

## The antecedents of horizontal violence among nurses: a descriptive qualitative study

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### Abstract

**Background and aim:** Horizontal violence (HV), including verbal, non-verbal, and physical violence, is a serious challenge in nursing. Many different factors may put nurses at risk for HV. The aim of this study was to explore the antecedents of HV among nurses.

**Methods:** This descriptive qualitative study was undertaken in 2022–2023. Fifteen nurses were purposively selected from five hospitals affiliated to Hamadan University of Medical Sciences, Hamadan, Iran. In-depth semi-structured interviews were held to collect the data and the conventional content analysis method proposed by Graneheim and Lundman was used to analyze them.

**Findings:** Data analysis led to the development of two categories, each with two subcategories. The categories were specific personality traits and violence-laden culture of nursing. The subcategories were bullying personality, oppressed personality, discriminatory and unjust behaviors of managers, and tense work atmosphere.

**Conclusion:** Personality traits, managers' discriminatory behaviors, and tense work atmosphere are the most important antecedents of HV among nurses. These factors can negatively affect nurses' physical, mental, emotional, and social health, reduce their professional interest, undermine care quality, and lead to their intention to quit nursing. Nursing managers need to identify the antecedents of HV among nurses and use appropriate strategies for its effective prevention and management. Intervention for HV management should be implemented systematically and involve all healthcare workers.

**Keywords:** Horizontal violence, Lateral violence, Bullying, Nursing, Qualitative study, Content analysis



## Introduction

Horizontal violence (HV) is a serious challenge for all nurses, particularly novice nurses (1). HV, also known as lateral violence, horizontal hostility, bullying, aggression, and disrespect (2), is a negative interaction or interpersonal struggle among two nurses with the same organizational position (3). It may be of psychological, verbal, or physical type or manifested as prejudice, discrimination, or limited support (4). The most common types of HV include non-verbal innuendo, verbal offenses, sabotage, scapegoating, backstabbing, lack of confidentiality, public criticism or humiliation of a colleague, postponing career advancement, and isolation of a colleague (5). The prevalence and the type of HV vary in different countries and contexts (6, 7). Despite the increasing number of studies into HV prevalence in the past thirty years, there are still no reliable data about its prevalence (8) because it is mostly underreported. Recent studies showed that 65%–80% of nurses experience HV (9–12). A study in Saudi Arabia showed that 94% of nurses had witnessed at least one HV behavior during their practice (13). Another study on Iranian nurses also reported that 34.9% of nurses experienced at least one episode of HV per month (14).

HV has many different consequences which affect almost 85% of nurses (15). A study reported that from 87.4% of nurses exposed to HV, 75% experienced physical and mental symptoms, 10% experienced posttraumatic stress disorder, and some young nurses opted for quitting the profession (16). HV has destructive consequences such as high job turnover, financial losses, and physical and mental problems (17) and negatively affects nurses' physical, mental, and social health (11). Inappropriate environmental interactions at workplace can alter employees' performance and cause disappointment, conflict, job burnout, turnover, and low care quality (18). HV can also lead to fear over retaliation, fear over being ridiculed, disappointment, and job dissatisfaction (13). Episodes of HV can cause discomfort for nurses, alter their concentration and judgment, reduce relationships and collaboration among nurses, and thereby, endanger patient care (19). These consequences in turn increase nurses' absence from work and their intention to quit their job (16, 20–22) and thereby, increase the workload of the remaining nurses, reduce their job satisfaction and tolerance towards colleagues, make them irritable, and increase the risk of further HV (23, 24).

Various factors can contribute to HV. According to Freire's Pedagogy of the Oppressed, oppressed people feel worthless, have low self-esteem, and experience anxiety because of their perceived inferiority in a culture dominated by a powerful group of people. However, their fear prevents them from showing their anger. Moreover, their powerlessness and fear move them towards showing their aggression and anger to their own group members. These behaviors prevent the group from developing organization, unity, and integrity which are necessary for power gain (25). Nurses are known as an oppressed group due to their lack of control and power in their physician-dominant workplace (26). Power imbalance at work causes nurses problems such as low self-esteem, suppressed anger, passive-aggressive communication, and inattention towards their own needs (27). Hierarchical culture, ineffective managerial style, and sense of personal insecurity in such culture may eventually lead to HV (17, 28, 29). Moreover, stressful work conditions (19, 30), heavy workload,

incoherent work group (30), nursing leaders' misuse of their authority, bullying, and lack of organizational policies to manage abusive behaviors (30–32) can contribute to HV.

A review study introduced HV as a complex personal and interpersonal issue influenced by personal, organizational, and social factors (8). Another study reported inequities among nurses due to rigid hierarchical system in nursing as well as nurses' heavy workload and occupational inferiority as factors contributing to some negative emotions and subsequent HV in the process of emotional release (33). Moreover, most nurses are women who are inherently more sensitive and emotional and show extreme reactions even to trivial events and thereby, may engage in HV (34). Other predisposing factors for HV include age, gender, work experience (35), ward type, staff shortage (6), working with critically-ill patients, organizational position, reporting system (36), leadership style, unfair work conditions, limited occupational control (30, 37, 38), organizational atmosphere (39).

Although there are numerous studies into HV, some aspects of the phenomenon, particularly in nursing, are still poorly known (42, 43) and HV is still a major problem in nursing (44). Therefore, more studies are essential to further explore the different aspects of this phenomenon (45), its contributing factors, and strategies for its prevention (46). A study recommended that qualitative designs may be appropriate to obtain a comprehensive understanding of HV (16). Therefore, we conducted the present study with a qualitative design to explore the antecedents of HV among nurses.

## Methods

This descriptive qualitative study was undertaken in 2022–2023. The corresponding author of the study purposively selected fifteen nurses from five hospitals affiliated to Hamadan University of Medical Sciences, Hamadan, Iran. A work experience of at least one year, working in hospital as a nurse, and agreement for participation were the selection criteria.

The corresponding author held face-to-face semi-structured interviews to collect the study data. All interviews were held in a room in the study setting and after participants' work shifts and were audio-recorded using a smartphone. The duration of the interviews was 45–60 minutes. The following questions were used to start and continue the interviews: "May you please explain about one of your work shifts?", "Have you ever experienced HV in your relationships with your colleagues?", "May you please explain about your experience of your colleagues' HV against you?", and "What were the effects of that experience on your personal and occupational life?" Probing questions like "May you please explain more?" and "Can you give a clear example about this?" were asked to continue the interviews. At the end of the interviews, interviewees were asked whether they wanted to add any missing point in order to further clarify the HV phenomenon.

The conventional content analysis method proposed by Graneheim and Lundman was used to analyze the data. The five steps of this method are immediate transcription of each interview, reading the transcript to get a general understanding of it, determination of the meaning units and primary codes, categorization of the codes, and determination of the latent content of the data (48, 49). We transcribed each interview word by word immediately after holding it,

determined its meaning units, and coded the meaning units using participants' or our own wording. The codes were frequently read and compared and combined with each other, and were categorized based on their similarities. Comparison of the codes and the categories was continuously performed until the end of data analysis. Member checking and concurrent data collection and analysis were used to ensure credibility. Dependability was ensured through immediate interview data transcription, peer checking, and member checking. Peer checking and audit trailing were also employed to maintain confirmability, and provision of direct quotes from participants' experiences and peer checking were employed to maintain transferability.

The ethical approval for this study was received from the Ethics Committee of the University of Social Welfare and Rehabilitation Sciences, Tehran, Iran, with the code of IR.USWR.REC.1400.240. Clear and simple explanations were provided to participants about the study aim, confidential data handling, deletion of the audio data after the final report of the findings, and freedom to unilaterally leave the study. Written and verbal consents for participation and verbal consent for interview data recording were also obtained from participants.

## Findings

Fifteen nurses with an age range of 20–55 years and a work experience mean of  $13.86 \pm 5.83$  years participated in the study. Twelve participants were female and ten participants were married (Table 1).

Table 1. The characteristics of participants

No.	Participant Type	Age (Years)	Gender	Work experience (Years)	Educational level	Affiliated ward	Marital status
1	Nurse	32	Male	4	Bachelor's	Intensive care unit	Married
2	Nurse	46	Female	20	Bachelor's	Intensive care unit	Single
3	Nurse	30	Female	9	Bachelor's	Intensive care unit	Single
4	Nurse	28	Male	5	Bachelor's	Emergency room	Married
5	Nurse	26	Female	2	Bachelor's	Internal medicine	Single
6	Nurse assistant	50	Female	27	Bachelor's	Emergency room and transplantation ward	Married
7	Nurse	40	Female	16	Bachelor's	Intensive care unit	Single
8	Nurse	50	Female	24	Bachelor's	Emergency room and transplantation ward	Married
9	Nurse	40	Female	15	Master's	Intensive care unit	Single
10	Nurse	32	Female	10	Master's	VIP	Married
11	Nurse	32	Female	11	Bachelor's	Hospital security	Married
12	Nurse	33	Male	10	Bachelor's	Hospital security	Married
13	Nurse	46	Female	24	Bachelor's	Nursing management	Married
14	Nurse	45	Female	25	Master's	Nursing management	Married
15	Nurse	26	Female	6	Master's	Head nurse	Married

The experiences of participants respecting the antecedents of HV in nursing were categorized into four subcategories and the two main categories of specific personality traits and violence-laden culture of nursing (Table 2).

**Table 2. The antecedents of horizontal violence among nurses**

<i>Categories</i>	<i>Subcategories</i>
<i>Specific personality traits</i>	Bullying personality
	Oppressed personality
<i>Violence-laden culture of nursing</i>	Discriminatory and unjust behaviors of managers
	Tense work atmosphere of nursing

## 1. Specific personality traits

This category had two subcategories, namely bullying personality and oppressed personality.

### 1.1. Bullying personality

According to the participants, individuals with bullying personality have a sense of self-superiority, are jealous of their colleagues, publicly humiliate them, ignore them, unjustly impose their tasks and beliefs on them, are nonadaptive to others, are impolite and aggressive, bully others, do not help their colleagues, mistreat them during shift handover or patient transfer, and may even commit physical violence against them.

*When I started my practice in the cardiac care ward, my senior colleague never minded me, considered himself superior to me, never helped me, and did not answer my questions. I had very bad feelings and had fear and anxiety over bad events. As I liked working in cardiac care ward, I tolerated those problems. But, it was very difficult for me (P. 6).*

*We have a colleague who bullies all colleagues and nobody can tolerate her. She can't stay in a ward for more than six months and does not adhere to the rules. For example, she never works evening shift. She believes that nobody can say anything to her because she secures formal permanent employment. They had changed her ward several times because workload is on her colleagues and she continuously nags. Authorities prefer to accept her conditions and this encourages her bullying (P. 15).*

*We have a talkative colleague who violates others' privacy and creates noise pollution in the ward. She is always aggressive and doesn't mind others. These behaviors can cause violence and abhorrence and hence, colleagues keep distance from her (P. 1).*

### 1.2. Oppressed personality

Participants highlighted that individuals with oppressed personality are fearful, isolated, and unable to defend themselves and solve their personal and occupational problems, underestimate themselves, and have poor communication skills, low self-confidence, and limited work experience. These traits may lead to HV.

*One day, I requested an hourly leave in the beginning of the shift for some bank affairs. But, I attended the ward at 09.30 instead of 0.9:00. My colleague whose work experience is less than me publicly shouted at me in front of colleagues, physicians, and patients and said, "Is this the right time to attend the ward?" I greatly felt ashamed and cried because I usually don't shout at others like him and manage these situations with silence (P. 4).*

*At the beginning of my nursing practice, I mostly did evening and night shifts and my colleague used to allocate one more patient to me and also allocate new patients to me. Moreover, I had to manage patient transfers. I thought it was a hospital rule and hence, I never complained for a long time in order not to experience any problem (P. 5).*

## 2. Violence-laden culture of nursing

Violence-laden culture of nursing was the other main category of the antecedents of HV in nursing. The two subcategories of this category were discriminatory and unjust behaviors of managers and tense work atmosphere of nursing.

### 2.1. Discriminatory and unjust behaviors of managers

Participants reported managers' discriminatory and unjust behaviors as an antecedent for HV. These behaviors include head nurses' unjust patient allocation to nurses, head nurses' and supervisors' unjust monthly shift allocation to nurses, managers' polar behaviors towards nurses, head nurses' unjust conduct in performance evaluation or giving encouragements, unjust differences in payments, and lack of meritocracy.

*We have a colleague who is a relative of our head nurse. She always takes the head nurse to her house by car. Her monthly work schedule is determined based on her preferences and she rarely has night or vacation shifts. Whenever we object, the head nurse says that we should not be preoccupied with others' work schedule. This behavior is discriminatory; but we can't do anything (P. 11).*

*When the head nurse arranges a better work schedule for a nurse without any reason, other nurses reduce their collaboration with that nurse (P. 15).*

### 2.2. Tense work atmosphere of nursing

The tense work atmosphere of nursing also plays indirect role in HV among nurses. Factors such as nurses' limited support for each other, poisonous atmosphere in nursing, heavy workload, staff shortage, differences among nurses respecting their employment status and salaries, traditional and inflexible atmosphere of nursing, hierarchical structure of nursing, unusual work shifts in nursing, and difference among different wards regarding work difficulty can make remaining in nursing impossible for nurses and may lead to behaviors such as HV.

*I have experienced these tense behaviors of my colleagues many times. For example, at the time of shift handover, I noticed that the nurse of the evening shift had left some of her tasks*



undone. When I told her that she had to complete her tasks before leaving the ward, she threw the Kardex and said that she was too tired of that heavy workload, and left the ward.

Employment type influences salaries. I have a small monthly salary as a corporate nurse, while the monthly salary of my colleague, who has the same work experience as me, is two times more than mine. Although she is not responsible for this unequal payment, this causes problems such as concern, nervousness, hostility, and animosity (P. 3).

One of the occupational tensions is related to the rest time. Colleagues who are awake at the second half of the rest time at night shifts should administer all medications of all patients and hence, have heavy workload. This causes tension. Moreover, some colleagues want to stay awake with the colleagues who are their friends though all of them may be novice. Novice nurses may not be able to manage serious conditions and hence, they should always work with more experienced nurses. The request of novice nurses to stay awake and work together may cause tensions at work (P. 8).

## Discussion

This study explored the antecedents of HV among nurses. These antecedents came into two categories, i.e., specific personality traits and violence-laden culture of nursing. Our findings indicated nurses' specific personality traits as one of the main antecedents of HV among them. Some nurses with bullying personality may be impolite and aggressive, impose their tasks and beliefs on others, bully others, and thereby, cause HV. Managerial support for these nurses promotes their unprofessional behaviors. On the other hand, nurses with oppressed personality and characteristics such as limited work experience, poor communication skills, low self-confidence, inability to defend themselves, and senses of loneliness, isolation, and fear are at risk for their colleagues' HV and hence, have significant role in the promotion of HV in healthcare organizations. Bullying and HV at work are determined by multiple factors such as limited professional experience, role conflicts, low self-confidence, low job satisfaction, heavy workload, insufficient managerial support, poor communications (50), gender, age, educational level, and organization type (51–53). Low-level aggressions each nurse may usually show during a bad workday are also a predisposing factor for bullying and high-level aggressions and hence, should effectively be managed to prevent HV (5). Bullies are individuals who intentionally humiliate colleagues and cause them physical or mental stress. They have craving for advancement, limited self-esteem, limited social competence, ineffective leadership style, narcissistic personality, retaliation feelings, and bad habits to promote cruelty and aggression towards others (54).

In agreement with our findings, a study showed that sociodemographic characteristics may contribute to bullying at work. It reported that bullying at work had significant negative relationship with age and work experience and noted that nurses with weaker internal source of control, lower psychological capital, and poorer coping with social norms were more at risk for bullying at work (52). Another study reported that the victims of bullying are horrified, disturbed, rejected, humiliated, and prevented from claiming their rights, and their resources are robbed (55). Moreover, a study found demographic characteristics, personality characteristics, organizational culture, work characteristics, leadership, and hierarchy as the

significant predictors of bullying at work and highlighted that bullying at work negatively affects organizational outcomes and patient safety (51). A study also showed that the victims of bullying had lower self-esteem and were more anxious and neurotic (56). Besides, a concept analysis of nurse-nurse HV revealed that the root causes of HV are rigid hierarchy, role-related issues, cruelty, low self-esteem, perceived inability, anger, and power structure (57).

We found managers' discriminatory behaviors as a very important antecedent of HV. These behaviors include unjust task allocation, unjust monthly work schedules, and unjust staff evaluation. A study found that nurses suffer from oppression and cruelty more due to workplace environment than their own personality traits, and highlighted that nursing leaders need to engage nurses in decision making and improve their self-esteem through recognizing their abilities (58). Another study found head nurses' support, good workplace atmosphere, good group behaviors among nurses, and balanced interpersonal interactions as protective factors against nurse-nurse HV (59). Similarly, a study reported work-related behaviors and work schedule as the catalyst of HV. Work-related behaviors included unprofessional behaviors, conflicts about nursing care strategies, and disappointment, while work schedule included conflicts due to non-adherence to protocols, patient allocation to nurses, resource shortage, and heavy workload (60). Nursing managers may also indirectly facilitate HV with their tone and expectations (44). On the other hand, their supportive attitude towards nurses may strengthen nurses' mutual support for each other and foster a healthy environment which may in turn protect nurses against HV (61).

The tense work atmosphere of nursing was another antecedent of HV in the present study. Findings showed that factors such as unsupportive and poisonous atmosphere among nurses, heavy workload and occupational stress, staff shortage, differences among nurses respecting their employment status and salaries, and hierarchy in nursing may result in extreme fatigue, tension, aggression, and HV among nurses. In line with this finding, a review study showed that contextual factors such as resource shortage, heavy workload, and organizational failures can act as the major catalysts of HV (41). Another investigation found that better occupational characteristics, higher quality of interpersonal relationships, staff-oriented leadership styles, and positive organizational culture may be associated with lower risk of bullying in the workplace (52). Moreover, a study reported that the rigid hierarchical system of nursing and the poor occupational position and heavy workload of nurses may lead to inequities, negative feelings, and HV among nurses (33). Another investigation highlighted that heavy workload, anxiety, conflicts, roles, values, inequities among employees respecting their autonomy and authority, and constant instability of work conditions due to rotating shifts and staff handover may lead to HV and hence, their effective management is essential to prevent HV (62).

## Conclusion

In order to effectively manage HV, organizations need to focus more on the organizational culture which promotes unprofessional behaviors than on individuals, and need to show firm commitment to the identification and management of the underlying causes of HV (8). Furthermore, organizational authorities need to provide nurses with strong organizational



support, create a just and clear system for problem reporting, and appropriately manage those shortages and failures of their organizations which may increase employees' emotional and physical burden, contribute to HV, and endanger patient safety. They also need to improve employees' knowledge of HV, communication skills, ability to identify those interpersonal interactions with negative personal and organizational outcomes, analytical skills to analyze the root causes of HV, and ability to identify those failures of the system which may lead to stress and ineffective problem solving (8).

#### Study limitations

Some participants shared their experiences with some organizational considerations. We attempted to handle this limitation by creating a safe and peaceful environment for participants to freely share their experiences.

#### Conflict of interests

The authors have no conflict of interest.

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## References

### Abstract

The abstract appears before the keywords. Abstract must be about 200 words. However, it must be limited between 150 to 200 words. The abstract should clearly state, the objective, results and the conclusion of the work.

**Keywords:** maximum of eight keywords seperated by “,”.

## Introduction

The paper must not exceed 12 pages. Please use the following guidelines in preparing your full papers. If papers are not prepared according to the following guidelines they will be withdrawn from the conference program.

## Elements of a Paper

The basic elements of a paper are listed below in the order in which they should appear:

- Conference header
- Paper title
- Author names and affiliations
- Abstract
- Keywords
- Introduction
- Main body of paper, including figures and tables, page numbers and footer, headings, enumerations, etc.
- Conclusions
- Acknowledgments
- Nomenclature(Not-necessary for two-page summary paper)
- References
- Appendices

## Paper Preparation

All papers must be written in either English or Persian (Farsi). Paper will be presented in the language that it is written.

Paper must send by uploading in the conference websit. Don't use Email for sending papers.

For English papers; the fonts for the different parts of a paper are in Times New Roman as follows:

- Title: 12 pt bold (centered)
- Author(s): 10 pt bold (centered)
- Affiliations: 10 pt (centered, italic)
- Keywords: 10 pt
- Section Headings: 11 pt bold
- Subsection Headings: 10 pt -Others: 10 pt

Each A4 page is prepared in one column. The Abstract starts 90mm from the top of the page on the first page.

Papers must be prepared using Word 2003 or higher. They must be submitted a word file(Full Paper).

The headings will start from the far left.

Use single spacing with no space between the section headings and the paragraph following it. Put one space between the texts of main sections.

Paper must have page numbers.

## System of Units

SI system of units is deemed to be used. If necessary use the equivalent value in the other system of units in brackets after the SI system of units.

## Equations

Equations start from the far left of the column and numbered consecutively. The equation numbers must be bracketed and placed opposite to the equation on the far right of the line in that column.

$$\sigma_r = \frac{E}{1-\nu^2}(\epsilon_r + \nu\epsilon_\theta - (1-\nu)\alpha\Delta T) \quad (1)$$

## Tables, Figures and Photographs

Tables must be numbered and the title of the table must be placed on the top of the table with the footnotes on the bottom. Tables must appear where (or as close as to) they are first mentioned in the text. They must be referred in the text as "Table 1".

Figures must be numbered and the caption of the figure must come at the bottom of the figure. All the legends and the numerical values on the axes of the curves must be clear and readable. Figures must appear where (or as close as to) they are first mentioned in the text. They must be referred in the text as "Figure 1".

Photographs must original and follow 2 above for numbering and captions.

Leave one space between the Table/Figure and the text following it.

Table 1-major cities on the 21 routes to london

Route number	City 1	City 2	City 3	City 4	City 5	City 6
1	Halifax	Sheffield	Nottingham	Bedford		
2	Plymouth	Exeter	Salisbury			
3	Tiverton	Taunton	Frome			
4	Bristol	Bath	Reading			
5	Southampton	Winchester				
6	Portsmouth	Chichester				
7	Canterbury	Rochester				
8	Yarmouth	Ipswich	Colchester			
9	Norwich	Bury				
10	King's Lynn	Ely	Cambridge			
11	Berwick	Newcastle	South Shields	Sunderland	Durham	
12	Bradford	Leeds				
13	Whitby	Scarborough	York			
14	Manchester	Derby	Northampton	Leicester		
15	Hereford	Gloucester	Cirencester			
16	Beverley	Hull	Lincoln	Boston		
17	Whitehaven	Liverpool	Macclesfield	Lancaster	Carlisle	Kendal
18	Shrewsbury	Birmingham	Wolverhampton	Coventry	Dudley	
19	Worcester	Oxford				
20	Kidderminster	Warwick	Banbury			
21	Chester	Lichfield	Coventry			

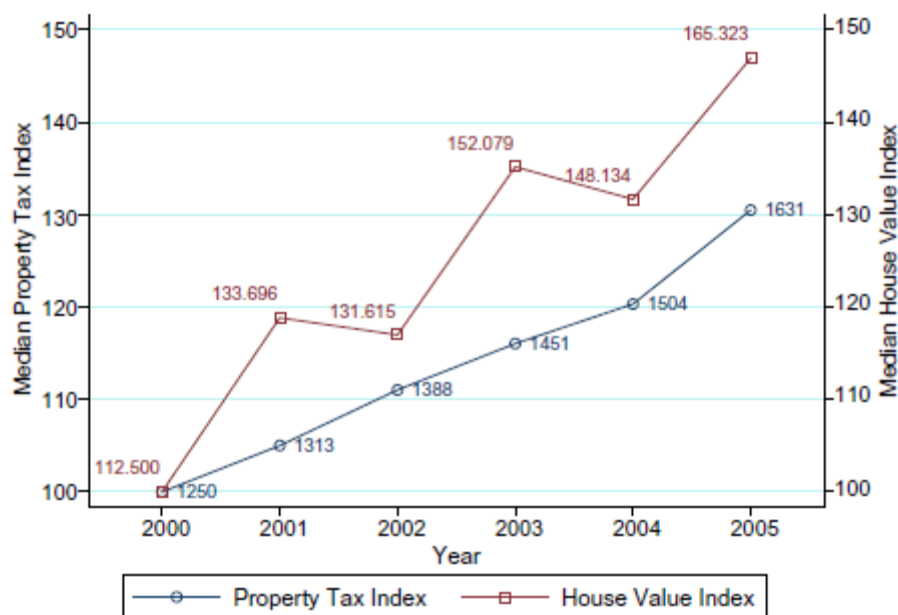


Figure (1) median property taxes and house value in the united states, 2000-2005

## Results Discussion

All the obtained results should be carefully investigated and compared with the other works. Two page summary papers must include results and discussion sections.

## Conclusions

Main conclusions of the paper must be put here.



## List of Symbols

The list of symbols comes after the acknowledgment and before references. The English symbols come first followed by the Greek symbols. Both must be typed in alphabetical order and separated.

## References

References must be numbered and be listed in the list of references in the order that they are referred to in the text. Their number must be put in squared bracket, i.e. [1].

The complete details of the references will appear in the list of references.

For journal papers, books and conferences papers use the following formats:

- [1] Assembly Jobs, Economic Development, and the Economy Committee, 2006. 20, Years of California Enterprise Zones: A Review and Prospectus, Sacramento, California, April 12, 2006.
- [2] Timoshenko, S.P. and Woinowsky-Krieger, S., 1959, *Theory of Plates and Shells*, New York: McGraw-Hill Book Company.
- [3] Billings, Stephen, 2009. Do enterprise zones work? An analysis at the borders. *Public Finance Review* 37 (1), 68–93.