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Junior nursing students' experiences of vertical violence during clinical rotations

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Horizontal violence is a form of workplace violence, a phenomenon that is prevalent in the nursing profession. Research has revealed a variety of negative peer-to-peer behaviors that lower morale and lead to turnover. However, little research has been conducted on "eating our young" (violence occurring between individuals with unequal power, such as staff nurse and student). We propose "vertical violence" as the appropriate term when abusive registered nurse (RN) behavior is directed towards students. We report a content analysis of stories written by junior nursing students about incidents of injustice perpetrated by staff RNs during their clinical experiences. Four levels of injustice were described. Nursing leadership, both in hospitals and educational institutions, must become engaged in efforts to eradicate vertical violence towards students.

More than 20 years ago, Meissner¹ proposed that nurses "eat our young," assigning blame for the phenomenon to nurse educators. Researchers discovered that many nursing students felt embarrassed, intimidated, and humiliated by their teachers in the clinical setting as well as the classroom.^{2,3} There is some evidence that registered nurses (RNs) on hospital units perpetuate this intimidation when new graduates assume their first positions following completion of nursing education programs.⁴ In fact, hazing is considered a factor in the rapid attrition of many new graduates—attrition that the profession can ill afford during a critical nursing shortage. For example, in a study by McKenna et al,⁴ one in 3 of the new graduates had considered leaving nursing because of abusive or humiliating incidents.

The present study was conceived after the first author (an anger researcher) delivered an invited lecture to

junior nursing students about anger management. Prior to the lecture, the instructor of the class solicited examples of anger episodes from the students, so that major aspects of student concern might be addressed in the lecture. The richly detailed stories were disturbing, depicting staff RNs as the major provocateurs of junior students' anger, consistent with previous literature about "eating our young." Not having Institutional Review Board (IRB) approval, this set of stories could not be retained for research purposes. However, for the next 4 years, following IRB approval, anger narratives were collected and systematically analyzed. Prior to revealing the study findings, we examine "eating our young" in light of the larger phenomenon of nurse-to-nurse horizontal hostility and violence that has commanded the attention of nurse researchers in Europe and Australia, as well as in the United States.

REVIEW OF LITERATURE

Horizontal violence is a form of workplace violence, a phenomenon that is not confined to the nursing profession. Horizontal violence (also called lateral violence) is a term used to depict abusive behaviors between coworkers of similar status, such as staff nurses, in the workplace.⁵ Explanations of the phenomenon often rely on Freire's⁶ oppressed group model, in which oppressed individuals come to believe that they are inferior to the dominant group. In this literature, authors often point to the hegemony of medicine and the predominantly female gender of the nursing profession. Roberts^{7,8} has compared nurses to other oppressed groups, such as colonized Africans and Jews. Because of nursing's remarkable advances in the past 2 decades, contemporary RNs may judge an "oppressed group" conceptualization to be outdated or inadequate.⁹ Most nurses, however, still work in hierarchical systems. Research continues to show that nurses often feel powerless within the hierarchy and unsupported by management.^{5,10} Reynolds¹¹ called attention to organizational cultures of "shame and blame" that contribute to the negativity of employees, negativity that is manifested in "emotional dumping" on coworkers.

Hutchinson et al⁹ utilized Clegg's "circuits of power" model, based on Foucault's conception of disciplinary power, to illustrate how horizontal violence can perpetuate, yet remain hidden in the workplace. By drawing

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attention to organizational rules, coworkers influence the forces of power as it flows through complex influential organizational social networks.

Nurse-to-nurse horizontal violence includes deliberate, unwanted or unwarranted behavior bestowed by one nurse coworker towards another with the intent to hurt, manipulate, degrade, sabotage, or isolate.^{5,9,12} Horizontal violence can be covert and subtle (such as withholding information or disseminating gossip) as well as overt and direct (such as criticism in front of other staff, false accusations, or menacing body language).^{5,9,12} Other forms of the phenomenon, described both in nursing and non-nursing literature, include bullying, mobbing, intimidation, and aggression.^{13–20} At present, there is considerable conceptual confusion in the literature, although the terms “bullying” and “mobbing” should be reserved for behavior of groups rather than individuals. Bullies form alliances and engage in repeated, deliberate acts to destroy self-confidence of their victims; consequences of bullying have included lowered staff morale and productivity, increased absenteeism, medication errors, resignations, and even suicide.^{4,20–23}

Recent studies indicate that nurse-to-nurse violence is widespread. In a survey at a large medical center, 65% of respondents reported that they frequently observed lateral violence behaviors among coworkers.²² Similarly, other researchers found that 75% of nurses at an urban teaching hospital had been verbally abused by other nurses.²³ Negative behavior from other nurses has been reported to be more frequent and/or disturbing than behavior of physicians, patients, or family members.^{14,23,24} Over time, repeated hostile acts can take a cumulative toll on the recipient, resulting in psychological, physical, or professional harm.^{5,21,25,26} Hostility between coworkers can also affect the work environment. Military metaphors permeated nurses’ descriptions of the hostile work environment in a study by Smith et al¹⁰ (eg, “It’s like an armed camp;” “I become very fatigued by having to do all these battles.”)

Overlooked in extant literature is a crucial distinction among forms of nurse-to-nurse violence. While the terms *horizontal* or *lateral* are appropriate to describe the abusive behaviors perpetrated between nurses at the same level in a hierarchical system (eg, staff RN to staff RN), the phenomenon of “eating our young” occurs between individuals with unequal power (eg, instructor to student, staff RN to student). The term *vertical* is used to describe abusive behaviors from a coworker in a superior position towards a subordinate.²⁷ Therefore, we propose that the term vertical violence is more appropriate when the recipients of abusive behaviors are students.

Little attention has been given to investigating the occurrence and effects of vertical violence on American students, although a few studies have been conducted in

other countries. Randle²⁸ performed a 3-year qualitative study of 39 nursing students in Britain, exploring how clinical experiences influenced development of self-esteem. Students not only witnessed patients being bullied by staff nurses, but they themselves were also recipients of hostile acts. Negative clinical experiences were distressful and adversely influenced the students’ feelings about themselves and their chosen profession. Focus group interviews in New Zealand²⁹ revealed that students felt disempowered, insulted, and marginalized by negative staff nurse behavior. A survey of Turkish nursing students³⁰ found verbal and academic abuse to be more devastating than sexual or physical workplace abuse. Abusers included nursing school faculty as well as staff nurses.

One recent report³¹ did focus on American students. Forty-seven seniors in a baccalaureate program responded to a brief survey (7 yes-or-no questions). The most frequently reported behavior was “being put down by a staff nurse.” The majority (72%) agreed with the statement “nurses eat their young.” Limitations of the study included the small sample size and the dichotomous response option of the questionnaire. The study we report herein expands understanding of the phenomenon of vertical violence, as vividly described in narratives written by junior nursing students.

METHOD

Procedure

Each year from 2004–2007, junior nursing students in a university Bachelor of Science (BSN) program were asked to write narratives about anger they had experienced in connection with nursing classes or clinicals. This assignment was made by the instructor of a leadership course in which conflict and emotion management were discussed; the researchers were not known to the students and had no role in the class. Instructions for the assignment did not direct students to discuss interactions with RNs (or with any other specific individuals). Typed narratives were transmitted to the researchers electronically after names of all persons and institutions were removed. Subsequently, segments from these narratives were used to illustrate key points in anger management lectures given annually by the first author. Students indicated to their instructor in writing whether they wanted their narratives to be retained for research purposes. Narratives were discarded if students did not consent for them to be retained. This procedure was approved by the IRB. Participation in the research was not considered in computation of student grades. Of 248 submitted narratives, 27 were eliminated because they did not pertain to incidents experienced while in the role of nursing student.

Setting of the Study

The study was conducted at a public state university in the Southeastern United States. During the years of data collection, the majority of the junior students ranged in age from 20–22 years, although a few were in their 50s; Caucasian was the predominant race, and female was the predominant gender. As is typical in BSN programs, some clinicals take place in community settings (eg, home visiting), but most junior student experience takes place in the acute care units of general hospitals.

Analysis

Content analysis³² was used to code thematic elements of 221 junior student nurse stories. The stories were commonly 1–2 single-spaced typed pages. Thus, the data set comprised several hundred pages of text. Content analysis refers to “any qualitative data reduction and sense-making effort that takes a volume of qualitative material and attempts to identify core consistencies and meaning.”³³ Coding involved identifying important data segments (ie, those containing the most pertinent information to answer the research questions). Stories were interrogated to ascertain: (1) What caused the student to become angry? (2) What was the target of the anger, and was it overtly expressed or suppressed? (3) What was the outcome of the incident? During the analysis phase of the project, the second author assisted in coding approximately half of the narratives. Narratives were independently examined and coded by each investigator, and minor discrepancies between coders were resolved by face-to-face and/or e-mail discussion.

FINDINGS

Student nurse (SN) anger was provoked far more often in clinicals than in classes. Because the classroom-related anger pertained to typical student grievances (unexpected material on exam, perception of unfair grading, “busy work,” etc.), in this article we focus exclusively on anger provoked during clinical experiences. The main cause of SN anger in clinicals was *perceived injustice* (unfair or unjust treatment). Two broad themes of injustice predominated across the SN stories: (1) pejorative, unfair treatment of the students themselves, and (2) violation of patient rights. Because of the complexity of the moral distress and outrage produced by injustices to patients, these data will be presented elsewhere. We focus here on injustices experienced by students. Although incidents of unjust treatment involved doctors, instructors, patients, and/or ancillary healthcare personnel, the most frequently reported perpetrators were hospital staff nurses. Descriptors of unjust RN behavior included *condescending, overbearing, rude, sarcastic, disrespectful, patronizing, and degrading*. The severity of the incidents was conceptualized on a continuum by the researchers. Less severe incidents involved RNs ignoring the SNs or

patronizing them (Level 1) while the most severe and troubling RN behaviors clearly merit the label “vertical violence” (Levels 3 and 4). Verbatim excerpts from the students’ narratives will be used to illustrate incidents of each degree of severity.

Level One Injustice Incidents: “We Were Unwanted and Ignored”

The words of a student introduce this theme perfectly:

Most of us start completely new to the hospital setting. I was so excited about finally being in the hospital, and I had such high expectations about what I would see and learn. I guess I thought that everyone on the floor would welcome me and my classmates . . . How wrong I was. I have never felt so unwanted in my life. The nursing staffs made me feel like a complete nuisance.

Often, RNs failed to display the simple courtesies humans extend to one another upon initial introductions, as in the following exemplar:

As I was introducing myself [to the RN], I stuck out my hand to shake hers. She simply stared back at me and asked, “Do you know how to do anything?”

Failure to make eye contact is another dismissive, rejecting interpersonal behavior. The next exemplar depicts the behavior of Nurse A, whom the student encountered in his or her first clinical rotation:

I communicated to Nurse A my eagerness to observe her with the patients and help with any procedures she would do. Nurse A responded with a grunt . . . For that matter, I don’t think she even made eye contact with me . . . She seemed annoyed by my presence . . . Nurse A could have facilitated my learning experience, but instead seemed more interested in her need to feel superior. I felt as though I was her amusement for the day . . . This day’s experience left me feeling intimidated.

Discouragement, rather than intimidation, was the outcome of being ignored in the next student vignette:

I was assigned to a specific nurse to follow around the ER throughout the day . . . She was constantly on the computer . . . looking at pictures on the Internet of beauty pageants . . . and searching all over eBay for good deals on prizes that she could give away to contestants in a pageant that she was hosting . . . I felt like she was purposely ignoring me . . . I was very discouraged about the nurse I had been assigned to.

RN refusal to answer a simple question was common (eg, “she blew me off”) and left SNs in a quandary

because an instructor might not be immediately available to offer guidance. The following story is illustrative:

The nurse was very dismissive to me throughout the day, but one incident in particular is what really angered me . . . I approached her to find out what my client's blood sugar was and whether or not he could eat his lunch tray . . . because he said he had not received any insulin yet. I asked her if I could ask a quick question and she responded by saying, "No, not really," without even looking up at me, and then walked away.

Level Two Injustice Incidents: "Our Assessments Were Distrusted and Disbelieved"

In the next excerpts from the data, unjust treatment of SNs moves beyond incivility and ignoring to incidents in which their patient assessments were challenged:

I heard rales in the lower lobes of the patient's lungs. When I told staff Nurse A, she dismissed it. Perhaps she was busy and did not want to bother listening to the lungs again . . . I went to clinical instructor B, who listened to the lungs and told me they were indeed rales.

The RN was constantly going back and doing all the work I had previously done. For example, I took 0900 vitals and charted my findings, and the nurse would come in a few minutes later, do vitals again, and chart over my writings . . . I felt very hurt, angry, and annoyed that this nurse had such little confidence in me and complete disregard for my feelings.

I noticed unusual, undocumented skin abnormalities while bathing Patient A. I decided that I should ask Nurse B about what I had noticed. He/she had no idea of what I was talking about and acted as though the issues I had brought to his/her attention were meaningless. He/she ignored me and provided me with no assistance.

Belittling a student's knowledge is not only disrespectful, but also could result in deleterious consequences for a patient, as illustrated in the following exemplar:

Nurse K was overlooking potentially serious problems related to her patient. When I explained that the patient had an oxygen saturation of 84, Nurse K rolled her eyes and had no other response to me. Nurse K acted as if this low of an oxygen saturation was not a problem and I was *just* a nursing student irritating her (emphasis in the original).

Level 3 Injustice Incidents: "We Were Unfairly Blamed"

Particularly painful to the students were incidents in which RNs used SNs as scapegoats (eg, an RN told a patient "This is your student nurse, you should be mad at *her*") and/or made pejorative comments, as in the following exemplars:

The nurse approached me in my patient's room and asked me why I had not given the 0900 meds. I was not scheduled to give meds, and my clinical instructor had made that very clear . . . The nurse turned to my patient and said, 'The student forgot to give you your meds, so now they are late.'

I was in my first semester nursing clinicals at Hospital A. I was assigned a new patient that morning because my patient was discharged . . . I was reviewing my new patient's chart when Nurse A asked me why I hadn't taken any vitals on her patient. I tried to explain that I had just been assigned this new patient . . . Nurse A snapped at me . . . and said, 'Some student nurses are so lazy!' I was very angry because I wasn't being lazy. She wouldn't give me a chance to explain.

Level Four Injustice Incidents: "I Was Publicly Humiliated"

Public criticism and humiliation constituted the most egregious form of injustice. Among the verbs used in the Level 4 stories to depict RN behavior were: "yelled," "screamed," "chastised," and "shouted." Examples of the SN stories follow:

The nurse belittled me in front of my colleagues and the patient to whom I was delivering care . . . She wanted me to administer a subcutaneous injection when I had no further training than bathing, changing linens . . . She ridiculed me for not wanting to do it . . . At one point in time she exclaimed to me that she hated nursing school . . . I found it discouraging since it was only my second day of clinicals.

The nurse singled me out in the hallway among many others to inform me of my mistake . . . After that, I pretty much stayed out of her sight . . . I guess she was able to exert her dominance, and I hoped it made her feel better. She disregarded my strengths.

The nurse lashed out at me because the room was not up to her standards, although it was only 8 AM and we had only been there for an hour . . . I never showed anger because I am the student and really have no say [but] I certainly did feel the anger.

The RN placed the patient on 3L of oxygen. Looking out for the best interest of the patient, I

just nicely asked if she thought that we should put humidity with the oxygen so that we did not worsen his sore mouth. She gave me this awful look but told me she guessed that would be okay. As I walked away and had gotten about 10 to 15 feet away from her, she yelled at me, asking “Just what year of nursing school are you?” I think I offended the nurse. . . . I felt like the nurse had totally disrespected me. . . . It upset me that she thought she could treat me that way just because she was in a higher position.

As shown in the final exemplars, SN anger in these episodes of vertical violence was most often suppressed. Students did not perceive that they could successfully confront staff RNs about their behavior. Their narratives demonstrated acute awareness of the power differential between the RNs and themselves. Students described feeling cheated out of learning experiences and unable to let go of their anger (“By the end of the shift, the anger at A came back to me and still is not gone”). Suppressed anger lingers when there is no opportunity to engage in dialogue or problem-solving with the provocateur.⁵ Students sometimes ruminated for a prolonged period (“I continued to be upset for about a week”). Among the words students used to describe the residue of painful feelings were: *hurt, defeated, confused, frustrated, mortified, livid, sad, upset, appalled, annoyed, misunderstood, embarrassed, disappointed, insecure, discouraged, bitter, and horrible.*

Clinical instructors, for the most part, displayed empathy and support in the incidents our study participants related. However, students did not always reveal the level of RN abuse to their teachers. Regrettably, one instructor timidly stood behind the SN and failed to confront the abusive RN, while several other instructors made excuses for staff RNs who were allegedly “busy” or “stressed.”

DISCUSSION

In hospital staff parlance, the hospital is often referred to as “the house,” as in “the house is wild tonight” or “the house is quiet.” Experienced RNs who inhabit this house bear responsibility for welcoming nursing’s newest practitioners: junior students. These students are entitled to a supportive milieu for learning. Juniors who shared their eloquent narratives with us were not welcomed hospitably to the hospitals to which they were assigned for their early clinical experiences. Ours is the first study to explore vertical violence in a sample of beginning students. We make no claim that findings of this study would be replicated in *all* of nursing’s “houses,” but the RN behavioral characteristics described by SNs were entirely consistent with the intergenerational transmission of pathology termed “eating our young.” Convergence of the findings with previous

research on students is evident,^{28–31} lending urgency to a search for solutions.

Why were hospital RNs inhospitable, given the widely publicized nursing shortage? Why did they not welcome extra hands to help with their work? It was not our aim in this article to debate the etiology of the nurse behavior, but rather to give students the opportunity to describe it from their perspective. Credibility of the student narratives is enhanced by the lack of cueing in the assignment instructions regarding our interest in RN behavior. Further, SNs would have had no incentive to falsify or exaggerate their accounts, since anonymously submitted papers could confer no personal benefits.

IMPLICATIONS

There are several reasons why “zero tolerance” must become the policy in all institutions where students engage in clinical work. To state the obvious, early clinicals are stressful enough without the addition of abusive treatment. Secondly, the physiological and psychological consequences of suppressed anger and rumination are well-known (eg, elevated blood pressure, self-medication via overeating and substance misuse, depression, burnout).⁵ Finally, patient care is compromised in hostile work environments. Yet-to-be-researched are the effects of vertical violence on students with regard to academic achievement, learning outcomes, and carryover effects once the student enters the workforce. One student astutely commented, “I will most likely need to learn how to not let other people’s negativity cause me to be negative as well.”

Nursing leadership, both in hospitals and educational institutions, must become engaged in efforts to eradicate vertical violence toward students. While it is unrealistic to expect clinical faculty to “police” situations, students should be encouraged to report abusive incidents; abusive behavior should not be attributed to RNs’ “stress” or “workload.” Faculty could teach students assertive responses and effective techniques to discharge lingering anger, such as vigorous exercise, journaling, or meditation.⁵ Celik and Bayraktar³⁰ recommend that preparation for work abuse be included in nursing curricula to prepare students for the inevitable.

Research on successful interventions with students is sparse, although one Turkish study discovered that students coped better when they spoke with their abusers about the event.³⁴ Griffin³⁵ tested an intervention for new graduates, in which they were taught a cognitive rehearsal technique as a “shield” for lateral violence. Follow-up evaluation revealed that lateral violence stopped when nurses confronted abusers. One Australian hospital, concerned with bullying at every level (and a high nurse turnover rate), instituted day-long workshops for nursing supervisors and anti-bullying policies; afterward, turnover decreased.³⁶

Nursing must move toward *preventive* interventions, not just strategies designed to disrupt the old patterns of

negativity that seem so well-entrenched. Bartholomew³⁷ recommends an annual roundtable involving managers from the hospital and instructors who supervise clinical rotations. Partnerships between schools of nursing and hospitals will provide mutual benefit. In such partnerships, staff nurses could serve as positive role models, mentors, and/or clinical instructors.

Ten years from now, when someone replicates this study, let us hope that junior nursing students tell the researchers stories of welcoming clinical environments and supportive mentors. Then we can retire the phrase “eating our young”!

REFERENCES

- Meissner J. Nurses: Are we eating our young? *Nurs* 1986; 16:51-3.
- Kleehammer K, Hart AL, Keck JF. Nursing students' perceptions of anxiety-producing situations in the clinical setting. *J Nurs Educ* 1990;29:183-7.
- Mozingo J, Thomas SP, Brooks E. Factors associated with perceived competency levels of graduating seniors in a baccalaureate nursing program. *J Nurs Educ* 1995;34:115-22.
- McKenna BG, Smith NA, Poole SJ, Coverdale JH. Horizontal violence: Experiences of registered nurses in their first year of practice. *J Adv Nurs* 2003;42:90-6.
- Thomas SP. *Transforming Nurses' Stress and Anger: Steps Toward Healing*. New York, NY: Springer; 2004.
- Freire P. *Pedagogy of the Oppressed*. New York, NY: Continuum; 2000.
- Roberts SJ. Oppressed group behavior: Implications for nursing. *Adv Nurs Sci* 1983;5:21-30.
- Roberts SJ. Developing a positive professional identity: Liberating oneself from the oppressor within. *Adv Nurs Sci* 2000;22:71-82.
- Hutchinson M, Jackson D, Vickers M, Wilkes L. Workplace bullying in nursing: Toward a more critical organizational perspective. *Nurs Inq* 2006;13:118-26.
- Smith M, Droppleman P, Thomas SP. Under assault: The experience of work-related anger in female registered nurses. *Nurs Forum* 1996;31:22-33.
- Reynolds JJ. Negativity in the workplace. *AJN* 2007;107: 72D-72G.
- Jackson D, Clare J, Mannix L. Who would want to be a nurse? Violence in the workplace—a factor in recruitment and retention. *J Nurs Manage* 2002;10:13-20.
- Davenport N, Elliott GP, Schwartz RD. *Mobbing: Emotional Abuse in the American Workplace*. Ames, IA: Civil Society Publishing; 1999.
- Ferrell GA. Aggression in clinical settings: Nurses' views. *J Adv Nurs* 1997;26:501-8.
- Fornes VJ, Reines FJ, Sureda GC. Mobbing in nursing: A pilot study. *Revista ROL de Enfermeria* 2004;27:8-10,13-6.
- Institute for Safe Medication Practices. Intimidation: Practitioners speak up about this unresolved problem (Part 1). Medication Safety Alert. (2004, March 11). Available at: www.ismp.org/Newsletters/acutecare/articles/20040311_2.asp. Accessed on September 10, 2006.
- Leymann H. *Bullying: Whistleblowing*. The Mobbing Encyclopedia; 1996. Available at: www.leymann.se/English/frame.html. Accessed on February 2, 2007.
- Linsley P. *Violence and Aggression in the Workplace: A Practical Guide for all Healthcare Staff*. Seattle, WA: Radcliffe Publishing; 2006.
- MacIntosh J. Experiences of workplace bullying in a rural area. *Issues Ment Health Nurs* 2005;26:893-910.
- Sa L, Fleming M. Bullying, burnout, and mental health among Portuguese nurses. *Issues Ment Health Nurs* 2008; 29:411-26.
- Hutchinson M, Vickers MH, Jackson D, Wilkes L. “They stand you in a corner; you are not to speak”: Nurses tell of abusive indoctrination in work teams dominated by bullies. *Contemporary Nurse* 2006;21:228-38.
- Stanley KM, Martin MM, Nemeth LS, Michel Y, Welton JM. Examining lateral violence in the nursing workforce. *Issues Ment Health Nurs* 2007;28:1247-65.
- Rowe MM, Sherlock H. Stress and verbal abuse in nursing: Do burned out nurses eat their young? *J Nurs Manage* 2005;13:242-8.
- Cox HC, Kerfoot KM. Nursing management considerations. *Nurs Econ* 1990;8:416-7.
- Ferrell GA. From tall poppies to squashed weeds: Why don't nurses pull together more? *J Adv Nurs* 2001;35:26-33.
- Thomas SP. Horizontal hostility: Nurses against themselves: How to solve this threat to nurse retention. *AJN* 2003;103: 87-8,91.
- Buback D. Home study program: Assertiveness training to prevent verbal abuse in the OR. *AORN Journal* 2004;79: 148-70.
- Randle J. Bullying in the nursing profession. *J Adv Nurs* 2003;43:395-401.
- Vallent S, Neville S. The relationship between student nurse and nurse clinician: impact on student learning. *Nursing Praxis in New Zealand* 2006;22:23-33.
- Celik SS, Bayraktar N. A study of nursing student abuse in Turkey. *J Nurs Educ* 2004;29:201-7.
- Longo J. Horizontal violence among nursing students. *Arch Psychiatr Nurs* 2007;21:177-8.
- Waltz CF, Strickland OL, Lenz ER. *Measurement in Nursing and Health Research*. New York, NY: Springer; 2005.
- Patton MQ. *Qualitative research and evaluation methods* (3rd ed). Thousand Oaks, CA: Sage; 2002.
- Lash AA, Kulukac O, Buldukoglu K, Kukulcu K. Verbal abuse of nursing and midwifery students in clinical settings in Turkey. *J Nurs Educ* 2006;45:396-403.
- Griffin M. Teaching cognitive rehearsal as a shield for lateral violence: An intervention for newly licensed nurses. *J Contin Educ Nurs* 2004;35:257-63.
- Stevens S. Nursing workforce retention: Challenging a bullying culture. *Health Affairs* 2002;21:189-93.
- Bartholomew K. *Ending Nurse-to-Nurse Hostility: Why Nurses Eat Their Young and Each Other*. Marblehead, MA: HCPro; 2006.