Teaching Cognitive Rehearsal as a Shield for Lateral Violence: An Intervention for Newly Licensed Nurses

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ABSTRACT

Background: Recent literature defines lateral violence as nurses covertly or overtly directing their dissatisfaction inward toward each other, toward themselves, and toward those less powerful than themselves. Newly licensed nurses are an identified group that is vulnerable to lateral violence during their socialization to nursing practice. The use of cognitive rehearsal, an applied cognitive–behavioral technique, was used as an intervention and the theoretical underpinning for this study.

Method: Twenty-six newly licensed nurses hired by a large acute care tertiary hospital in Boston, Massachusetts, participated in an exploratory descriptive study. They were taught about lateral violence in nursing practice and the use of cognitive rehearsal techniques as a shield from the negative effects of lateral violence on learning and socialization. Small laminated cueing cards with written visual cues for the appropriate responses to the most common forms of lateral violence were provided. One year later, videotaped focus groups designed to collect qualitative data about the applied intervention were conducted.

Results: Twenty-six newly licensed nurses in three different focus groups were videotaped responding to six open-ended questions designed to elicit information on their experience with lateral violence, use of cognitive rehearsal as an intervention, and the overall socialization process.

Conclusions: Knowledge of lateral violence in nursing appeared to allow newly licensed nurses to depersonalize it, thus allowing them to ask questions and continue to learn. The learned cognitive responses helped them confront the lateral violence offender. Confrontation was described as difficult but resulted in the resolution of the lateral violence behavior. Overall, the retention rate in this study population was positively affected.

The concept of lateral violence, also known as horizontal violence and more recently called "bullying or aggression," has been discussed in the nursing literature for almost 2 decades (Farrell, 1997; McKenna, Smith, Poole, & Coverdale, 2003; Roberts, 1983, 1996; Roberts & Chandler, 1996; Smythe, 1984; Street, 1992). Lateral violence in the professional practice of nursing is born out of the construct of nurses being part of an oppressed population. The origins of the theory evolve from the study of oppression in colonized Africans (Fanon, 1963; Freire, 1972; Okri, 1997). In the United States, a paucity of literature on the pragmatics of operationalized lateral violence exists. However, the opposite is true internationally (Duffy, 1995; Freshwater, 2000; Glass, 1997; Hastie, 1995; Leap, 1997; McCall, 1996; McKenna et al., 2003; McMillan, 1995).

Agreement exists on what embodies lateral violence and how it is manifested. Freshwater (2000) reiterated the connection of lateral violence in the nursing profession to behaviors of oppressed groups. The inter-group manifestation of conflict is seen in the context of being excluded from the power structure. "It is contended that because nurses are dominated (and by implication, oppressed) by a patriarchal system headed by doctors, administrators and marginalized nurse managers, nurses lower down the hierarchy of power resort to aggression among themselves" (Farrell, 1997, p. 482).

The body of knowledge grows related to the concept of lateral violence in clinical practice. The overt behavioral manifestations of lateral violence are expressed by infighting among nurses, withholding pertinent information (sabotage), scapegoating, criti-

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cism, and failure to respect confidences and privacy (Duffy, 1995; Farrell, 1997; McCall, 1996). Farrell (1997) described lateral violence as "professional terrorism" and further cited "eyebrow raising, snide remarks, turning away and withholding information as some of the covert nursing behaviors associated with lateral violence" (p. 504). Although many nurses may not be familiar with the term lateral violence, they probably have experienced it at some time during their career (Hamlin, 2000). Some victims of lateral violence in nursing practice, similar to other victims of bullying, have resorted to suicide (Hastie, 1995).

In an attempt to empirically examine the extent of lateral violence in nurses' work settings, Farrell (1997) undertook a grounded theory study. Farrell identified three forms of aggression in nursing practice: nurse/patient (or patient/nurse), nurse/family (or family/nurse), and nurse/nurse. His overall findings suggested that the most personally troubling for nurses was the nurse/nurse aggression, or professional lateral violence. Internationally, 1 in 3 nurses leave their position because of lateral violence or workplace bullies (McMillan, 1995).

Usually nurses in the least organizationally powerful position manifest lateral violence among themselves and particularly toward those with the least power (newly hired or newly registered nurses). Further, nurses may be more vulnerable (Farrell, 1997; Freshwater, 2000; Hamlin, 2000). Tolerance for some forms of nursing practice lateral violence is seen historically in the context of a right of passage or expressed in the thought "this is how people were to me, when I was learning."

Newly registered nurses face many obstacles to knowledge development and skill acquisition. Today's population of patients are more acute and the staffing patterns often do not allow for downtime or extra support nurses. Job conflict and stress are reported to be the number one problem for new graduates in their first year of professional employment (McKenna et al., 2003). One of the known reasons that newly registered nurses are more vulnerable is because they have known areas of knowledge need and no past experience as registered nurses, making their work more subject to micro-managing or scrutiny. Any advancement for a newly licensed nurse, whether to a preferred time schedule or changes in role, is dependent on a clinical peer in a higher power position.

In the United States, the annual non-retention (turnover) rate for clinical practicing nurses is 33% to 37%, for newly registered nurses it ranged from 55% to 61%, and approximately 60% of newly registered nurses leave their first position within 6 months because of some form of lateral violence perpetrated against them (Beecroft, Kunzman, & Krozek, 2001; McKenna, Smith, Poole, & Coverdale, 2003; Winter-Collins & McDaniel, 2000). There are currently no national studies that examine lateral violence in nursing as an individual form of stress for newly registered nurses. A reduction in attrition rate would not only have a large economic impact, but also, and more important, an impact on nursing practice and professional practice life.

CHALLENGE TO THE PROFESSION

The challenge to the profession of nursing is to explore these issues and behaviors. Oppressed behaviors that manifest into lateral violence in the practice of nursing will not change unless a conscious effort is made to point out the construct to those involved. Methods and mechanisms that interrupt the cycle of lateral violence can be designed. There is no clear evidence that education about lateral violence is an established part of newly registered nurses' orientation, nor is there any evidence that it is taught in the nursing curriculum (Roberts, 1996). Lateral violence stops newly licensed nurses from asking questions, seeking validation of known knowledge, and feeling like they fit in, and stops them from acquiring the tacit knowledge-build necessary in clinical practice (Sternberg & Horvath, 1999).

STRUCTURING AN AWARENESS OF LATERAL VIOLENCE

Providing an educational forum on lateral violence for newly licensed nurses in orientation is essential for raising consciousness. After there is an awareness of this possible impediment to knowledge and skill acquisition, the need for an effective intervention for newly licensed nurses becomes clear. Cognitive process is the mechanism all individuals use to take in information and structure perceptions of the world (Kaplan & Sadock, 1998). The literature reveals that the negative effects of lateral violence (e.g., lowered self-worth, decreased job satisfaction, and stress) can be ameliorated or markedly decreased through education (Freshwater, 2000; Roberts, 1983). The goal of the educational process of teaching about lateral violence is to liberate the oppressed individuals by helping them to see that stopping the dominant group or individual from oppressing them is within their capabilities. Further, by not allowing lateral violence to continue, they become liberated. The liberation is

TABLE 1
THE 10 MOST FREQUENT FORMS OF LATERAL VIOLENCE IN NURSING PRACTICE[a]

1. Nonverbal innuendo (raising of eyebrows, face-making).
2. Verbal affront (covert or overt, snide remarks, lack of openness, abrupt responses).
3. Undermining activities (turning away, not available).
4. Withholding information (practice or patient).
5. Sabotage (deliberately setting up a negative situation).
6. Infighting (bickering with peers).
7. Scapegoating (attributing all that goes wrong to one individual).
8. Backstabbing (complaining to others about an individual and not speaking directly to that individual).
9. Failure to respect privacy.
10. Broken confidences.

[a]Ordered from most often encountered to less frequently encountered.
Adapted from Duffy, 1995; Farrell, 1997; McCall, 1996; McKenna, Smith, Poole, & Coverdale, 2003.

TABLE 2
EXPECTED BEHAVIORS OF THOSE WHO CALL THEMSELVES PROFESSIONALS

- Accept one's fair share of the workload.
- Respect the privacy of others.
- Be cooperative with regard to the shared physical working conditions (e.g., light, temperature, noise).
- Be willing to help when requested.
- Keep confidences.
- Work cooperatively despite feelings of dislike.
- Don't denigrate to superiors (e.g., speak negatively about, have a pet name for).
- Do address coworkers by their first name, ask for help and advice when necessary.
- Look coworkers in the eye when having a conversation.
- Don't be too overly inquisitive about each others' lives.
- Do repay debts, favors, and compliments, no matter how small.
- Don't engage in conversation about a coworker with another coworker.
- Stand-up for the "absent member" in a conversation when he/she is not present.
- Don't criticize publicly.

Adapted from Arglye & Henderson, 1985; Chaska, 2001.

what allows learning to continue. Therefore, the education is emancipating (Freshwater, 2000).

Cognition is the human process of obtaining, organizing, and using intellectual knowledge. Cognitive learning theories focus on an individual's understanding of the connections between cause and effect and between action and the consequences of that action (Pruitt, 1992). Cognitive strategies are mental plans that individuals can, and do, use to understand themselves and their environment. Cognitive rehearsal techniques are often taught by therapists to individuals with impulse control issues. Studies have found that behavior and responses to events can change through techniques in which people learn specific responses by listening to or reading instructions (Glod, 1998; Kaplan & Sadock, 1998).

A strategy that conceptually employs the use of cognition and automatic thoughts is cognitive rehearsal. Cognitive rehearsal asks individuals to hold in their mind information that they have just received. The act of consciously not responding, or not reacting, allows individuals time to process the information based on what they have previously been taught about the information coming in. In the case of lateral violence, the deprecating remark or behavior is processed on the basis of a previously learned response. Theoretically, this allows individuals to stop and not automatically process the event as a personal affront. Individuals then learn to respond differently to the potential professionally and personally harmful inferences of lateral violence.

Many forms of lateral violence exist (Chaska, 2001; Duffy, 1995; Freshwater, 2000; Glass, 1997; Hastie, 1995; Leap, 1997; McCall, 1996; McMillan, 1995) (Table 1). As stated by Hamlin (2000), all nurses have probably participated in some form of lateral violence at one time or another. Teaching this content raises awareness of the existence and practice of lateral violence in nursing and provides a mechanism of defense or a "shield" to integrate the knowledge and skills required for a beginning-level practitioner.

WHAT WAS DONE

The specific aims of the research were to (1) provide a theoretical basis for understanding the origins and manifestations of the professional practice of lateral violence in nursing; (2) identify and acknowledge the vulnerability of newly registered nurses; and (3) provide instruction on the use of cognitively rehearsed prototypical suggested responses to the 10 most frequent forms of lateral violence in nursing.

METHODS

The study used an exploratory design with an applied intervention to better understand how and if lateral violence in the practice of nursing could be controlled to allow newly registered nurses the opportunity to acquire practice knowledge and skills without

TABLE 3
CUEING CARDS ATTACHED TO IDENTIFICATION BADGE

Side 1	Side 2	Single Card Attached to ID
Nonverbal innuendo (raising of eyebrows, face-making). • I sense (I see from your facial expression) that there may be something you wanted to say to me. It's okay to speak directly to me. Verbal affront (covert or overt, snide remarks, lack of openness, abrupt responses). • The individuals I learn the most from are clearer in their directions and feedback. Is there some way we can structure this type of situation? Undermining activities (turning away, not available). • When something happens that is "different" or "contrary" to what I thought or understood, it leaves me with questions. Help me understand how this situation may have happened. Withholding information (practice or patient). • It is my understanding that there was (is) more information available regarding this situation and I believe if I had known that (more), it would (will) affect how I learn or need to know.	Sabotage (deliberately setting up a negative situation). • There is more to this situation than meets the eye. Could "you and I" (whatever, whoever) meet in private and explore what happened? Infighting (bickering with peers). Nothing is more unprofessional than a contentious discussion in non-private places. *Always* avoid. • This is not the time or the place. Please stop (physically walk away or move to a neutral spot). Scapegoating (attributing all that goes wrong to one individual). Rarely is one individual, one incident, or one situation the cause for all that goes wrong. Scapegoating is an easy route to travel, but rarely solves problems. • I don't think that's the right connection. Backstabbing (complaining to others about an individual and not speaking directly to that individual). • I don't feel right talking about him/her/situation when I wasn't there, or don't know the facts. Have you spoken to him/her? Failure to respect privacy. • It bothers me to talk about that without his/her/their permission. • I only overheard that. It shouldn't be repeated. Broken confidences. • Wasn't that said in confidence? • That sounds like information that should remain confidential. • He/she asked me to keep that confidential.	• Accept one's fair share of the workload. • Respect the privacy of others. • Be cooperative with regard to the shared physical working conditions (e.g., light, temperature, noise). • Be willing to help when requested. • Keep confidences. • Work cooperatively despite feelings of dislike. • Don't denigrate to superiors (e.g., speak negatively about, have a pet name for). • Do address coworkers by their first name, ask for help and advice when necessary. • Look coworkers in the eye when having a conversation. • Don't be too overly inquisitive about each others' lives. • Do repay debts, favors, and compliments, no matter how small. • Don't engage in conversation about a coworker with another coworker. • Stand-up for the "absent member" in a conversation when he/she is not present. • Don't criticize publicly.

the barrier of lateral violence interfering. The sample (N = 26) was drawn from the population of newly registered nurses hired for their first position at a large tertiary acute care hospital in Boston, Massachusetts. Consent was obtained from all newly registered nurses who participated. Additionally, during the first week of general nursing orientation to the hospital, 2 hours were set aside for the consenting subjects to participate in the educational part of the study.

The first hour of the educational portion was dedicated to providing a didactic lecture on the theoretical constructs of lateral violence and its impact on nursing practice, professionalism, and the vulnerable populations of nurses. The second hour was interactive instruction on cognitive rehearsal and the appropriate responses to any of the 10 most frequent forms of lateral violence.

At the conclusion of the classroom instruction, the newly registered nurses were given two laminated cueing cards. The first card (Table 2) had the universally accepted behavioral expectations for any given group calling itself a profession (Argyle & Henderson, 1985). These behaviors were identified in the classroom setting as behaviors individuals would aspire to if they were going to call themselves professional. The second card (Table 3) was the actual cueing card. The card had each of the 10 most frequent forms of lateral violence aligned with an appropriate response. These were the same responses that had been taught in the classroom setting. The cards were designed to attach

to the back of identification badges. All of the newly registered nurses agreed to report any problems and to participate in a videotaped focus group after 1 year.

INSTRUMENTATION

Videotaped focus groups were used (Joseph, Griffin, & Sullivan, 2000). There were 62 newly registered nurses hired in the time frame of the study and all received the education about lateral violence. However, only 26 newly registered nurses participated in the study.

The study was approved by the institutional review board of the hospital where the newly registered nurses had been hired. An approved consent to participate form was required and signed by those newly registered nurses taking part in the study. Three videotaped focus groups were scheduled to accommodate those who participated at the end of 1 year. Three groups were required because of the diversity of work schedules. The group meetings were each an hour in length.

RESULTS

There were 26 newly registered nurses enrolled in the study; 24 were women and 2 were men. This represented 39% of the newly registered nurses who gained employment during the study year. The study year ran from May 2001 through May 2002. At the time of the videotaped focus groups, 50% (n = 13) of the newly registered nurses had been working at the hospital for 11 to 12 months. Twenty-seven percent (n = 7) were employed for 9 to 10 months and 23% (n = 6) for 6 to 9 months. All of the newly registered nurses (n = 26) who participated in the videotaped focus groups had been employed full-time for more than 6 months.

There were six open-ended questions asked at each of the videotaped focus groups. The questions asked resulted in dominant ideas that were synthesized and described. The first question was "Did you witness any nurse practice lateral violence since you started your employment?" Their response was that they had seen lateral violence on the units where they worked within their first year of employment (n = 25; 96.1%). Forty-six percent (n = 12) of the newly registered nurses stated that the lateral violence they witnessed was directed at them. They described the nature of the lateral violence to be: setting them up to fail with an "unreasonable assignment," sabotage, undermining, or not being available. One young woman described a situation that she felt was lateral violence but couldn't categorize it. Another individual in the group (n = 1, 3.8%) reported that she did not witness or receive any form of lateral violence perpetrated against her.

The second question was "Did you respond to the lateral violence when it happened?" A resounding 100% of all those who had lateral violence perpetrated against them confronted the responsible individual. Their descriptions of the confrontation and the outcomes were similar (Sidebar). All of the newly registered nurses in this group (n = 12; 46%) articulated that confrontation, no matter how civil they tried to make it, was difficult. They described that they were markedly emotional and delivered their message about the laterally violent occurrence with either crying or speaking through a very tight larynx.

There appeared to be one distinctive outcome among those confronted. The laterally violent behavior against the newly licensed nurse stopped. Notably, there were several ways in which the laterally violent nurses responded to being confronted by the newly registered nurses. Nine of the nurses (75%) whom the newly licensed nurses spoke to (confronted) about a particular situation responded by stating that they were shocked that the newly registered nurse felt that way. Seven (58%) apologized, and two (17%) did not. Three (25%) of those who were confronted had no retort and for a period of approximately 2 weeks shunned the newly registered nurse. In the responses, the end result was that the laterally violent behavior ceased.

The third question was directed at the cueing cards and asked "Did you use the cueing cards to help you respond?" All of the newly registered nurses who took part in the study believed that they did not use the cards "on the spot," but rather that they understood what was on them and just used the informa-

AN EXAMPLE OF CONFRONTING LATERAL VIOLENCE

On one particular night, the shift included three nurses: a newly licensed nurse, her preceptor who spoke English as a second language, and another nurse who also spoke the preceptor's native language and English as a second language.

The newly licensed nurse felt that the two experienced nurses were talking about her shortcomings in their native language and that they excluded her from general conversation for the entire shift.

The newly registered nurse did confront her preceptor but not until the next shift. The preceptor apologized and assured the new nurse that she was not talking about her and would be more conscious of her casual conversations.

tion they had learned. The three groups did have similar dominant ideas about the cards reminding them that lateral violence exists. Most (n = 24; 92%) articulated that they remembered the lecture and the interactive sessions, and the content, so they did not really need to look at the cards. Some (n = 22; 85%) said that the cards gave them a sense of security or empowerment. One individual (4%) memorized each response verbatim and used the exact words in his encounter with a laterally violent nurse.

The fourth question was "Did any of the lateral violence keep you from learning what you needed to know?" Most of the newly registered nurses who were victims of lateral violence (n = 8; 46%) and confronted the offending nurse believed that they had continued to learn. However, others (n = 4; 15%) reported that they felt like they were "walking on eggshells" and at times afraid to ask questions. Ultimately, these four newly registered nurses were relocated in another area of the hospital.

The fourth and fifth questions were connected. The fifth question asked if any of the newly registered nurses had thought about leaving their position at the hospital. The four individuals who had reported the dominant idea of "walking on eggshells" were thinking of leaving and were assisted to take other positions within the hospital and remained employed.

A phenomenon of note that had universal agreement was that of a period of perceived non-friendly communication in their chosen nursing area. The first 4 weeks of the newly registered nurses' hospital experience was spent in a primer program with at least five other newly registered nurses on a designated orientation unit. The orientation unit was staffed with nurses who chose to work with new nurses and the atmosphere was warm and friendly. Subsequently, the newly registered nurses moved to their respective home units. The new nurses described a period of time, usually 4 weeks to 2 months, of feeling as if everything that was communicated to them felt laterally violent. This feeling about the experienced nurses around them changed when the newly registered nurses began to know their coworkers better and realized that these individuals were "just very direct" and did care that they learned.

The last question was "Do you have any recommendations?" The overwhelming majority (n = 25; 96%) of recommendations were to educate all of the hospital's nurses about lateral violence in nursing. Many of the newly registered nurses said that the experienced nurses did not have any knowledge of lateral violence and thought that they were "making-up the term." The newly registered nurses collectively believed that the interpersonal conflict between the physicians and nurses, and between ancillary staff and nurses, should also be addressed.

CONCLUSION

Using the intervention of cognitive rehearsal as a response to lateral violence in this study may have helped to raise consciousness about lateral violence in the general nursing population. As a specific intervention for newly registered nurses, it is unclear whether cognitive rehearsal or just knowledge of what lateral violence is and some suggestions for responding to it was important. It appears that a behavioral intervention (e.g., immediate confrontation) positively influenced changes in actions of laterally violent nurses. Knowledge of lateral violence and a behavioral action to stop it (cognitive rehearsal) in this sample of newly registered nurses served to empower them to confront laterally violent nurses. Understanding how nurses practice lateral violence allowed the newly registered nurses to view the behavior in a different context, which may have kept them vested in their personal learning needs, as opposed to self-flagellation. This introspective endeavor appears beneficial in terms of newly registered nurses' successful integration and retention.

The retention rate for the total population (N = 62) of newly registered nurses from May 2001 to May 2002 was 91%. The experienced nurse hospital retention rate reported annually is 95% (Hayes & Lancaster, 2001). The annual national retention rate for newly registered and experienced nurses was reported to be between 40% and 60% (Beecroft et al., 2001; Winter-Collins & McDaniel, 2000). Further study with the intervention alone or education alone in a larger sample of newly registered nurses might provide more insight. What is clear, however, is that learning about lateral violence in the professional practice of nursing and what to do about it appears to have been helpful.

The profession of nursing has an obligation to reduce lateral violence. The population of newly registered nurses is an ideal place to start. They collectively represent the profession of the future.

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