.

I maintained a safe and nonjudgmental environment for participants to share their narratives. The public facility allowed prevention of isolation, while the private office provided privacy and anonymity. I did not conduct any interviews in a back to back fashion which

prevented the overlapping of participants. In addition, this allowed me the ability to review each recording at an interview conclusion, which provided a period of reflection of my personal observations of each face-to-face participant.

Applications of pseudonyms were implemented by me, as participants often denied the fear of being identified. I implemented an alphabetic system for assignment of pseudonyms. Each participant was assigned a number and a corresponding letter, names were later derived based on that number and letter (for instance, participant one was assigned the letter A, participant two the letter B, etc.).

Recordings were converted into text by a transcriptionist and were then sent to my personal e-mail address as an attachment. The transcriptionist was only provided a number (such as this is interview one, two, etc.). Upon receipt of each text, I made comparisons between the text and the recording, adjusting for any necessary discrepancies. Once I felt confident in the accuracy of the text, I erased the recorded interview. These documents (transcripts, consents, and field notes) were then uploaded to UA box, an encrypted, password protected site, and were accessed only by two dissertation team members.

Data Analysis

Data analysis in qualitative research requires the researcher/analyst to organize the collected data for the identification of themes through the process of coding (Creswell, 2013). There were several methods available to assist me with this process. Data management begins through "phenomenological reflection" (van Manen, 1990, p.77). This phenomenological reflection is applied to gain the basic idea of what the phenomenon meant to the individual (Creswell, 2013). For the purpose of analysis, I implemented the use of Colaizzi's method.

Colaizzi Method

The method utilizes a seven-step process that allowed me to secure the integrity of the data collected. Using first-person accounts of the phenomenon being studied as gathered through face-to-face or electronic interviews, the data included personal thoughts, emotions, actions, and behaviors related to the lived experience.

Table 1

Steps in Colaizzi's Descriptive Phenomenological Method

Step	Description
1. Familiarization	I read all transcripts to become familiar with narratives provided by each participant a minimum of three times and compared written text to the verbal accounts.
2. Identifying significant statements	I identified significant statements relevant to the phenomenon. An example of a significant statement was: "I'm trying to prove I can be a good nurse; I'm still learning." (Allison)
3. Formulating meanings	I identified meanings relevant to the phenomenon that arise from careful consideration of significant statements; the researcher must "bracket" pre-suppositions related to the phenomenon (complete bracketing is never possible). An example of formulated meanings was: The above statement from Allison resulted in "intimidated", "lack of mentoring", and "a lack of trust."
4. Clustering themes	I clustered themes common across all accounts; bracketing is crucial to avoid potential influence of existing theory. Clustering themes allowed the reduction of the data to better form fundamental structures. Examples were actions of more experienced nurses, personal expectations, fear of independence within the working environment, and oppressive behaviors.
5. Developing an exhaustive description	I wrote full and inclusive description, incorporating themes produced in step 4. Examples were supported or unsupported actions from more experienced nurses, struggles neophyte nurses faced upon arrival to the practice setting, and personal values and beliefs held by neophyte nurses.

(*table continues*)

Step	Description
6. Producing the fundamental structure	I condensed exhaustive description to a short, dense statement that captures aspects essential to the phenomenon. Development of fundamental structure consisted of: The lack of empathy neophyte nurses perceived more experienced nurses to demonstrate toward them; the conflict of neophyte nurses personal values and beliefs of what the profession should be compared to the reality they now discovered themselves in; neophyte nurses lack of experience to practice autonomy for fears and apprehensions found within the working environment; and neophyte nurses personal values and beliefs of the profession compared to the reality of oppression within nursing.
7. Seeking verification of the fundamental structure	I returned fundamental structure statement to all participants to assess whether it captures their experience; researcher modifies findings in the light of feedback. Examples of verification were: "You nailed it." (Allison)

Note. (Morrow et al., 2015, p. 2).

Familiarization. As a researcher I had to be familiar with the content of the narratives from each participant to capture the phenomenon as a lived experience. This occurred through repetitive review of both the verbal content and the transcribed text (Morrow et al., 2015). I listened to the recorded interviews a minimum of three times and compared transcribed text with recordings.

Identifying significant statements. I inspected the collected data for significant wording or emergent conceptual ideas. An accurate identification of statements relevant to the study were gathered through the narratives presented at the interview process (Morrow et al., 2015). Color coding was implemented for identified statements.

Formulating meanings. I took a more critical review of these identified significant statements for the process of formulating meanings of the lived narrative (Morrow et al., 2015). This step took the what and the how (the essentials of the lived experience) and converted them into what the experience meant to each individual (Moustakas, 1994). The what was preserved

through a certain color box or circle, while the how was preserved by an alternating color. This allowed rapid identification once all data had been reviewed. These meanings became specific to the phenomenon being studied and allowed a foundation for study objectives. I was acutely aware of the possibility of personal bias or influence being augmented into these identified meanings and took steps to prevent any personal bias. Bracketing assisted with this process.

Coding

The first step of Colaizzi's method required that the researcher become familiar with the narratives provided through the in-depth face-to-face interviews. Utilizing steps 1through 3 of Colaizzi's method, I highlighted, circled (using a colored system), or boxed significant statements presented by participants (Creswell, 2013; Saldana, 2016). This preserved the rich text that carried participants' subjective impression of the lived experience of LV (Saldana, 2016). Throughout this process codes emerged allowing me to develop exhaustive descriptions and structured statements about the phenomenon. The development of a codebook was imperative to me when analyzing data (Morrow et al., 2015; Saldana, 2016). Coding was conducted manually (researcher captured and handwritten codes) through the application of Colaizzi's method. I utilized triangulation of field notes (recorded body language and other relevant information), and participant review (or audit) to ensure accurate representation of coded text (Saldana, 2016).

Clustering themes. This step ensured that all themes occurring consistently across these narratives were identified. The phenomenon of LV among neophyte nurses may differ in meanings and personal assumptions for each participant. The risk of summarization of these meanings based on personal experience remained valid for this study. Bracketing was

implemented to remove my personal biases, as Morrow, cautioned could interfere with study outcomes (Morrow et al., 2015).

Developing an exhaustive description. A colorful description of the lived experience of LV among neophyte nurses was developed from the meanings and themes identified from the text of data. The study began to reveal a descriptive narrative (Morrow et al., 2015) of how LV was experienced, described, and lived through the views of neophyte nurses.

Producing the fundamental structure. The exhaustive description was reduced to a more workable statement for use by nurse educators about the phenomenon of LV. The commonalities (the what and the how) that were woven throughout the study were converted into useful aspects (Moustakas, 1994) of the lived experience for use in gaining a better understanding of how neophyte nurses experience LV within the first 12 months of practice.

Seeking verification of the fundamental structure. Participants reviewed the study results and provided feedback to me. If participants found any aspect to be irrelevant to their personal experience, I modified the process through application of these seven steps a second time. Capturing the true experience, free from outside influence, was the trustworthiness this study sought (Morrow et al., 2015).

Trustworthiness

To ensure trustworthiness throughout this study I executed several steps. I acknowledged that my personal bias, beliefs, behaviors, and conclusions related to participants' narratives could result in misrepresentation of the true experience. Therefore, steps were taken to prevent such occurrence by implementing the following steps.

Participant audit. Each typed narrative was returned to the original source to ensure that the content was accurate and reflected their personal description of their lived experience of LV.

This was done to prevent any misrepresentation or bias from myself and to ensure that I had captured the true experience accurately. In addition, my dissertation committee members provided feedback that prevented me from losing focus of the aim of this study.

Reactivity. I retained a nonjudgmental approach in both my verbal language and my body language throughout the interview process. When I interviewed participants with whom I have personal acquaintance (through clinical or didactic experience), I reiterated that the focus of this study and their personal experience with LV, rather than any personal relationship we may have developed over time.

Experienced researcher. I utilized the resource of experienced researchers for my analyzed data and coding process. In addition, application of an accepted resource for coding (Colaizzi's method) was employed to ensure both induction and objectivity was met. Following steps in Colaizzi's method allowed me to develop significant statements, themes, and meanings as presented by participants within this study.

Participants. Each participant was given clear and concise explanation of the study objective and encouraged to be honest and open in their sharing of an LV experience. I provided all participant with the respect and appreciation they deserved and encouraged them to engage in their right to decline to answer any question I posed, the right to withdraw from the study at any time, and the suspension of the study if needed. In addition, I provided a safe nonjudgmental environment with limited comments, opinions, values, and beliefs concerning their narrative.

Conclusion

The benefit of a qualitative approach into the lived experience of LV provided the most accurate way of understanding how neophyte nurses defined and described this phenomenon. In addition, what neophyte nurses perceived nurse educators could do to better prepare nursing

students in LV. Collection of data through interviews provided neophyte nurses the opportunity to share personal narratives. The application of Colaizzi's method supported the foundation for identified themes for future studies. I maintained a strict protocol for maintaining the integrity of this study.

None of the participants requested the suspension of the interview process, nor did any participant require the need for professional counseling. Participants were provided personal contact information; in the event they chose to withdraw from the study following the initial interview. None of the participants withdrew. Participants were supportive of this research study and expressed the hope that their narrative would somehow create a more positive working environment for all nurses.

The results from this study are presented in Chapter IV. These results include identified fundamental structures and concepts that surfaced as I meticulously worked through each of the seven steps in Colaizzi's method. Fundamental structures were identified as follows: the presence of lack of empathy from more experienced nurses toward neophyte nurses, the presence of personal expectations of nursing related to cognitive dissonance, the inability of neophyte nurses to practice professional autonomy, and the presence of cognitive dissonance related to oppression in nursing practice. Results will support fundamental structures through in vivo narratives and significant statements as presented from the lived experiences of neophyte nurses.

CHAPTER IV:

RESULTS

The results of the qualitative phenomenological study are presented within this chapter. The results cover data collected related to the lived experience of LV by neophyte nurses within the first 12 months of becoming a practicing nurse. The analysis followed the seven steps of Colaizzi's method, as explained in Chapter III. The research questions sought to answer the following:

1. What is the lived experience of LV in neophyte nurses?
2. How do neophyte nurses describe LV?
3. What content areas do neophyte nurses perceive that nurse educators could include for aiding and preparation to recognize and respond to LV?

Main Results

Participant Characteristics

Gender. All ten participants were female by study design. The design study was limited to female nurses related to the assumption of oppression among the nursing profession. As reported in the literature nursing is predominantly female; therefore, males were excluded for several reasons. The fact that the hierarchy of the medical field allows males to hold more powerful positions, and nursing remains predominantly female (Jasmine, 2009; Jinks & Bradley, 2003) led me to exclude males from this study.

Race. This study population was Caucasian. I attempted to recruit a diverse population; however, the resulting sample included only Caucasian participants.

Age. The age range of participants was 22 to 57 years of age. Four participants were 22 to 28 years of age, three participants were 30 to 37 years of age, one participant was 43 years of age, and the remaining two were 50 to 57 years of age.

Demographics. All participants resided within the United States. Nine of the ten resided in the Southeast and the remaining participant resided in the Midwest. The geographical location of this study embodied the scrutiny of southern culture. All participants were born and raised in the south.

Level of Education. Two of the participants held a Bachelor of Science in Nursing. The remaining eight participants held an Associate of Science in Nursing.

Table 2

Participant Information

Participant	Age and Demographics	Educational Level
Allison	Age 22 First career nursing, surgical unit, residence-rural Southeast	ADN
Becky	Age 28 First career nursing, acute care setting, residence-rural Southeast	BSN
Carol	Age 26 First career nursing, specialized unit, residence -rural Southeast	ADN
Donna	Age 25 First career nursing, specialized unit, residence-rural Southeast	ADN
Erica	Age 36 First career nursing, physician office, residence-metropolitan Southeast, LV education in nursing school	BSN
Felicia	Age 43 Second career nursing, (previously manager in grocery industry), acute care setting, residence- metropolitan Southeast	ADN

(*table continues*)

Participant	Age and Demographics	Educational Level
Gigi	Age 37 First career nursing, Ambulatory Center, residence-metropolitan Southeast	ADN
Heidi	Age 57 Second career nursing (previously hairdresser), acute care, residence-Midwest for past 5 years (previous 52 years Southeast)	ADN
India	Age 30 First career nursing, specialized unit, residence metropolitan Southeast	ADN
Jackie	Age 50 First career nursing, private practice, residence-metropolitan Southeast	ADN

Data Analyses

Data analyses followed Colaizzi's descriptive phenomenological methodology to ensure that this study accurately collected, analyzed, and reported results of the lived experience of LV as presented by neophyte nurses who experienced LV within their first year of nursing practice. The application systematically followed each of the seven steps to retrieve the entire experience, including emotional, physical, and professional effects. The seven steps in Colaizzi's method include (1) familiarization, (2) identifying significant statements, (3) formulating meanings, (4) clustering themes, (5) developing an exhaustive description, (6) producing fundamental structure, and (7) seeking verification of fundamental structure.

Familiarization

This step required that I became familiar with the data (narratives) through repetitive reviews. This was completed through audio reviews of a minimum of three times before allowing the transcriptionist access to the recordings for the purpose of conversion into text. Completion of recordings into text required that I compare each recording to the text a minimum of four times to ensure consistency and study trustworthiness. Reviewing the text and circling

words that “spoke” to me in a colored ink, allowed me to develop a tone for each lived experience.

Identifying Significant Statements

Identification of statements that were directly relevant of LV among neophyte nurses within their first 12 months of nursing practice were gathered according to each narrative. These statements are presented in table format to allow expeditious access when processing the subsequent steps in Colaizzi’s method. Table 3 presents individual participants’ statements as provided within the interview process.

Table 3

Individual Participants’ Statements as Provided Within the Interview Process

Participants	Identifying Significant Statements
Allison	“They (Scheduling nurse) panicked to fill the position.” (lived experience) “Pushing me to switch weekends.” (lived experience) “Trying to convince me it would help so much.” (lived experience) “I was off (at home) so I didn’t know what was going on.” (lived experience) “Nurses were pushing and manipulating me to change my rotation.” (lived experience and definition of LV) “I don’t want to, but I feel uncomfortable saying that.” (lived experience) “I thought she was my friend. I have concerns.” (lived experience and definition of LV) “I’m trying to prove I can be a good nurse; I’m still learning.” (lived experience) “Kept my head down and my mouth shut.” (lived experience) “Lateral violence should be given a name.” (nursing curriculum) “Let students know that LV is real.” (nursing curriculum) “That LV is reality of the current profession.” (nursing curriculum)

(*table continues*)

Participants	Identifying Significant Statements
Becky	"I want to say I'm doing the best I can." (lived experience) "Discharging a patient is not my priority; I have patients I don't even know about." (lived experience) "It's all about how we make the hospital look, they want faster turn arounds, faster this, faster that." (lived experience) "This is not why I made a nurse." (lived experience) "We (nurses) aren't safe, they (patients) aren't safe, but the hospital looks good." (lived experience and definition of LV) "They (hospital administration) don't care about us (nurses)." (lived experience) "Nursing directors walk out and we (nurses) are struggling." (lived experience) "I never can do enough. They always want you to do more." (lived experience) "Such a difference in my priorities and theirs." (lived experience and definition of LV) "I never knew LV was real." (nursing curriculum) "Tell them it might happen to them." (nursing curriculum)
Carol	"I was told that night shift always treats blood sugars, which are your job." (lived experience) "I'm not confrontational." Lived experience and definition of LV) "I did it (administering insulin) before I left, even though I knew it wasn't correct; just so I could keep the peace." (lived experience) "She threw her pen down and said what about that don't you understand. She was loud." (lived experience and definition of LV) "People were staring." (lived experience) "I just want to work in a place without drama." (lived experience and definition of LV) "She intimidates me." (lived experience and definition of LV) I'm afraid she will come back at me with something I don't know, and I would look stupid." (lived experience and definition of LV) "Inform the students about it." (nursing curriculum) "How important it is to have an experienced nurse you trust and can discuss thing with." (nursing curriculum) "It happens." (nursing curriculum)

(*table continues*)

Participants	Identifying Significant Statements
Donna	"My nursing supervisor told me she didn't want me on her unit." (lived experience and definition of LV) "She had personal knowledge of my disability (ADHD)." (lived experience and definition of LV) "I had to fight for my position." (lived experience and definition of LV) "I went to the stockroom and cried." (lived experience) "It made me second guess myself in nursing." (lived experience and definition of LV) "I'm a crier, I don't want you to see me cry, it's like I don't want to give you that, so I escape." (lived experience and definition of LV) "I busted my butt to do everything I could to take care of my patients and they make you feel like it's never enough." (lived experience and definition of LV) "That's the worst feeling." (lived experience and definition of LV) "I made a mistake and got written up for a HIPPA violation." (lived experience and definition of LV) "I took the fall for the hospital basically." (lived experience and definition of LV) "They make it sound life a fairy tale job, it's not." (nursing curriculum) "Tell students how to cope when it happens." (nursing curriculum) "It makes you feel like it's all your fault, but no one told you it's gonna happen." (nursing curriculum)
Erica	"My experience was pretty mild compared to others I talked to." (lived experience) "I was giving report and the nurse would just walk away or roll her eyes if I missed some information." (lived experience and definition of LV) "I try to be more organized." (definition on LV) "I focus on what I'm saying so I don't irritate her." (lived experience and definition of LV) "Unfortunately, I think that's just how she is." (lived experience and definition of LV) "I would never confront her." (lived experience and definition of LV) "They (nurse educators) need to include real-life stories of LV within the curriculums." (nursing curriculum) "Leadership classes would really help nursing students." (nursing curriculum) "Simulations of LV situations would be helpful as well." (nursing curriculum)

(*table continues*)

Participants	Identifying Significant Statements
Felica	“No honey that’s not how we do it here.” (lived experience and definition of LV) “My preceptor was passive/aggressive; she should help me, not be ugly to me.” (lived experience and definition of LV) “She (preceptor) came into my patient’s room where I was working and said let me scan your badge so I can give this insulin.” (lived experience and definition of LV) “I knew I was not supposed to let her scan my badge and our policy is to have two nurses verify insulin orders.” (lived experience and definition of LV) “She put me in a really bad position.” (lived experience and definition of LV) “I was more afraid of her than getting in trouble, so I let her.” (lived experience and definition of LV) “It made me feel like I didn’t have anybody I could trust.” (lived experience and definition of LV) “I thought about leaving nursing.” (lived experience and definition of LV) “Just be honest with the students that it probably will happen.” (nursing curriculum) “If we had even heard about it, we could have at least known it does happen.” (nursing curriculum) “They never even mentioned it to us.” (nursing curriculum)
Gigi	“It’s hard to narrow down just one, there are so many LV experiences.” (lived experience) “I’ve had nurses tell me that I didn’t know what I was doing, or that I wasn’t listening, or that got angry with me when I didn’t understand something.” (lived experience and definition of LV) “I think sometimes they forget I’m new. I immediately become defensive and go on the attack to defend my actions.” (lived experience and definition of LV) “I feel like they are saying I’m not smart enough.” (lived experience and definition of LV) “As females, we are all pretty sensitive.” (lived experience and definition of LV) “They don’t realize how they come across, their tone of voice, the way they word things, they go after you to hurt you.” (lived experience and definition of LV) “I would catch them (experienced nurses) talking about me behind my back.” (lived experience and definition of LV) “No one wants to talk to you about your mistakes, but they sure want to tell everybody else.” (lived experience and definition of LV) “They are rooting against you and wanting you to fail.” (lived experience and definition of LV) “Setting you up for failure.” (lived experience and definition of LV) “Lecture with real-life experiences.” (nursing curriculum) “Allow students to ask questions about it.” (nursing curriculum) “Bring in people that it happened to so they can give an account of what it looks like.” (nursing curriculum)

(*table continues*)

Participants	Identifying Significant Statements
Heidi	"While I was working with my preceptor she came into my patient's room and said what have you done?" (lived experience and definition of LV) "You never do anything without me." (lived experience and definition of LV) "You are a dangerous nurse!" (lived experience and definition of LV) "I was shocked by how she was talking to me, and, I said I have not done anything without you." (lived experience and definition of LV) "She said this in front of my patient and his family." (lived experience and definition of LV) "She yelled at me in front of them and they were already upset and worried about their loved one." (lived experience and definition of LV) "Now they think I'm a dangerous nurse." (lived experience and definition of LV) "All the nurses were gossiping and talking about what I had done." (lived experience and definition of LV) "I was terrified that I would lose my license, I felt so threatened." (lived experience and definition of LV) "The whole experience left me broken." (lived experience and definition of LV) "All I did was cry." (lived experience and definition of LV) "I felt like I was being judged, all eyes were on me." (lived experience and definition of LV) "Anytime a suit came onto the unit I thought it was coming to get me." (lived experience and definition of LV) "We hear that nurses eat their own, but you really don't understand what that means." (nursing curriculum) "Somebody needs to tell us it can happen to anyone anywhere." (nursing curriculum) "It really sucks when it happens to you." (nursing curriculum)

(*table continues*)

Participants	Identifying Significant Statements
India	“This one nurse seemed to find a way to belittle, put us down; ummm it was almost like she was insecure of someone coming in with a more advanced degree in the same position as her, even though she had been doing it longer, she was just ugly.” (lived experience and definition of LV) “She made us (neophyte nurses) feel like we didn’t know anything about what we were doing.” (lived experience and definition of LV) “She didn’t want to show us anything and if she did show me something it was wrong.” (lived experience and definition of LV) “Then she would point out my mistake to others and say see she doesn’t know what she is doing.” (lived experience and definition of LV) “Kind of sabotage at the expense of the patient. “(lived experience and definition of LV) “I had good grades in nursing school and my preceptors had really good things to say about me, but when she was around, I just felt humiliated especially in front of patient’s family members.” (lived experience and definition of LV) “She would criticize me and make me feel stupid.” (lived experience and definition of LV) “I would go to the restroom and burst into tears and think I’m leaving and I’m never coming back, you know?” (lived experience and definition of LV) “I’ve never felt so worthless in my life.” (lived experience and definition of LV) “It’s got to be told that it happens.” (nursing curriculum) “They never mentioned this in school.” (nursing curriculum) “It completely knocks you off your game when it happens.” (nursing curriculum)

(*table continues*)

Participants	Identifying Significant Statements
Jackie	"I was under the microscope and they (experienced nurses) were just trying to find things I messed up to get me into trouble." (lived experience and definition of LV) "My first job in nursing was the most horrible work experience I had ever had." (lived experience and definition of LV) "When you are starting out you are unsure about so much and they were writing me up and I never even knew it until they called me in on it." (lived experience and definition of LV) "I was like if you have a problem with something I've done, you need to tell me so I can fix it." (lived experience and definition of LV) "I got to the point where I was leaving nursing, it was such an unhealthy environment for me to be in." (lived experience and definition of LV) "I started getting anxious to go into work, or anxious to leave for the day, for fear they would find more mistakes." (lived experience and definition of LV) "I turned in my notice and as I left the hospital, I knew no one would ever threat me like that again." (lived experience and definition of LV) "I questioned myself as to whether or not I was a good nurse that little nagging voice in the back of my head was always there." (lived experience and definition of LV) "It (LV) makes you feel so stupid." (nursing curriculum) "If only they had informed us about it, we could have been prepared." (nursing curriculum) "Who is responsible informing us?" (nursing curriculum) "I could have never imagined something like this happens." (nursing curriculum)

Formulating Meanings and Clustering Themes

Formulation of meanings from significant statements and clustering themes (steps three and four) followed. The development of an additional table allows a quick visual reference to underlying meanings within the narratives of the lived experience from participants (Table 4). This table further allowed for the identification of meanings of words that corresponded to the phenomenon being studied and assisted with reflexively bracketing. Table 4 presents meanings that were derived from narratives of the participants. Meanings were identified within each statement and isolated in the right column for use in Colaizzi's fifth step. It is from these meanings that I postulated emerging themes that I felt significant to my study (Table 4).

Table 4

Participants' Statements Derived from Narratives of the Lived Experience of LV

Significant Statements	Clustered Themes
"She was so confrontational; I just treated the blood sugar to try to keep the peace" (Becky). "We (neophyte nurses) are struggling and they (experienced nurses) just walk out the door" (Becky).	"confrontational" "unsupportive"
"They (experienced nurses) were pushing and manipulating me to change my rotation. "I don't want to, but I feel uncomfortable saying that" (Allison).	"manipulator" "unprofessional" "pushy"
"I had to fight to get my position because my charge nurse had personal knowledge of my disability and she told me she didn't want me on her unit, and; I should have never made a nurse." "I had to escape" (Donna).	"intimidating" "hurtful" "lack of mentoring" "victimizing neophyte nurses"
"No honey, that's not how we do it here." "My preceptor put me in a bad position when she scanned my badge for a medication administration (unethical and against policy)" "I didn't have anyone I could talk to or trust" (Felica). "You are a dangerous nurse" (said in front of the patient and the patient's family) "She yelled so everyone would know what I had done wrong." "It left me broken, all I did was cry" (Gigi).	"passive/aggressive" "lack of trust" "lack of mentoring" "ugly" "lack of mentoring" "victimize neophyte nurses" "setting you up for failure" "loud and demanding"
"They (more experienced nurses) would belittle us, put us down, and just be ugly to us." "Kind of sabotaging us at the expense of the patient." "She would criticize me and make me feel stupid." "I'm leaving and never coming back; I've never felt so worthless in my life" (India).	"passive/aggressive" "ugly" "victimizing neophyte nurses"

The Emergence of Significant Themes

Developments of themes were the result of reflexive bracketing. When I further examined significant statements, formulated meanings, and clustered themes I ascertained several fundamental structures. These fundamental structures included a reported lack of empathy from more experienced nurses to neophyte nurses, the presence of personal

expectations of nursing related to cognitive dissonance, the inability of neophyte nurses to practice professional autonomy, and the presence of cognitive dissonance related to oppression within the nursing profession. Table 5 presents fundamental structures through exhausted descriptions.

Table 5

Fundamental Structures and Exhaustive Descriptions

Fundamental structure	Exhaustive Descriptions
Lack of Empathy from more experienced nurses toward neophyte nurses.	"confrontational" "unsupportive" "manipulating" "unprofessional" "pushy" "intimidating" "hurtful" "lack of mentoring" "victimizing neophyte nurses" "passive/aggressive" "not trustworthy" "ugly" "setting you up for failure" "loud and demanding"
The Personal Expectations of Nursing R/T Cognitive Dissonance	Professional Practice Ethical Morals Difference in Priorities Proficiency Professional Beliefs Organizational Methods Self-confidence Nursing Judgment

(*table continues*)

Fundamental structure	Exhaustive Descriptions
The Inability of Neophyte Nurses to practice Professional Autonomy	Need to Escape Terrified Threatened Fearful Anxious Self-questioning Judged Targeted Tearful Difference in Priorities
Presence of Cognitive Dissonance R/T Oppression in the Nursing Profession	Knowledge is Power Inability to accurately identify LV Make the Institution "look good" "Still learning" Voiceless "Written up" Confronted Manipulated Intimidated Unsupported
Inaccurate Prolegomenon to the Nursing Profession	"It's real" "Might Happen" "Not a fairy tale" "It's not your fault" "Leadership is needed" "Never told us"

Fundamental Structures Supported by Exhaustive Descriptions

The phenomenon of LV continues to plague the nursing profession. A detailed exhaustive description of the fundamental structures as presented in Table 5 were supported through narratives from participants' lived experiences of LV.

Although Freire wrote pedagogy of the oppressed for the discipline of education, the five dimensions of oppression remain applicable to the nursing profession. As I worked through the data analysis, I applied the dimensions of oppression to participant's verbal accounts of LV. The narratives of neophyte nurses confirmed that one or more of these dimensions were present continually while neophyte nurses strived to achieve acculturation in nursing. These five

dimensions of oppression as introduced by Freire (1970) are (1) assimilation, (2) marginalization, (3) low self-esteem and self-hatred, (4) submissive-aggressive syndrome, and (5) horizontal violence (referred to as LV within this study). To better understand how the dimensions of oppression appeared within nursing, table 6 was developed for visual clarity.

Table 6

Freire's Five Dimensions of Oppression

Dimension of Oppression	Example of Dimension of Oppression as Presented Within Nursing
Assimilation: The process of receiving new facts or of responding to new situations in conformity with what is already available to conscious.	"I kept my head down and my mouth shut" (Allison) "Discharging a patient was not my priority; I have patients I don't even know about yet" (Becky "No honey, that's not how we do it here" (Felicia)
Marginalization: To relegate to an unimportant or powerless position within a society or group.	"I did it before I left, even though I knew it wasn't correct; I did it to keep the peace" (Carol) "I'm trying to prove I'm a good nurse; I'm still learning" (Allison) "I would focus on what I was saying to her so I wouldn't irritate her, I'd be more organized" (Erica)
Low self-esteem and self-hatred: A lack of confidence and satisfaction in oneself; hatred directed toward oneself rather than toward others.	"I made a mistake and got written up for a HIPPA violation" (Donna) "I was more afraid of her than getting into trouble, so I let her scan my badge" (Felicia) "I caught them talking about me behind my back, I couldn't do anything right" (Gigi)

(*table continues*)

Dimension of Oppression	Example of Dimension of Oppression as Presented Within Nursing
Submissive-Aggressive Syndrome: submitting to others; pushy.	"They (more experienced nurses) asked me to change my rotation, when I declined, I was excluded from any casual conversations" (Allison) "My preceptor would tell me to do a task, then point out to other nurses that I had made a mistake saying see she doesn't know what she's doing" (India) "She (mentoring nurse) didn't want to show me how to do anything and if she did it was wrong" (Heidi)
Horizontal Violence: "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 behaviors"	My mentoring nurse said I was a "dangerous nurse in front of my patient and my patient's family" (Heidi) The more experienced nurses would "belittle me" (India) More experienced nurses "would criticize me and make me feel stupid" (Jackie)

(Freire, 1970; Merrian-Webster, 2020; Throben,2007.

Lack of empathy from more experienced nurses as reported by neophyte nurses. For example, the more experienced nurse who Carol was reporting to inquired about the treatment of a patient's blood sugar. The hospital policy set a cutoff time of 7:30 am for night shift to stop administering medications, the order for insulin was written for the insulin to be given at 8:00 am. When Carol attempted to explain to this nurse that "the order was a later time and was ordered to be given immediately before the breakfast tray arrived at 8 o'clock," the more experienced nurse "threw down her pen and loudly demanded I told you to treat the blood sugar, what about that do you not understand?" (Carol).

Carol's narrative is an example of assimilation, marginalization, submissive-aggressive syndrome, and horizontal violence as described by Freire. Carol understood the order needed to be enforced to ensure that her patient received the maximum benefit of the insulin prior to

mealtime. However, the more experienced nurse manipulated both Carol and the system to force Carol to complete the administration prior to the daytime shifts arrival.

Personal information about Donna's disability became an issue on her unit when this was shared with nursing peers. "I busted my butt to do everything to care for my patients and they (more experienced nurses) still made me feel like I wasn't worthy" (Donna). As evidenced through her nursing practice being under "constant review and judged for everything I did" (Donna). This example of marginalization was soon followed by self-doubt which led to self-hatred and low self-esteem. Donna confirmed a lifelong passion toward nursing only to begin to question her nursing future after her experience.

Gigi reported that "nurses were always talking about me behind my back, I caught them several times" and "they (more experienced nurses) were rooting for me to fail, almost like they were setting me up to fail through sabotage" (Gigi). Examples of submissive-aggressive syndrome were present as she discovered she was the topic of conversation. In addition, marginalization occurred as she continued to perform nursing tasks as directed.

When Heidi was still in her preceptorship, her nursing mentor sent Heidi in to prepare medications in a patient's room. Heidi reported "going through the process through the Lexi comp making sure everything was compatible" she stated that she then "got the green light through the system to administer IV piggyback medications." Heidi "spiked the bags but did not hang them or attach them to the patient." When the mentoring nurse came in and realized that Heidi had spiked the bags the mentoring nurse "stated in an angry and loud voice; you are a dangerous nurse" this was "done in front of the patient and the patient's family members." "It left me broken" (Heidi). While Heidi was following the instructions of her mentoring nurse, she quickly experienced the negative downfall of doing so. Examples of assimilation (performing

nursing tasks as instructed), marginalization (understanding the policy of her task), and submissive-aggressive syndrome occurred when the autonomy given to her to perform the task then stripped away any self-confidence she may have gained in her ability to complete said task.

Felicia reported that her mentoring nurse came into the room where Felicia was working with a patient and said, “let me scan your badge so I can give this insulin.” “I knew I wasn’t supposed to” let any other nurse scan my badge for medication administration, as this is against policy and insulin administration requires two nurses to check off the order; however, Felicia stated that she “was more intimidated of the nurse than she was of breaking policy” (Felicia). This narrative represents an example of assimilation, marginalization, submissive-aggressive syndrome, self-hatred and low self-esteem, and horizontal violence. Felicia confirmed she was so anxious to be accepted she was willing to participate in activities that contradicted her personal values, the policy of the institution where she worked and the ethics of the profession.

Personal expectations of nursing related to cognitive dissonance. Neophyte nurses reported personal struggles as a result of errors in judgment based on the behaviors of nursing peers. This personal expectation of nursing is directly related to those personal beliefs of what nursing should be which were held prior to entering the nursing profession. These beliefs turn to understanding the reality and inconsistency of those beliefs after beginning practice in the profession. These nurses reported a change in their attitudes, thoughts, and beliefs once they joined the nursing population. Subconsciously the transference of power was given to more experienced nurses, when neophyte nurses allowed experienced nurses to become their moral arbitrator.

Statements such as “I knew I shouldn’t, but I let her” (Felicia); “I did it just to keep the peace” (Carol); “I couldn’t say anything she knew so much more than me” (Allison). All

narratives demonstrate examples of assimilation, marginalization, self-hatred and low self-esteem as discussed in the five dimensions of oppression presented by Freire. Simple tasks such as transferring a patient into bed or making the patient's bed reportedly became an opportunity for neophyte nurses to question their personal attitudes and behaviors as well as their abilities. Neophyte nurses enter the nursing profession with the idea of what they perceive nursing to be, are rapidly faced with what the reality of nursing is. Requests from supervisors for neophyte nurses to suspend one nursing task to perform another task were met with conflicted self-morals, "This is not why I made a nurse" (Becky). This demonstrates marginalization of neophyte nurses to abandon personal values to fulfill organizational requirements. Following an incident, one of the neophyte nurses was written up and an institutional policy was developed. Donna stated, "I took the fall for the hospital basically." This demonstrated assimilation and marginalization of neophyte nurses as personal mistakes became magnified through policy development. Another neophyte nurse described, "I was shocked by how she was talking to me and I said I haven't done anything without you" (Heidi). Evidenced through this example of submissive-aggressive syndrome, Heidi was simply following delegated instructions from her nursing mentor.

The inability of neophyte nurses to practice professional autonomy. Neophyte nurses reported an increased level of stress over practicing nursing autonomously. Neophyte nurses reported the following:

Jackie reported that when she "first started out I was so unsure and every time I turned around, they (experienced nurses) were writing me up for something I had done wrong, and I had no idea. I just wanted them to tell me what I've done wrong so I could fix it" (Jackie). This example of assimilation might have been easily deflated through open communication among the more experienced nurse and Jackie.

India reported “they (more experienced nurses) let us know we didn’t know anything about what we were doing; they would sabotage us (neophyte nurses) at the expense of the patient.” “I was criticized and made to feel stupid” (India). India’s transition into the working environment consisted of assimilation, while she experienced marginalization following sabotage by more experienced nurses.

Another neophyte nurse reported that her experience included the following: “When I was given a task I would do it to the best of my ability, then my preceptor nurse would come in and blast me for what I had done or not done.” This is representative of submissive-aggressive syndrome at the hands of more experienced nurses. “Once she (mentoring nurse) told me to get medications ready and I checked the compatibility off through the Lexi program and she (mentoring nurse) got mad.” “She (mentoring nurse) said you never do anything without me, you are a dangerous nurse.” (Heidi). Also representative of submissive-aggressive syndrome as described by Freire.

Felicia reported being chastised for the way she made the patient’s bed. “The nurse (experienced nurse) told me no honey that’s not how we do it here. I knew it was exactly how we learned it in nursing school” (Felicia).

Presence of cognitive dissonance related to oppression in the nursing profession. Oppression within the nursing profession first came to light when Roberts (1980) introduced the theory in an attempt to explain behaviors present among nurses. Neophyte nurses approach the nursing profession with their personal beliefs, attitudes, morals, and values, seeking to change the world and provide patient care like no other. Unfortunately, the presence of cognitive dissonance in relation to oppression creates a personal turmoil that has led to an inconsistency in beliefs, values, and attitudes.

Lateral violence then becomes the outward expression of the inward frustration for these more experienced nurses. Neophyte nurses are unaware of the culture of nursing and these projected behaviors are a foreign concept to them. Their initial belief that nursing is a compassionate and caring profession becomes shattered and on occasion leads to complete abandonment of the nursing profession. Cognitive dissonance related to oppression was supported through the following narratives of the lived experience from study participants.

Becky reported that the first time she experienced oppression as behaviors of LV, she wanted to say, “Look I’m doing the best I can” she expressed “this is not why I made a nurse” (Becky). Becky reported a confliction of personal priorities when compared to those of the organization where she was employed. She described patient care remained her highest priority, but felt the organization overall was more focused on the perceived public impression of the institution. This is supported by her statement of “She (experienced nurse) told me to stop taking care of patients and discharge another one of my patients, I thought they can wait I need to give my medications first” (Becky). Becky confirmed feelings of self-hatred and low self-esteem over little control of her working environment.

Lack of adequate staffing placed Allison in a position to experience LV from more experienced nurses. “They (scheduling and staffing nurse) panicked to fill the position, so they tried to manipulate me into switching my rotations to fill that spot.” Allison disclosed she had no desire to rearrange her entire schedule to accommodate this vacancy. Allison admitted she had reservations about speaking out of fear of hostility from nursing peers that wanted her to fill the opposite weekend position. These nursing peers were texting and calling Allison pressuring her to fill that spot. Allison confirmed though statements that she felt she needed to prove herself worthy of being in that working environment, “I’m new and I’m trying to prove I can be a good

nurse, I'm still learning." She felt these experienced nurses had waited until she was not working (so she had no control over the evolving situation of her work schedule and would not be able to defend her position) so they could apply pressure without the knowledge of her superiors and could have no active participation within this ongoing dilemma. Upon Allison's return to work and the confirmation of her decision to remain on her current rotation, these experienced nurses became malicious, hostile, and nasty. Confirmation was evident through statements like, "When I say experienced nurses were mean to me, I mean they were just plain nasty" and "I just kept my head down and my mouth shut and took care of my patient" "I was completely isolated from any personal conversations" (Allison). All five dimensions of oppression were present within Allison's narrative.

It was evidenced that some experienced nurses used their experience to force neophyte nurse Carol into going against the organizational policy. She reported through sheer "intimidation" she administered insulin outside of the ordered time frame "just to keep the peace" (Carol). After Carol found her voice and reported the incident to her nurse manager, the experienced nurse "started coming in early just to change the order times to 7:30 am so I had to administer before going home" (Carol). Assimilation quickly followed by a demonstration of submissive-aggressive syndrome.

Donna recounted the blatant disregard of her personal privacy when experienced nursing peers shared her disability information throughout her unit and then used this information to have her removed from that unit. "I had to fight to keep my spot." She shared that the entire experience made her "question whether or not she should be a nurse" (Donna). This demonstrates assimilation, marginalization, followed by self-hatred and low self-esteem, submissive-aggressive syndrome and ending in LV (horizontal violence). Seeing firsthand how

experienced nurses treated her with open disregard changed her entire outlook on the profession. She "considered leaving the profession because that's not what I thought nursing was" (Donna).

Inaccurate Prolegomenon of the Nursing Profession

The unrealistic representation of the nursing culture further impacted the lack of knowledge on the phenomenon of LV. Neophyte nurses were ill prepared to assimilate either to the mental aspect or the physical aspect of nursing culture. Participants confirmed the unrealistic expectations of nursing were based on how nurse educators portray the profession through clinical experience.

One participant stated "they (nurse educators) told us we could go anywhere and get a job and we would make lots of money" but they never once "told us what LV was or that it might even happen to us" (Becky). Another participant told me "after we talked initially, I had to google what LV was to be sure I could participate." She confirmed "they (nurse educators) need to let students know this is real" (Allison).

Carol described that she realized "how important it was to have an experienced nurse I could trust and talk about LV with" as this was greatly needed following her experience with LV. She included that the need for nurse educators to tell students that "it's real and it does happen" (Carol), remains imperative for the future of nursing. Another participant revealed that "If we had even heard about it, we could have at lease known it does happen" (Felicia).

Seeking Verification of Fundamental Structure

For verification of the fundamental structure and to maintain trustworthiness of the study I sought participant feedback**.** All participants were provided a copy of the fundamental structures listed above for verification. I engaged in lengthy conversations regarding these developed descriptions and all fundamental structures were confirmed and verified by

participants. Often remarks like “that’s exactly how I felt only I didn’t know how to word it” (Carol); “you nailed it” (Allison); and “If only I could have put it so eloquently, that’s what I would have said” (Jackie). “I love the way you captured my life as a new nurse, I sure hope it helps others” (Donna). “Yes, that is how it happened, just like that” (Heidi). Based on, the feedback I received I felt that the narratives were accurately represented.

Conclusion

This study was developed to gain an understanding of how neophyte nurses experience LV within the first 12 months of nursing practice. The following research questions were designed to address that experience:

1. What is the lived experience of LV in neophyte nurses?
2. How do neophyte nurses describe LV?
3. What content areas do neophyte nurses perceive that nurse educators could include to aid in preparing them to recognize and respond to LV?

Participants provided narratives based on personal experience with LV for data collection and analysis. These experiences included feelings of manipulation, self-doubt, sabotage, exclusion, and being targeted. In addition, descriptions included feeling unable to speak up when unethical or unprofessional issues arose regarding patient care, as a direct result of inexperience. Being marginalized through not having a voice compromised patient care, which, in several incidences, resulted in neophyte nurses being reprimanded.

The lack of education preparation for nursing students in the phenomenon of LV contributed to the detrimental impact on neophyte nurses. This is largely related to the fact that LV is not inclusive within most nursing curriculums. When neophyte nurses were not

knowledgeable of LV the occurrence carried a more devastating effect. All participants reported the experience of LV could have been better represented within nursing curriculums.

The relationship between a reprimand and the intent to abandon the profession is related to a lack of trust by neophyte nurses toward more experienced nurses. The following chapter will discuss the significance and implications of this study. Furthermore, Chapter V offers recommendations for future nursing studies and posits possible implementations of content for future nursing students that will better prepare them for the experience of LV.

CHAPTER V:

DISCUSSION, CONCLUSION, AND IMPLICATIONS

The purpose of this research study was to gain an understanding of how LV among neophyte nurses was experienced while establishing their professional role as a practicing nurse (12 months or less in the practice setting) and to gain insight into what content may need to be added to nursing programs. The study investigated the experience of LV among neophyte nurses, including how neophyte nurses defined actions of LV and their perceived view on what nurse educators could do to better prepare future nurses in the phenomenon. The narratives provided personal descriptions of actions and behaviors from more experienced nurses toward the neophyte nurses and explicated information about how that conduct may have changed neophyte nurses' views about the nursing profession.

Comparisons were made of the study findings with current literature available on the phenomenon of LV among nursing. The research questions that formed the basis of this study were as follows:

1. What is the lived experience of LV in neophyte nurses?
2. How do neophyte nurses describe LV?
3. What content areas do neophyte nurses perceive that nurse educators could include to aid in preparing future nurses to recognize and respond to LV?

Discussion of Findings

Research Question 1: What is the lived experience of LV in neophyte nurses? Lateral violence resulted in an emotional attack on the professional, personal, and social aspect of each

participant. These experiences created self-doubt in their nursing abilities, which on many occasions resulted in participants questioning their dedication to remain within the profession. Furthermore, LV experiences tarnished the views and perceptions of each participant about the profession itself. Participants affirmed feeling unsupported, noted a lack of empathy from more experienced nurses and felt vulnerable when they arrived at the working environment.

Research Question 2: How do neophyte nurses describe LV? These actions were described through personal and professional attacks of their ability to perform nursing tasks. In addition, the lack of empathy from more experienced nurses when neophyte nurses were performing daily nursing tasks. Lateral violence was described as any opportunity to remove personal self-confidence from the neophyte nurse and replace self-confidence with apprehension and self-doubt. The organizational demands for neophyte nurses to carry the same patient loads as more experienced nurses further impacted the acculturation process for neophyte nurses and participants affirmed this created an environment rich in LV.

Research Question 3: What content areas do neophyte nurses perceive that nurse educators could include to aid in preparing future nurses to recognize and respond to LV? The response included an overall resounding need for nursing students to be educated in the phenomenon of LV. Only two of the interviewed participants had received any educational background on LV, which indicated a deficit of academia in informing future nurses on this phenomenon. The two participants who did receive content on LV perceived a milder experience of LV, or at least an improved ability to disregard the behavior as a personal attack on their nursing ability. This study did not explore how the levels of education or the presence of LV education may have affected how neophyte nurses experienced LV. I felt it interesting to note that of the ten participants, the two who received some education of LV did share that their

experience was not as significant as some of the other nurses they had talked with in the past. Calling LV by its name gave neophyte nurses the ability to identify that these behaviors were not new and should not be accepted in the profession. The label of LV made the behaviors more understandable for neophyte nurses.

The foundational structures derived from the study included (1) lack of empathy from more experienced nurses toward neophyte nurses, (2) the personal expectations of nursing related to cognitive dissonance, (3) the inability of neophyte nurses to practice professional autonomy, (4) the presence of cognitive dissonance related to oppression in the nursing profession, and (5) the inaccurate prolegomenon of nursing culture.

Lack of Empathy from more Experienced Nurses

One prevalent fundamental structure that occurred in most narratives was a suggestion of lack of empathy toward neophyte nurses from more experienced nurses. Experienced nurses who developed feelings of frustration as a direct result of oppression allowed feelings to surface as behaviors of LV directed toward nursing peers, often less experienced peers, or the neophyte nurse (Freire, 2000). This concept is evidenced within my study through comments such as "I'm trying to prove I can be a good nurse" (Allison). "I can never do enough; they (experienced nurses) always want me to do more" (Becky). "She (nurse mentor) intimidates me" (Carol). "I had to fight for my position" (Donna). "It made me second guess myself as a nurse" (Donna). "I would never confront her (experienced nurse)" (Donna). "I felt I didn't have anyone I could trust" (Felicia). "I immediately become defensive and go on the attack to defend my actions" (Gigi). "You are a dangerous nurse!" (Heidi). "The whole experience left me broken" (Heidi). "She (more experienced nurse) didn't want to show us (neophyte nurses) how to do anything and

if she did, it was wrong" (India). "I was under a microscope and they (more experienced nurses) were just trying to find things I had messed up to get me into trouble" (Jackie).

The emergent development of the concept is not new to current literature and is addressed through actions and behaviors from more experienced nurses toward neophyte nurses. These attitude characteristics of more experienced nurses toward neophyte nurses are often considered the rite of passage or even "nurses eating their young" (Meissner, 1999). The acceptance of such behaviors has been present in nursing literature from the development of the profession itself (Roberts, 1983). Confirmation of study findings with literature findings consisted of reported interruption in patient care as a direct result of a failure of more experienced nurses to collaborate in patient care; attacking one's personal integrity or professional reputation; or even misplacing the blame when an error or mistake had occurred (Blair, 2013). Issues of LV impact the self-confidence of neophyte nurses and this fact is detrimental to both the person and the profession. Lack of experience, personal insecurity, lack of confidence, and impaired professional identity create an environment full of opportunity for experienced nurses to exercise LV toward neophyte nurses (Griffin, 2004).

Unfortunately, Blair (2013) declared that experienced nurses dismiss these behaviors or actions as the "nature of the beast" (the nursing profession), or simply argue they were too busy to be "touchy-feely" toward neophyte nurses (p. 75 para 3). More experienced nurses are expected to approach the mentoring role for neophyte nurses with the same compassion as the conduction of patient care. However, failure to support and mentor neophyte nurses remained an underlying issue throughout the narratives provided. This fact will continue to have repercussions on patient care and the healthcare industry.

Neophyte nurses enter the nursing profession with personal ideation of their perception of what nursing is; however, when environments are rich with LV from more experienced (and admired) nurses, the reality of nursing becomes tarnished. The support needed by neophyte nurses to develop skilled communication and critical decision-making skills is greatly affected by the presence of LV (Longo & Hain, 2014). Apprehension over the possibility of litigation, backlash from patient dissatisfaction, organizational requirements for cost containment, and the technical challenges are a large portion of this stress (Murry, 2018).

When work environments lack empathy, the risk of untoward patient outcomes is much greater than an environment where empathy exists. Furthermore, lack of peer support and overwhelming fear of an LV event contributed to failed interprofessional relationships and contributed to job dissatisfaction (Hubbard, 2014). Unfortunately, when nursing peers failed to assist neophyte nurses who were targeted by LV, a message of acceptance of that behavior often resulted in perceived approval that LV is acceptable behavior within the profession (Hubbard, 2014).

Griffin (2004) described a lack of empathy among nurses through actions of infighting, withholding pertinent information, and the failure to respect the privacy of neophyte nurses (Duffy, 1995; Farrell, 1997; & McCall, 1996). Even covert actions such as eyebrow-raising, failure to engage in conversation with the neophyte nurse and snide remarks made under their breath were examples that a lack of empathy from more experienced nurses is prevalent within the profession (Griffin, 2004). Other factors of lack of empathy were presented that included a communication breakdown, understaffing, and failed recognized LV actions by management, assisted with an environment that was ripe with disrespect and disregard for nursing peers (Lim & Bernstein, 2014). Furthermore, the literature supports that nurses who were targeted with LV,

often go on to become perpetrators of LV toward neophyte nurses in the future (Vessey et al., 2009), which further perpetuated the cycle of violence within the profession.

The Personal Expectations of Nursing Related to Cognitive Dissonance

Cognitive dissonance is not readily discussed within the literature in relation to neophyte nurses and LV; however, once results were analyzed the presence became obvious. Neophyte nurses approach nursing with a passion to change the world, one patient at a time. This theme is supported within this study through comments such as “My priorities didn’t always line up with that of the institution” (Becky). “This is not why I made a nurse” (Becky). “I just want to work someplace without drama” (Carol). “I started to second guess my career as a nurse” (Donna). “They (experienced nurses) aren’t very professional” (Felicia). “They (experienced nurses) are setting you up for failure, not helping you succeed” (Gigi). “I felt so threatened, fearful I would lose my license” (Heidi). “They (experienced nurses) would sabotage you at the expense of the patient” (India). “I turned in my notice and left the hospital, no one would ever treat me like that again” (Jackie).

Neophyte nurses have reported increased anxiety over the fear of personal failure compared to the enormity of caring for patients with higher acuity and the patient care load expected of them once they enter the working environment, as compared to the expectations of clinical rotations (Gessler & Ferron, 2012). When neophyte nurses are unsupported in their professional role by more experienced nurses, personal views on nursing become altered (Anderson & Pearson, 1999). Dichotomized values of patient care are reported as personal internal conflict, creating cognitive dissonance among neophyte nurses. Because the nursing profession is comprised of a compassionate and caring perception, neophyte nurses reported that they too felt they would be treated likewise; however, the presence of LV among neophyte

nurses quickly shattered their image of what nursing should have been. Often neophyte nurses admitted that they felt a personal struggle when organizational goals did not line up with their morals or beliefs, creating an unease, and disillusioned views of their chosen profession. Furthermore, Kramer (1974) declared that institutional demands of clinical expediency and loyal obedience (mental consensus of doing a task the way the organization wants it done, compared to personal knowledge on the correct procedure), often led to internal discomfort and turmoil.

Neophyte nurses are required to apply self-awareness to gain understanding as to why they behave differently in certain settings (Rasheed, 2015). Personal narratives confirmed a high level of knowledge deficit and uncertainty in their role as a new nurse, which, according to Weaver (2013), is one of the variables for abandoning the nursing profession. Issues arose from a lack of acculturation as neophyte nurses were faced with the reality of the nursing culture and the shock of the professional demands. When neophyte nurses are transitioned rapidly into nursing practice their self-confidence is impacted, creating a vulnerability that contributes to environments rich in LV (Berry, Gillespie, Fisher, Gormley, & Haynes, 2016; Belcher, 2012; Blair, 2013; Chu & Evans, 2016; Embree et al., 2013; Hutchinson et al., 2006; Littlejohn, 2012; Roberts, 2015).

Systemic barriers further impacted neophyte nurses' personal views on motivational biases, as neophyte nurses were expected to carry the same workload as experienced nurses and complete nursing processes as rapidly as more experienced nurses (Lim & Bernstein, 2014). The reality of the professional demands created an unrealistic timeframe for patient care, and this was a major obstacle for neophyte nurses (Pellico, Brewer, & Kovner, 2009). When organizations or institutions failed to address LV when it occurred neophyte nurses who pursued peer feedback became targeted subjects to additional events of LV (Bartholomew, 2014). Furthermore, when

neophyte nurses verbalized personal concerns over the lack of time allowed to perform nursing tasks and deliver patient care they reported that they were viewed as complainers or not team players from nursing management and the hierarchy of the medical tier (Taylor, 2016).

The Inability of Neophyte Nurses to Practice Professional Autonomy

The inability for neophyte nurses to practice professional autonomy is directly related to personal and professional inexperience, lack of professional confidence, and failure of having achieved acculturation into the profession. When LV is present within the work environment the desire to practice professional autonomy often resulted in dilemmas for neophyte nurses. These dilemmas are reported through breach of patient dignity, breach of patient care, breach of patient safety, clinical errors (including medication errors), and communication breakdown among healthcare members (Rees, Monrouxe, & McDonald, 2014). Evidenced by this study through statements such as the following: “When starting you are so unsure about so much and they were writing me up and I never even knew what I had done wrong” (Jackie). “I felt like I was being judged, all eyes were on me” (Heidi). “I have never felt so worthless in my life” (India). “I knew it was unethical, but I didn’t feel comfortable saying no” (Felicia). Failure of neophyte nurses to perform professional autonomy created increased levels of anxiety among the neophyte nurse, irritability of unidentified etiology, depression, unstable emotional outbursts, significant loss of personal confidence in their nursing ability, and feelings of shame (Yidirim, 2009).

Reportedly, neophyte nurses seek confirmation from more experienced nurses to build and improve their professional practice. However, when LV was present in the working environment, neophyte nurses admitted to not seeking validation of the nursing process, building nursing skills, or seeking assistance when faced with a time-oriented nursing task (Griffin, 2004).

When neophyte nurses abandoned the profession as a direct relation to LV or the inability to become acculturated within the profession, the retained nursing population is further taxed with fulfilling the gap. Neophyte nurses may be pushed into practicing nursing before they had accurately orientated into the profession, which further impacted their self-confidence and professional autonomy (Simons & Mawn, 2010). Furthermore, lack of accountability toward LV perpetrators may send the message to neophyte nurses that this is an accepted practice by the organizational leaders (Berry, Gillespie, Fisher, Gormley, & Haynes, 2016; Belcher, 2012; Blair, 2013; Chu & Evans, 2016; Embree et al., 2013; Hutchinson et al., 2006; Littlejohn, 2012; Roberts, 2015), which reportedly increased the lack of support neophyte nurses experienced.

When LV remained as a normal part of the nursing environments neophyte nurses reported the inability to concentrate and deliver competent patient care (Griffin, 2004). These compromises were reported through medication errors (missed medication doses, wrong medication, wrong patient, and wrong route), increased patient falls, and an increased amount of untoward patient outcomes, including frequent hospital readmissions (Vassey et al., 2009).

Nurses confirmed that fears associated through nursing practice contributed to medication errors, missed medication dosing, and failure to preform nursing tasks were seldom reported related to looking incompetent (Taylor, 2016). Furthermore, neophytes are given the same patient load, patients with higher physical acuities, and comorbidities as the more experienced nurses (Embree et al., 2013). Neophyte nurses reported their personal beliefs and values often conflicted with that of the institution where they were employed, which further impacted their feelings of dichotomy (Kramer, 1974).

The Presence of Cognitive Dissonance Related to Oppression in the Nursing Profession

Freire (1970) did not specifically write for the nursing profession; however, many of the ideas and concepts declared can be readily applied to nursing. One-way oppression is represented is through the existence of LV among the nursing profession. This fact impacted the ability of nurses to practice autonomy; therefore, the profession required the need to be governed. Currently, nursing is dominated by the nursing board, physicians and hospital administrators creating and sustaining oppression within nursing culture (Rainford et al., 2015). As neophyte nurses enter the profession the reality of oppression became a fortuitous reality. Confirmation of this concept is represented in this study by comments such as follows: “Nurses were pushing me and manipulating me to change rotations, I didn’t want to, but I didn’t feel comfortable saying so” (Allison). “Nursing directors walk out of work, while we’re still struggling to get work done, and I haven’t eaten or even been to the bathroom” (Becky). “I’m afraid she will come back at me with something I don’t know, and I’ll look stupid” (Carol). “I made a mistake and got written up for a HIPPA violation; I basically took the fall for the hospital” (Donna). “I focus on what I’m saying to her in the report, so I don’t irritate her” (Erica). “She (nursing preceptor) put me in an unethical position asking to scan my badge so she could give insulin (which was against policy, it requires two nurses verify the order), she put me in a bad spot” (Felicia). “Nobody talks to you about your mistakes, but they sure want to tell everybody else how you messed up” (Gigi). “Anytime a suit came on to the unit I thought they were coming to get me for something I had done wrong” (Heidi). “I started getting anxious about going into work, or anxious to leave work for the day, for fear they would discover some mistakes I had made” (Jackie).

The desire of neophyte nurses to be accepted into the nursing culture often resulted in their acceptance of the values and beliefs of the more dominant nursing peers. The neophyte

nurses who were interviewed confirmed the five dimensions of oppression as introduced by Paulo Freire's model of oppression (Mathenson & Bobay, 2007). These five dimensions of oppression are: 1) assimilation, 2) marginalization, 3) self-hatred, low self-esteem, 4) submissive-aggressive syndrome, and 5) horizontal violence (Freire, 1970). Participants affirmed that they found themselves processing through the five steps of the model of oppression. The most poignant revelations declared were self-hatred and low self-esteem (step 3), marginalization (step 2), and submissive-aggressive syndrome (step 4) (Freire, 1970).

Neophyte nurses also corroborated that being under constant scrutiny from more experienced nurses, governing boards and organizational hierarchy further indicated that oppression was a major factor in their cognitive dissonance. Participants affirmed the alteration of personal values and beliefs as a means of acceptance into the nursing culture. As neophyte nurses (as an oppressed group) internalize personal beliefs the values of more experienced nurses' (as the dominant group) become enforced (Blair, 2013; Chu & Evans, 2016). These power imbalances that result from oppression are experienced through feelings of low self-esteem, self-loathing, and self-hatred (Bartholomew, 2006). Furthermore, when these feelings are suppressed there are direct correlations to job dissatisfaction, increased anxiety and incivility (Griffin, 2004). The result is that experienced nurses may have accepted the cultural practice and abandoned the nursing core values (Wolff et al., 2010).

Neophyte nurses cannot accurately identify unacceptable behaviors among the nursing culture, which further disoriented their cognitive rationalization. As neophyte nurses enter the nursing culture their personal ideation of what they perceive nursing to be became inconceivable. The reality of their chosen profession required that personal values and beliefs about nursing must be altered if they chose to remain a practicing nurse.

The Inaccurate Prolegomenon of the Nursing Culture

Participants affirmed that the lack of educational inclusion on LV within nursing curriculums contributed to increased vulnerability for LV to occur. Luparell (2011) confirmed a demand for nursing curriculum to include formal preparation of nursing students on the phenomenon of LV. The literature offed a plethora of information regarding the effects of LV on nurses but provided no significant structure for educational inclusion in nursing curriculum.

Implications for Nursing Education

Nurse educators do an outstanding job preparing nursing students in the science of nursing; however, this study confirmed an obvious deficit of educators in the preparation of neophyte nurses regarding the phenomenon of LV. When neophyte nurses present to the workplace unprepared and uneducated about LV the impact can be quite detrimental for them. Nurse educators hold the power to chart the course that will lead to nurse empowerment by educating neophyte nurses of this blemish on our profession. When nursing students are educated on appropriate behaviors that improve the overall health of peers and patients, then empowerment may aid in eradicating LV from the profession.

Additional skills ingrained in students need to include advocating for fellow nurses in addition to advocating for patients. Allowing neophytes to understand the underlying issues of oppression within the profession is often the catalyst for LV events to occur and may better prepare them for the phenomenon. In doing simple steps in the beginning the ripple effect can result in a more supportive working environment for all professional nurses.

Academia is the one point in which nurse educators can better prepare future nurses for the challenges that await them in practice. Power can be gained from the giving and receiving of knowledge throughout programs that encourage and support not only neophyte nurses but nurses

across the discipline. This may allow experienced nurses to embrace new nursing specialties instead of experiencing burnout and abandoning the profession.

Recommendations for Research

Lateral violence continues to plague the nursing profession through uncivil behaviors toward among nurses. The nursing profession would greatly benefit from future studies about this phenomenon. Several areas for study would include discovering how LV among more experienced nurses is perpetrated and how they acted in the role of perpetrator of a LV event. The suggestion that LV occurs as a direct relation of oppression warrants interviewing male nurses and gathering data on how they experienced. Lastly, conducting studies of current nurses before implementation of LV education into a nursing curriculum and then revisiting the same study question with newly graduated nurses who had LV in their curriculum may provide ways to measure how this prepares nursing students for the reality of the profession.

As with many professions the need for continual monitoring of nursing culture will require diligence and perseverance to provide the nurses with skills and techniques to remain adaptable. Interviewing neophyte nurses should remain a top priority so that nursing academia can revise programs to best prepare future nurses in the phenomenon of LV. Nursing culture should embrace a more positive approach for the acculturation of neophyte nurses and ease the transition process into the profession.

Conclusions

Neophyte nurses were given the opportunity to share their personal experiences regarding LV as part of this research study. All participants interviewed did experience LV; however, the degree of that experience varied from narrative to narrative. The fact remains that LV continues to inflict negative outcomes on fellow nurses but may be more detrimental to neophyte nurses.

Furthermore, neophyte nurses are entering the professional arena without any educational armor to prepare them for this fact.

Let this serve as a call to arms for all professional nurses to declare a cease fire on our nursing colleagues. Through educational preparation and empowerment of all nurses, the profession can begin to heal. For experienced nurses, empowerment through programs of mentorship and becoming a trusted advisor will not only benefit neophyte nurses but also the self-esteem of the mentor. Investment in the future nursing population requires diligent and relentless advocacy for the nursing profession.

Nurse educators hold a key to bridge the gap and promote a healing environment for nursing students and future neophyte nurses. Discussion of the phenomenon and understanding that oppression is a major reason that LV exists within nursing is the start of eradication. Support for each other will ensure that the profession survives in a healthy and caring manner.

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APPENDIX A:

LETTER OF CONSENT

Research Invitation

Susan S Thrasher (Doctoral Student) from The University of Alabama under the direction of Dr. Alice L. March, RN, PhD is conducting a study called: Neophyte Nurses and Lateral Violence: The Lived Experience. The aim of this study is to collect stories about lateral violence (LV) experience from neophyte nurses (new nurses, the first 12 months of practicing in the nursing profession) to gain an understanding of this experience.

Taking part in this study involves a face-to-face interview to gather the information. These interviews will last approximately 60-90 minutes.

The assignment of the pseudonym that you pick will achieve the protection of your confidentiality. Susan Thrasher, transcriptionist, and the research committee will be the only persons to have access to collected data. Data collected will be password protected and printed text will be stored in a locked safe at the home of the researcher. Only summarized data will be presented at dissertation defense, nursing presentations, or publications of this study.

There will be no compensation or direct benefits to you as a participant. The findings will be useful to the nursing profession, nursing academe, and nursing faculty to develop curriculum to include how neophyte nurses encounter, define, and identify LV.

The chief risk is that recalling the experience of LV may be emotionally uncomfortable or upsetting for you. You may skip any question you do not want to answer.

If you have questions about this study, please contact Susan Thrasher at 256.504.6071 or ssthrasher@crimson.ua.edu. If you have questions about your right as a research participant, please contact Tanta Myles (University Compliance Officer) at 205.348.8461 or toll-free at 1.877.820.3066. If you have complaints or concerns about this study, file them through UA IRB outreach website at http://osp.ua.edu/site/PRCO Welcome.html. Also, if you participate, you are encouraged to complete the short Survey for Research Participants online at this website. This helps UA improve the protection of human research participants.

YOUR PARTICIPANTON IS COMPLETELY VOLUNTARY. You may stop or choose to not participate any time before your interview.

☐ I CONSENT to participate in this study.

☐ I DO NOT CONSENT to participate in this study.

Participant signature_______________________________________Date____________________

APPENDIX B:

IRB APPROVAL

THE UNIVERSITY OF
ALABAMA® | *Office of the Vice President for*
Research & Economic Development
Office for Research Compliance

December 16, 2019

Susan Thrasher
Capstone College of Nursing
The University of Alabama
Box 870358

Re: IRB # 19-OR-020-R1 "Neophyte Nurses and Lateral Violence: The Lived Experience"

Dear Ms. Thrasher:

The University of Alabama Institutional Review Board has granted approval for your renewal application. Your renewal application has been given expedited approval according to 45 CFR part 46. Approval has been given under expedited review category 7 as outlined below:

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

The approval for your application will lapse on December 15, 2020. If your research will continue beyond this date, please submit a continuing review to the IRB as required by University policy before the lapse. Please note, any modifications made in research design, methodology, or procedures must be submitted to and approved by the IRB before implementation. Please submit a final report form when the study is complete.

Good luck with your research.

Sincerely,

Carpantato T. Myles, MSM, CIM, CIP
Director & Research Compliance Officer

Jessup Building | Box 870127 | Tuscaloosa, AL 35487-0127
205-348-8461 | Fax 205-348-7189 | Toll Free 1-877-820-3066

APPENDIX C:

INTERVIEW QUESTIONS

Participant arrival: Period of introduction Orientation of the facility (restrooms, back exit, and interview setting) Introduction of audio recording equipment	
Refreshments provided Temperature of the interview setting adjustment if needed	
Questions/Interview	
1. Please tell me a little bit about your nursing career.	
2. Please describe your best day working as a nurse.	
3. Please describe your worst day as a nurse.	
4. Please describe your personal experience with lateral violence from an experienced nurse.	If she is unsure of what LV means to her, have her describe the covert or overt actions displayed by a more experienced nurse.
5. Tell me about your verbal response to the experienced nurse who subjected you to LV?	
6. What physical or psychological feelings did you experience following this event?	
7. What warning signs, if any, do you think were present before the LV event?	

8. Were you able to discuss this occurrence of LV with anyone (nurse manager, friend, nursing cohort, or family member)?	If no, why not?
9. Thinking about your experience, how do you describe lateral violence?	
10. Please tell me a little bit about your educational background.	
11. In your opinion what can we as nurse educators do to better prepare future nurses in LV?	
12. Is there anything you would like to add to this interview?	
13. Any additional questions that would help conduct a more in-depth interview into LV?	