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Recalibrating Normalcy: Healing Perspectives of Provisional Critical Care Nurse Leaders

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Abstract

The purpose of this research was twofold: to explore the paradox existing between nursing as a healing occupation and the normalized violence occurring within the profession, as such, to inform from the perspectives of healing and cultural recalibration; and, secondly, to investigate the perspectives of charge nurses who may or may not have recognized psychological trauma, transformed pain, or transcended woundedness from lateral violence in the workplace. With the deployment of a lifeworld, phenomenological method, combined with the nurse as wounded healer theory, this study qualitatively measured and thematically captured the descriptive essence of nine provisional critical care leaders or charge nurses, practicing in the New York State area. A sequence of semi-structured interviews and qualitatively organized research questions rendered four compelling and emergent themes: (a) charge nurse identity, (b) acknowledgment of colleague moral injury, (c) transformational intent, and (d) the transcending normalized practices. In conjunction with the emergent themes, the four findings were revealed: (a) nurses identified strongly and equated their efficacy with the duration and tribulations associated with their social preparation; (b) nurses were able to demonstrate situational awareness and acknowledgement of laterally violent behaviors; (c) nurses were able to describe their personal commitment to the charge nurse role, including actual, as well as potential, corrective measures; and (d) nurses instinctively accommodated wounded colleagues and accompanied them onto a trajectory of healing. Conclusions from this study informed recommendations for the recalibration of nursing processes, nursing leadership, and social justice.

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Dedication

First and foremost, I dedicate this dissertation to my Lord God, for whom all things come to fruition. To my elders who have gone home, Wilma and Gus Alex, Jesse and Lucile Jackson, and Janice and Robert Drummond, I know that, without fail, you still guide my hands. To my parents, Jerome, Linda, and Anthony, thank you for constantly revitalizing my spirit and my life. To my children, Johaun Jr., Khalia, Khiandra, Sophia, and James, it has been my life's honor to be your father; your support has been undeniably divine throughout my life. To my closest of cousins, Djaun, Eric, and Jamie, thank you for keeping me safe. To all of my Jackson/Alex family, you have carried me when I have fallen, encouraged me when I was weak, and protected me when I was afraid; I love you all. To my healthcare family, you have shaped and molded me over the course of two decades, and for this I am eternally grateful. I also dedicate this body of work to the magnificent faculty at St. John Fisher College. To my committee chair, Dr. C. Michael Robinson, who taught me to not just trust the process, but to respond to the challenges of any process. To my committee member, Dr. Cynthia Smith, undeniably a beacon and facilitator of greatness. To my advisors, Drs. Quigley and VanDerLinden, with the broken pieces I presented you, you both helped to make me whole. To my cohort, Confidimus Processus Six, forever my friends and forever my family. Finally, to my foundation and my life spring, my wife, Nicole Drummond-Jackson. Every step we have taken, we have taken them together. The light that you shine onto me, I will take throughout this life and into the next; I love you.

Biographical Sketch

Johaun T. Jackson is currently a Critical Care Registered Nurse serving as an educator for Loreto Health and Rehabilitation in Syracuse, New York. Mr. Jackson attended LeMoyne College from 2008 to 2012 and graduated with a Bachelor of Sciences degree in Nursing. He continued his studies at Lemoyne College from 2015 through 2017 and graduated with a Master of Sciences degree in Nursing Education. He came to St. John Fisher College in the summer of 2018 and began doctoral studies in the Ed.D. Program in Executive Leadership. Mr. Jackson pursued his research in "Recalibrating Normalcy: Healing Perspectives of Provisional Critical Care Nurse Leaders" under the direction of Dr. C. Michael Robinson and Dr. Cynthia Smith and received the Ed.D. degree in 2020.

Abstract

The purpose of this research was twofold: to explore the paradox existing between nursing as a healing occupation and the normalized violence occurring within the profession, as such, to inform from the perspectives of healing and cultural recalibration; and, secondly, to investigate the perspectives of charge nurses who may or may not have recognized psychological trauma, transformed pain, or transcended woundedness from lateral violence in the workplace.

With the deployment of a lifeworld, phenomenological method, combined with the nurse as wounded healer theory, this study qualitatively measured and thematically captured the descriptive essence of nine provisional critical care leaders or charge nurses, practicing in the New York State area. A sequence of semi-structured interviews and qualitatively organized research questions rendered four compelling and emergent themes: (a) charge nurse identity, (b) acknowledgment of colleague moral injury, (c) transformational intent, and (d) the transcending normalized practices.

In conjunction with the emergent themes, the four findings were revealed: (a) nurses identified strongly and equated their efficacy with the duration and tribulations associated with their social preparation; (b) nurses were able to demonstrate situational awareness and acknowledgement of laterally violent behaviors; (c) nurses were able to describe their personal commitment to the charge nurse role, including actual, as well as potential, corrective measures; and (d) nurses instinctively accommodated wounded colleagues and accompanied them onto a trajectory of healing. Conclusions from this

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Chapter 1: Introduction

Nurses represent the largest division of allied health workers in the United States, totaling more than 3 million in practice, with approximately 500,000 of those nurses practicing in critical care areas (BSNedu.org, 2020; Institute of Medicine, 2011). Critical care settings, such as emergency departments (ED) and intensive care units (ICU), contend with medically complex and profoundly ill persons requiring continuous monitoring of vital life functions. More than 5 million patients are admitted annually to U.S. ICUs for intensive or invasive monitoring; support of airway, breathing, or circulation; stabilization of acute or life-threatening medical problems; comprehensive management of injury and/or illness; and maximization of comfort for dying patients. (Lakanmaa, Suominenb, Perttila, Puukkae, & Leino-Kilpi, 2012; Society of Critical Care Medicine [SCCM], 2020). As an occupational subculture of healthcare, critical care nursing is qualified by implicit values, adaptations, and normalized behaviors specific to the clinical setting (Kennerley et al., 2012; Moore & Gaviola, 2018).

Moore and Gaviola (2018) described a culture as the summation of habitual behaviors, traits, and values supporting the routinized or normal existence of a social group. As such, compassionate, competent, knowledgeable, altruistic, and hypervigilant are some of the accolades used to define the culture of critical care nursing. Aligning with this pedagogy, critical care nurses are trained in the facilitation of intensive restorative services to vulnerable individuals. Through structure and control, critical care nursing intentionally demonstrates its recognition of duty through adaptations such as efficiency

and hypervigilance (Blake, 2016; Moore & Gaviola, 2018). As a vocation of caring, rooted in the philosophies of curing and healing, it is almost inconceivable that violence could prevail as an additional descriptor of the nursing culture. Lateral violence, which is displaced violence directed against one's peers rather than against one's adversaries, is deeply embedded within the continuum of the professional nursing culture, and it has been well described since before the start of the 1990s (Wilson, Diedrich, Phelps, & Choi, 2011). In the absence of a universal definition, studies have used terms, such as horizontal hostility, incivility, bullying, and microaggression, to describe the violence that is experienced, as well as perpetrated and perpetuated, by nurses (Ventura-Madangeng & Wilson, 2002).

Workplace violence is subdivided into acts—physical and psychological. Actions, such as hitting or slapping, occur with physical violence, whereas psychological violence arises from incidences such as verbal abuse and intimidation (Liu et al., 2018; Van De Griend & Hilfinger, 2014). In nursing, psychological, nonphysical violence arises when unsuitable, nonphysical interactions occur within the workplace setting, such as yelling, demeaning comments, withholding of pertinent information, or intentional humiliation (Coursey, Rodriguez, Dieckmann, & Austin, 2013; Shapiro, 2018; Shea, Sheehan, Donohue, Cooper, & De Cieri, 2017). When such acts occur between two or more persons who work on an equal level within an established hierarchical system, the directionality of violent behavior is considered as *lateral* (Shapiro, 2018; Spector, Zhou, & Che, 2014). This study converged on the residual trauma and woundedness imparted by psychological, nonphysical injuries occurring in the workplace between nurses of

equal position or administrative capacity. For the purpose of this study, the term *lateral workplace violence* is utilized to illustrate this phenomenon among nurses.

Laterally violent behaviors are common where curing and procedural expertise are valued over the interpersonal processes of healing (Christie & Jones, 2014; Vessey, DeMarco, Gaffney, & Budin, 2009). The combination of tension-charged atmospheres and increasingly complex patient care needs exert continuous pressure that often potentiates aggression between nurses (Mealer et al., 2014; Moss, Good, Gozal, Klienpell, & Sessler, 2016; Vessey et al., 2009). Adding to the stress of demanding patient needs, nursing roles in these critical care areas are often in flux. Provisional critical care nurse leaders are nurses who often fill temporary or intermittent leadership capacities. Commonly referred to as *charge nurses*, these healthcare professionals are sanctioned to direct others while temporarily executing limited administrative duties at the unit level or on a designated work shift (Eggenberger, 2012). Viewed as frontline workers, these charge nurses frequently return to nonadministrative roles. When this occurs, charge nurses experience heightened exposure to nurses with equal status and influence (Eggenberger, 2012). This power differential plays an essential role in the frequency and incidence in which laterally violent behaviors are observed, as provisionally empowered nurses struggle to govern nurses of equal rank (Eggenberger, 2012).

Christie and Jones (2014) and Liu and Chiang (2017) contended that conventional preparation fails to empower nurses with coping mechanisms against a workplace culture replete with pernicious psychological violence. When persistent and unacknowledged lateral violence occurs, nurses may acquiesce to wounded, maladaptive behaviors such as

aggression and defensiveness (Vessey et al., 2009). Prolonged exposure to lateral violence has been associated with various negative consequences for nurses and organizations (Schat & Kelloway, 2003) by individuals inflicting lingering, cumulative, and psychologically traumatic effects, which often decrease a nurse's ability to deliver optimal treatment, compromising patient care delivery and safety (Christie & Jones, 2014). Additionally, Becher and Visovsky (2012) reported that victims of lateral violence suffer from anxiety and depression, suggesting that powerlessness and anger triggered by lateral violence has levied psychological effects ranging from low self-esteem to suicidal behaviors. In fact, many nurses who have experienced the traumatic effects of lateral violence have subsequently considered leaving, or have left, the profession, damaging healthcare organizations and contributing to the national nursing shortage (Huntington et al., 2011). Characteristically intense and distressing, trauma produces psychological harm and social maladaptation (Shapiro, 2018).

According to McPhaul and Lipscomb (2004), nurses also experience psychological trauma from lateral violence as a direct result of underreporting, complexity, and a work culture that is resistant to the notion of nurses simultaneously operating as victims and perpetrators (McPhaul & Lipscomb, 2004; Tee, Ozcetin, & Russell-Westhead, 2016). Nurses adopt values of unspoken behaviors and discourses as a result of the patient care environment (Tame, 2012). Data from Jacobson's 2007 study of lateral violence in the workplace reveal that only 19% of nurses filed a formal report after an incident, 38% talked to a colleague about the incident, and others claimed that work pressures did not allow time for a formal report. Christie and Jones (2014) concurred, stating that violent behaviors between nurses often are deliberately displayed in a manner

that only other nurses are sensitized to recognize. Laterally violent behaviors are commonly masked, subtle, and repeated. Escalating slowly over time, lateral violence has become an accepted and normalized aspect of the nursing culture. The ethos of the nursing culture, entwined with professional relational dynamics, formed from intense workplace demands, often result in various acts of physiological violence of which Conti-O'Hare (2002) described as *woundedness*:

> The term wound describes an injury caused by a traumatic event. Whether physical or psychological, wounding indicates how an injury has in fact occurred. Whatever the source, a neglected wound can profoundly affect an individual, imparting long-term and maladaptive repercussions. When psychological wounding exists, devoid of recognition or resolution, the enduring trauma results in woundedness. (p. 51)

Although Conti-O'Hare (2002) concluded that nursing is a wounded profession, riddled with unresolved psychological trauma, and desperately searching for a process of healing, McGlone (1990) advocated that nurses continue to perform healing work, despite the socialization into a practice culture eroded by interprofessional violence and woundedness. Concepts of healing and curing are deeply imbedded within the nursing culture. McGlone (1990) purported that a distinction must be made between the definitions of curing and healing, as these terms are commonly viewed synonymously, but frequently they exist antithetically McGlone (1990).

Curing exemplifies an incomplete and linear dimension of wellness, strictly concerned with illness from the perspectives of a cause, effect, and final solution (Conti-O'Hare, 2002; Jackson, 2004). Essentially, curing assumes that the causative agent has

been or will be eradicated. As such, in today's medical community, registered nurses are professionally indoctrinated into curing through the application of therapeutic methods, surgical procedures, and pharmacological interventions (Federman, 1996).

Conversely, healing exists in a continuum situated to address human beings with vigilance and unconditional positive regard (Conti-O'Hare, 2002). Healing embraces the notion that the degree of woundedness may ebb and flow with intervention, but the inceptive wounds remain ever present (Christie & Jones, 2014). Facilitating the healing of others requires intentionality and the adoption of a belief system that recognizes all of life's experiences (McGlone, 1990). This acceptance informs reflection that empowers nurses to explore personal meaning in lived experiences and opportunities for integrating, changing, or recalibrating the modalities of healing (Jackson, 2004; McGlone, 1990). Though initially facilitated by an external event or person, the act of healing is intrinsically driven by those who have been wounded (Christie & Jones, 2014).

Nursing leaders serve as inspirational role models, employing clarity, as such, to affect the environmental, behavioral, and cultural experiences of subordinate nurses (Wilson, Paterson, & Kornman, 2013). Rather than recognizing the need for healing, the lens of the nursing leadership continues to focus on the action of curing. Obscured in culture and social dialogue is the capacity of nurse leaders to conceptualize the resultant, normalized behaviors as detriments to the individual, organization, and profession. As such, problem resolution in the form of patient care policy and nursing protocols becomes prioritized above interconnectedness (Jackson, 2004; Liu & Chiang, 2017). Although, lateral violence has been identified as a deeply embedded cultural problem within the nursing profession, Conti-O'Hare (2002) suggested that nurses serve as instruments of

healing when an openness is facilitated to enhance opportunities for others to feel secure, to realign a disharmony, and to gain the capacity to recover from woundedness. As a human service-oriented profession, nursing addresses vulnerable individuals through the promotion of physical and psychological healing (Christie & Jones, 2014). As a culture that facilitates the healing of others, Jackson (2004) suggested that nursing philosophies may be healed through those nurses who have recovered from such woundedness. Conti-O'Hare (2002) posited that nursing leaders must identify, transform, and transcend conventional notions of curing and healing from a patient care aspect toward establishing therapeutic connections among nurses to begin a recalibration of the nursing culture.

Recalibration occurs when an object is measured or remeasured against an accepted standard or point of reference to determine any deviation, as such, to ascertain the degree or factors of proper correction or adjustment (Merriam-Webster, n.d.). Recalibration of nursing's cultural normalcy involves the deconstruction and analysis of the traits supporting the presumed behaviors of nurses in the workplace. For the recalibration of the nursing culture to occur, the degree to which charge nurses acknowledge colleagues behaviors consistent with normalized lateral violence, psychological trauma, and woundedness were examined. Data collected from the lived experiences of nursing leaders in this study served as a basis for the recognition and interpretation of this phenomenon.

Problem Statement

McPhaul and Lipscomb (2004) stated that healthcare continues to lead all other industries in incidences of violence. Brous (2018) reported that healthcare workers experienced 9,200 occurrences of workplace violence, accounting for more than 67% of

violence-related reporting across all industries. Although this deliberate behavior can be openly displayed, it is commonly perpetrated subtly, over time, and in most instances, it goes unreported (Jacobson, 2007).

Lateral violence among nurses has been identified and exhaustively explored. When persistent and unacknowledged lateral violence occurs, nurses acquiesce to wounded, maladaptive behaviors such as aggression and defensiveness (Vessey et al., 2009). Obscured in culture and social dialogue of nursing practice is the capacity of critical care charge nurses to conceptualize the resultant and normalized behaviors of their colleagues.

This study set out to determine the degree to which charge nurses acknowledged and described peer behaviors that are consistent with normalized lateral violence, trauma, and psychological woundedness. Data collected from the lived experiences of these nursing leaders served as a basis for the recognition and interpretation of the elements of this phenomenon.

Theoretical Rationale

This study was guided by the theory of the wounded healer, arising from the philosophical and psychological healing theories of Carl Gustav Jung (1964, 1969). Edinger (1984) referred to Jung as the father of analytical psychology and a nativist, or one who seeks to discover what is inherently present within himself. Jung (1964) wrote of social justice, defining the world as socially galvanized through the psychological development of individuals and the healing processes of transcendence. Jung (1969) believed that it is a person's quest for connectedness that is unique, but connectedness must always be experienced in relation to the world and other people. Jung (1969)

suggested that a misconception exists whereby individuals must be free from troubles in order to be effective healers. All too often, nurses are reluctant to reveal themselves as healers because of the potential for vulnerability, primarily created by an orientation toward perfection and flawless performance (Conti-O'Hare, 2002). Schwab, Napolitano, Chevalier, and Pettorini-D'Amico (2016) stated that if nursing is to be an expression of healing for others in the healthcare system, the profession must make its own trauma visible. Jung (1969) referred to this healing perspective as *professional vulnerability*.

Drawing on the work of Jung (1969), Conti-O'Hare (2002) expanded the concept of professional vulnerability, conceiving the theory of the nurse as the wounded healer. Conti-O'Hare inductively reasoned that nursing was a profession in need of a healing process, where self-examination and transformation could be facilitated (Schwab et al., 2016). Conti-O'Hare (2002) emphasized the appropriateness of psychologically wounded nurses utilizing a healing paradigm to facilitate the healing of past psychological trauma within others. Exploring the concept of unresolved personal or professional psychological trauma, wounded healer theory couples traumatic pain recognition with a process of transformation and transcendence (Conti-O'Hare, 2002).

Walking wounded theory advances three primary assumptions. The first assumption is that all human beings experience trauma in their lives. According to Christie and Jones (2014), both conscious and subconscious factors, derived from personal experiences, drive human behavior. The second assumption posits that without intervention, pain from traumatic experiences are carried throughout life (Christie & Jones, 2014). Consequently, according to Conti-O'Hare (2002), individuals who are traumatized physically or psychologically, personally or professionally, and who are

divested of meaningful resolutions to past transgressions, harbor a sustained woundedness, and they can be identified as the *walking wounded*. The third and final assumption recognizes that nurses embracing a transformative process of self-reflection and spiritual growth can achieve an expanded awareness. As a result of this transformation, preexisting trauma is ameliorated, as nurses transcend the pain and become wounded healers (Christie & Jones 2014). This conduit to healing is dependent upon the achievement of three milestones: (a) recognition, (b) transformation, and (c) transcendence.

Recognition of woundedness is the initial step of the healing process for those who have been affected by psychological trauma. Acknowledgment of vulnerability, shame, or guilt encourages nurses to enter into the process of healing (Conti-O'Hare 2002). According to Jung (1964), openness to vulnerability, rather than clean hands or an untarnished history, represent a core virtue of the healing process. Secondly, the walking wounded must transform the pain caused by existing wounds. Christie and Jones (2014) described this process as the seeking of affirmation and the control over feelings through the sharing of painful experiences. The walking wounded who are seeking transformation, harness energy from past-acknowledged and reconciled psychological trauma to enhance their perceptions of the present (Conti-O'Hare, 2002; Shapiro, 2018). Finally, the walking wounded transcend the effects and strongholds of past pain by restructuring them with positive energies and evoking a higher level of understanding, permitting a simultaneous sharing of experiences and healing of others (Conti-O'Hare, 2002). Catalyzed by the acknowledgment of woundedness and transformation of pain, the walking wounded transcend their existing psychological trauma and subsequently emerge

as wounded healers, as seen in Figure 1.1. Conti-O'Hare (2002) stated that wounded healers can arise from a state of crisis to an existence of personal transformation. This awakening empowers the wounded healers' innate ability to articulate past woundedness and facilitate the healing of others (Christie & Jones, 2014).

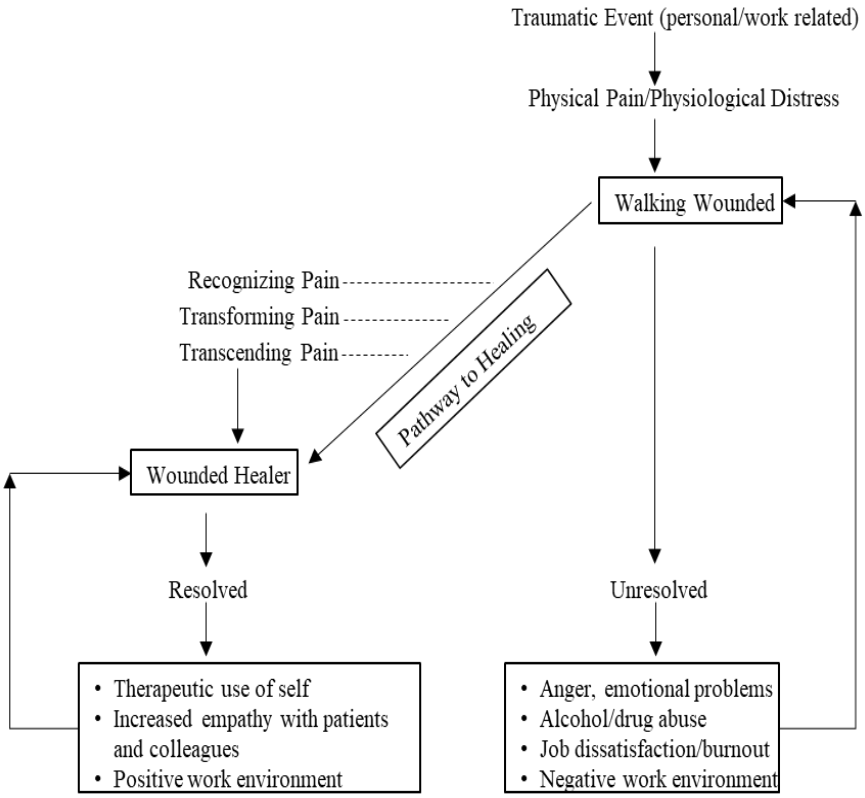

Figure 1.1. Theory of the Nurse as the Wounded Healer. Adapted from "The Theory of the Nurse as a Wounded Healer," by M. Conti-O'Hare (2002). Copyright 2002 by Jones and Bartlett Publishers.

With the walking wounded existing on one end of the trauma continuum and the wounded healer residing on the polar opposite end, distinct attributes of each group take form. Walking wounded nurses deny inner conflicts and vulnerabilities, projecting the

pain of past psychological trauma onto colleagues while considering themselves unharmed (Christie & Jones, 2014). As a consequence, walking wounded nurses lose the capacity to empathize with others. Conversely, wounded healers intentionally facilitate the healing of the walking wounded as a direct result of their reconciled psychological trauma (Conti-O'Hare, 2002; Schwab et al., 2016).

Research Questions

This study sought to address the following research questions:

1. What actions by colleagues inform charge nurses of laterally violent behavior as defined by this study?
2. What corrective actions do charge nurses recommend in the reduction or elimination of laterally violent behaviors exhibited by colleagues?
3. What behaviors indicate that a charge nurse has shifted personal behaviors to support colleagues affected by lateral violence as defined by this study?

Potential Significance and Purpose of the Study

Evidence suggests that lateral violence is considered an accepted norm within the culture of nursing (Giddings, 2005; Lather, 1986). A gap in the empirical research exists in the recognition of a process suited to recalibrate the cultural normalcy that is interfering with nurses' ability to identify lateral violence as a psychologically traumatic phenomenon. The potential significance of this study resides in the acknowledgement, transformation, and transcendence of psychological trauma. Theoretically, this research could align the efforts of healthcare employers, nursing educators, healthcare policy makers, and frontline nurses. Data collected within this study can potentially drive hiring practices, nursing curriculum design, and policy creation, situating each facet to identify

and mitigate lateral violence. Furthermore, by providing insight into cultural norms and contextually obscured woundedness, other industries may gain insight into the measures of recalibration designed to heal toxic workplace cultures. Although this study relies upon the perceptions of charge nurses, this discourse could be expanded to address any populous, thus setting the stage for further, industry-specific research.

Lateral violence in nursing continues to occur as a result of the profession's preponderance of individuals suffering from unresolved psychological trauma and unrecognized woundedness (Shapiro, 2018). The purpose of this study was twofold: to explore the paradox that exists between nursing, as a healing occupation and the normalized violence occurring within the profession, as such, to inform perspectives of healing and cultural recalibration; and, secondly, to investigate the perspectives of charge nurses who may or may not have recognized psychological trauma, transformed pain, or transcended woundedness from lateral violence in the workplace. To capture this data, a qualitative, descriptive, phenomenological research design was implemented with charge nurses practicing within New York State.

Chapter Summary

Chapter 1 provided a summation of the culturally normalized phenomenon of lateral violence embedded within the profession of nursing. Concurrently presented were the facets of continuing education, leadership, and the guiding theoretical framework of the walking wounded and walking wounded healer. When lateral violence between nurses goes unchallenged, behaviors become culturally normalized and perceived as appropriate (Vessey et al., 2009). Subsequently, the purpose of this study was twofold: (a) to explore the paradox between nursing, as a healing occupation, and the culturally

normalized violence that exists within the profession, and (b) to investigate the perspectives of charge nurses who may or may not have recognized psychological trauma, transformed pain, or transcended woundedness from lateral violence in the workplace.

Chapter 2 provides a review of the literature, elucidating the pervasiveness, recognition, and cultural perception of lateral violence in the nursing culture. Following the review of the literature, Chapter 3 describes the methodology and research design for this study. Chapter 4 presents an analysis of the interview data gathered during the study, and Chapter 5 provides a summary of the study findings, conclusions, and subsequent recommendations.

Chapter 2: Review of the Literature

Introduction and Purpose

Current empirical studies strongly support the existence of the inherent lateral workplace violence within nursing. Such acts of aggression lead to burnout, staff turnover, and eventually poor patient outcomes (Becher & Visovsky, 2012). Unfortunately, acts of violence have become commonplace and accepted in the practice of nursing (Palaz, 2013).The following literature review is concerned with the pervasiveness of lateral violence, nurse leaders' recognition of the phenomenon, and the cultural perceptions of these normalized behaviors among nurses.

Pervasiveness of Lateral Violence

The pervasiveness of lateral violence has had a significant impact on nursing, with evidence strongly suggesting a noticeable increase in occurrences across various settings (Ventura-Madangeng &Wilson, 2002). Thomas and Burk (2009) examined nurse-to-nurse lateral hostility and violence committed against nursing students. In this qualitative study, 221 Turkish junior Bachelor of Science in Nursing (BSN) students ranged from ages 20 to 22. As part of their graduation requirements, the students submitted journals of their collected experiences. With the permission of the students, the researcher obtained the written accounts for examination. Narratives were discarded if students did not consent for them to be retained. Participation in the research was not considered in the computation of the student grades. Narratives were coded for thematic organization. Three primary themes emerged from the Thomas and Burk (2009) study:

- Students perceived that they were unwanted and ignored.
- Students felt as if their assessments were distrusted and not believed.
- Students were exposed to public humiliation, especially in the presence of patients.
- Registered nurses' behavioral characteristics, described by the student nurses, were consistent with the intergenerational transmission of pathology termed *eating our young*.

A study conducted by Tame (2012) investigated the relationship between continuing professional education and lateral violence in the nursing practice setting. The purpose of the study was to examine the link between workplace culture and the intra-professional conflict associated with the acquisition of education. A descriptive or lifeworld qualitative framework was deployed with a purposive sampling of local, perioperative nurses. Participants were acquired through the electronic distribution of invitations and local nursing databases. Letters were also sent to nurses not appearing in the database to ensure the inclusion of all eligible participants. All data was anonymized and collected through audiotaped, semi-structured, face-to-face interviews. Analytical memos were examined immediately after the interviews to capture any residual, salient themes. Of the 23 nurses participating in the study, each had 2.5–25 years' experience in the nursing field (Tame, 2012).

Incompatibility, instigation, and obstruction were the three themes that emerged from the study. Within the theme of incompatibility, participants suggested that the culture of nursing practice was not always conducive to nurses' educational development (Tame, 2012). The pursuit of academic qualifications could be seen by colleagues as a

negative aspiration that detracted from the practice of caring (Tame, 2012). Second, participants perceived themselves as targets for lateral violence as a direct consequence of academic study. Tame (2012) discovered that negative attitudes and resentment from peers existed within unsupportive environments, as nurses seeking advancement through education were looked upon as instigators of change. Finally, participants described instances of academic obstruction. Utilizing terms, such as sabotage, participants expressed perceived hindrances to studies caused by colleagues (Tame, 2012). Participants acquiring an education sensed that nursing leaders felt threatened by the prospect of becoming obsolete or replaced. Demonstrating a general lack of interest and support, nursing leaders were perceived as passive impediments to academic growth.

Park, Cho, and Hong (2014) researched the prevalence and perpetrators of workplace violence against nurses to examine the relationship of work demands and justice in the workplace with the occurrence of violence. In this qualitative study, the investigator utilized a convenience sample within a university hospital in Seoul, South Korea. The sample consisted of 1,027 registered nurses across 48 patient care units. Data were collected with the Copenhagen Psychosocial Questionnaire. The themes emerging from the questionnaire included: nurses perceiving greater work demands and less justice were more likely to have been exposed to violence. The prevalence and perpetrators of violence varied considerably among nursing units. The study also reported that nurses with less nursing experience were more likely to experience violence from nurse colleagues. The Park et al. (2014) study demonstrated the articulation of lateral violence and perpetrators. Increasing generalizability, the researchers identified multiple and culpable healthcare disciplines that contributed to the phenomenon of lateral violence.

In a mixed-methods study of 3,835 Chinese registered nurses, Zhanga et al. (2016) studied the prevalence of workplace violence against Chinese nurses and associated influencing factors. Participants were randomly selected from 28 area hospitals and hand distributed a structured questionnaire. Of 4,125 distributed surveys, 3,835 were returned, demonstrating a response rate of 92.97%. A logistic regression analysis revealed that the nurses who had less experience or who worked in emergency departments, had low empathy levels, and they had greater odds of experiencing acts of violence. The study reported that nurses with less experience may lack the necessary defense mechanisms to safely navigate the practice terrain, subjecting themselves to more frequent acts of violence. Nurses operating in critical care areas suffered the highest risk of workplace violence. Lack of empathy correlated with violence among emergency department nurses. Empathy plays a vital role in nurses' routine work, and it is a significant predictor of beneficial clinical outcomes in patients (Zhanga et al., 2016). The regression model used in the study evaluated variables such as relationships with other healthcare professionals, nurse participation in hospital affairs, and working rotating schedules. By examining these and other variables, the researchers created a robust variety of possible contributing factors for future studies. As violence among nurses in critical care settings emerge as a global issue, collaboration on a global scale may lend itself to the creation of viable solutions.

Researchers, Liu et al. (2016), conducted a qualitative study of workplace violence, job satisfaction, burnout, and perceived organizational support and their effects on turnover intention among Chinese nurses in tertiary hospitals. In this qualitative study, the impact of the organizational support and turnover intention was analyzed against

nurses in Chinese tertiary hospitals. With a purposive sampling of 2,067 nurses from nine area hospitals, an anonymous, self-administered questionnaire was distributed along with face-to-face surveys. The study demonstrated strength and statistical significance in its demonstration of workplace violence and its positive association with turnover intention. Furthermore, turnover intention was also negatively correlated with job satisfaction. Burnout was positively associated with turnover intention. The Liu et al. (2016) study demonstrates a strong correlation between the harmful elements of workplace violence and nursing behaviors.

Tee (2016) explored the nature and the scope of workplace violence that nursing students experienced during clinical placement. In a cross-sectional, associational study of 657 nursing students, a questionnaire measuring violence exposure was deployed. Nearly 42.18% of the students indicated they had experienced bullying or harassment while on a clinical placement. The results demonstrate an unacceptable prevalence, and Tee (2016) the results should raise an alarm for those delivering nursing education. According to reports received from the participants, some of them considered leaving nursing as a profession. Others reported negative effects on patient care (12.3%) and their work with others (25.9%) were negatively affected. Surprisingly, a majority of the students knew where and how to report bullying (51.4%), but only one in five (19%) had actively reported an episode of bullying or violence. Students reported a myriad of negative emotions such as humiliation, confusion, anger, anxiety, and depression.

Cheung and Yip (2017) studied the psychological correlates of workplace violence among professional nurses. The emotional counterparts investigated were anxiety, depression, and stress. In this cross-sectional examination, 850 nurses were

obtained through convenience sampling. A survey was launched, utilizing the database of the Association of Hong Kong Nursing Staff (AHKNS), which represents the largest nursing association in Hong Kong. The web-based survey's response rate was 5.3% and was validated as a reliable self-administered psychological instrument. The prevalence of workplace violence was examined and presented in terms of frequency and the proportion of those encountering it. Quantitative data were analyzed using logistic regressions. Depression, anxiety, and stress scores were categorized into dichotomous, yes or no responses, before being submitted for analysis. Findings within the study demonstrate a positive correlation between workplace violence and the prevalence of anxiety, depression, and stress. Emergency departments, psychiatric units, and intensive care units emerged as the most common sites of workplace violence. Clinical position shift-work rotation, job satisfaction, conflict with colleagues, deliberate self-harm, and symptoms of anxiety emerged with significant correlations with workplace violence (Cheung &Yip, 2017).

Recognition of Lateral Violence by Nurse Leaders

Wong and Lee (2012) conducted a qualitative study of 180 students for the purpose of evaluating a participatory leadership training program. The researchers hypothesized that leadership training would be effective in increasing self-esteem and self-efficacy in secondary school students. Participants were randomized into an intervention group (n = 50) and a control group *(*n = 130). The control group did not participate in any training, while the intervention group participated in a 6-month program of leadership training and service learning. Service-learning activities included community services and friendship building with single living seniors in underprivileged

regions. Gender-stratified analysis of both the control and intervention groups revealed a rejected hypothesis. Leadership training was not effective in increasing self-esteem and self-efficacy in secondary school male students. Male students in both the control and intervention groups demonstrated no significant difference in self-esteem or self-efficacy. The utilization of service-learning activities had implications for the creation of models that could be applied to professions and organizations. Although the hypothesis met with rejection, the design and purpose may have an undiscovered utility in the professional world. Acquiring fundamental, service-leadership skills grounded in self-efficacy and self-esteem has the potential to engender healing mechanisms for nurses exposed to acts of psychological lateral violence.

Wilson et al. (2013) completed a qualitative study of person-centered leadership from a convenience sample of 21 nursing unit managers. Wilson et al. (2013) reported that beneficial leadership attributes included the ability to act as an inspirational role model as well as employing clarity. In this qualitative study, researchers designed inclusive group discussions with facilitators, experienced in both transformational facilitation and leadership. During the general meetings, the facilitators deployed a nursing leadership model that focused on critical reflection, self-learning, development of strategies, and enabling others. Prior to the conclusion of the study, three participants failed to complete as a result of competing responsibilities. Reflective journals were thematically coded and centered around the formation of groups, retention of professional support structures, transitions into practice, self-image formation, personal positive outcomes, and positive outcomes for others. The strength of this study was demonstrated in the organization and the scripted function of the focus groups. The placement of a

skilled facilitator drove the underlying purpose of the interactions, allowing for an abundant and purposeful description of events. Another notable strength was the distillation of the thematic coding. Each journal was systematically coded in a four-step sequential process. The value of this study resides in its proposed function of leadership enlightenment. Wilson et al. (2013) stated that as lateral violence among nurses persists, the fortitude of nurse leaders will require galvanized and concerted efforts to acknowledge this phenomenon.

Hoffman and Silverberg (2015) launched an evaluation of a global health education experience aimed at training the next generation of global health advocates. This mixed-methods study was conducted with 19 undergraduate health sciences and art students. The students were obtained by way of convenience sampling and were concurrently enrolled in the 12-week, college-level experiential education course focused on global health. Eight data sets were analyzed: five sets of graded work and three sets of ungraded work. Self-reflections, peer feedback, and portfolios were all obtained at the course's end. The students were confined within the boundaries of the course and expected to complete all associated tasks, assignments, and reflective journaling. As with any other collegiate-level course, formative and summative evaluation was incorporated. Coding of written work, reflections, and course evaluations revealed a rich description of the students nature and character, with the following themes: student advocates and empowerment, knowledge and skill acquisition, behavior changes for future, and learning about one's self. As a result of the study, three significant themes emerged: (a) authenticity is a key motivating factor, (b) experiential education is particularly

effective at teaching real-life skills, and (c) group dynamics in experiential education can affect learning.

Fitzpatrick, Modic, Van Dyk, and Hancock (2016) evaluated leadership education and development as a program designed to transform care by empowering clinical nurses to become leaders. In this qualitative study, two distinct cohorts were developed. The first cohort included nurses who worked full time as direct care providers (n = 33). The second cohort included nurse managers (n = 35). All of the selected participants were sampled from nine local hospitals, as well as 18 family health centers. Leadership practices were observed after the implementation of a leadership-specific training program, which evaluated at the end of the program, and 3 months after completion of the program. Fitzpatrick et al. (2016) reported that both cohorts experienced a significantly increased perception of the frequency with which they demonstrated leadership practices. Participants collectively reported value in the writing of their biographies, especially when compared to the leadership progression, as a result of the program.

Brann and Hartley (2017) conducted a quantitative study examining the deployment of an online course focusing on nursing student evaluations of workplace violence and prevention. This quantitative study assessed pre and posttest performance on an online course to educate nurses about violence prevention. A convenience sample of 60 nursing students with a BSN were solicited. The final survey sample included 48 students, out of 55, who completed the workplace violence prevention online course, resulting in a 79% participation rate. Students were tested before the online class, and again 4 weeks after the class. The study revealed a statistically significant difference

between the pre- and post-test awareness and knowledge scores. Brann and Hartley (2017) statically revealed that the course helped increase students' awareness of workplace violence prevalence. Content retention was significant, with reproducible results across both awareness and knowledge. The Brann and Hartley (2017) study demonstrated a generalizability that could potentially be applied to other industries.

Cultural Perceptions of Normalized Behaviors

Wilson et al. (2011) studied the impact of horizontal hostility on nurses working in a hospital setting with intent to leave. Horizontal hostility, also referred to lateral violence, was described as overt infighting among nurses, passive-aggressive behavior, and the intentional withholding of pertinent information (Wilson et al., 2011). The qualitative study sought to the determine the degree of lateral violence in the workplace and the extent to which perceptions of lateral violence affected the likelihood of nurses leaving their existing positions. The investigators began this study with a 28-item survey modeled after two validated survey tools: (a) the American Association of Critical Care Nurses (AACN) survey from the study *Silence Kills* (Maxfield, Grenny, McMillan, Patterson, & Switzler, 2005) and (b) the Lateral Violence in Nursing Survey. The Wilson et al. (2011) study surveyed registered nurses at a community hospital in the Southwest United States. Surveys were collected several times weekly throughout a 2-month period. Representing a 26% response rate, 130 surveys were completed. Participants were from inpatient units including telemetry, medical/surgical, maternal/child, pediatrics, orthopedics, and critical care. Of the respondents, 68% (n = 76) had at least 10 years of experience in their existing role. As a result of the study, nearly 40% of the participants disclosed the intent to leave their positions or they were considering leaving their

positions as a result of exposure to lateral violence. Lateral violence exerts a profound influence in the hospital setting on nurse job satisfaction and well-being, contributing to high turnover rates.

Freeman, Fothergill-Bourbonnais, and Rashotte (2013) studied the lived experiences of nurses working in designated trauma units. Guided by a qualitative approach, the researchers gathered a purposive sample of seven female registered nurses. This type of research design places its value on the lived experiences of the participants. Group discussions and taped interviews, lasting 60-90 minutes, provided the researchers with an adequate data source. Field notes were completed immediately after the interviews. Follow-up interviews were conducted with participants in order to determine if the analysis reflected their description, supporting the trustworthiness of the study. Through the process of questioning and comparison, being on guard all the time, feeling scared, and feeling disrespected emerged as dominant themes. Unlike other studies, this research outlined acts of violence committed by patients. Trauma nurses consistently spoke about feeling scared when taking care of young male patients who were admitted to the trauma unit as a result of gang-related activities. Nurses reported operating in fear of visitor retaliation after measures to ensure the peace had failed. Participants also expressed frustration at being unable to provide care as a result of the patients' persistent negative attitudes. These feelings were heightened when the nurses were given the same assignment for several days to promote continuity of care. These observations demonstrate another source of violence encountered by nurses. These exposures inform the practice identity of critical care nurses working within the units.

Freeman et al. (2013) reported that despite feeling challenged emotionally to work with patients who had caused harm to others, trauma nurses embraced their nursing obligations, committing to providing nursing care. Nurses in the critical care setting were able to see beyond the workplace violence to find meaning and satisfaction in their work. Freeman et al. (2013) posited that this observation will expand future research on the resilience of professional registered nurses.

Galian-Munoz, Ruiz-Hernandez, Llor-Esteban, and Lopez-García (2016) conducted a qualitative study of extrinsic job satisfaction and the relationship between nonphysical violence and emotional exhaustion. Utilizing a self-administered anonymous questionnaire, the nursing staff of 11 public hospitals yielded a participant pool of 1,489 randomly selected health professionals. The ages ranged between 20 and 67 years (*M* age = 42.09, *SD* = 9.75). Most of the participants were female (82.7% vs. 16.4%). Of the female nurses, 62.1% had a nursing diploma, and 36.7% were auxiliary nurses with a mean job tenure in the current post of 7 years and 5 months (*SD* = 97.57 months), and mean job tenure of 15 years 4 months (*SD* = 112.08 months). The study demonstrated that violence correlated positively with emotional exhaustion and negatively with job satisfaction. The study also revealed that job satisfaction played a protective role in the psychological health of workers exposed to nonphysical violence, and they were less likely to suffer burn out—even in the presence of aggression. The strengths of this study were noted by cyclic description of violence and emotional exhaustion. Galian-Munoz et al. (2016) purported that measures to suppress violence may have served to improve the emotional condition of nurses and reduce their burnout. Identification of workers at risk

for psychological stress, such as those in critical care areas, could serve as the impetus for the creation of proactive management strategies (Galian et al., 2016).

Chapter Summary

Chapter 2 provided a review of literature, expounding on the pervasiveness of lateral violence, leader recognition of the phenomenon, and the culturally normalized behaviors among nurses. Current research exhaustively discusses these occurrences in isolation, but it struggles to intimate them succinctly. Chapter 3 presents the methodology, instruments, participants, and analytical processes used to examine the connectiveness of theses phenomena and respond to the posed research questions.

Chapter 3: Research Design Methodology

General Perspective

The focus of this study was to determine the degree to which charge nurses perceived peer behaviors consistent with lateral violence and normalized psychological woundedness. Data collected from the lived experiences of nine provisional nursing leaders or charge nurses, catalyzed the recognition and description of this phenomenon.

A descriptive phenomenological methodology illustrated the presence of personal transformation, situated to detect and potentially recalibrate suspected or actual psychologically wounding behaviors of critical care nurses. This approach provided succinct depictions of emergent narratives and lifeworld accounts of the participants' experiences. This study investigated the phenomenon of lateral violence amongst critical care nurses by deploying the following research questions:

1. What actions by colleagues inform charge nurses of laterally violent behavior as defined by the study?
2. What corrective actions do charge nurses recommend in the reduction or elimination of laterally violent behaviors exhibited by colleagues?
3. What behaviors indicate that a charge nurse has shifted personal behaviors to support colleagues affected by lateral violence as defined by this study?

Research Context

New York State has the third-highest number of employed registered nurses in the country (BLS, 2017). The New York State Education Department, Office of the

Professions (2020) reported that 323,126 registered nurses are currently licensed throughout the state. At the time of this study, nine New York State critical care registered nurses self-selected their participation.

Research Participants

Phenomenological studies benefit from a concentrated focus on approximately five to 10 cases, with in-depth, sequenced interviews concerning participants' experiences and/or descriptions of a particular phenomenon (Durdella, 2019; Smith, Flowers, & Larkin 2012). Aligning with the phenomenological tradition, this study included a participant cohort of nine charge nurses working within the New York State area. All participants within this study met the following criteria for inclusion:

- Licensure as a registered nurse through the New York State Office of Professions
- At the time of the interview, working with 3 or more years of experience in a critical care setting
- Charge nurse experience in a critical care setting

The participants were representative of a robust, diverse assortment of gender, age, and ethnicity. Additionally, the participants discussed their years of nursing practice and duration of charge nurse preparation, as seen in Table 3.1. This information was provided during the preliminary introductory questions of the study. Initially, this data did not seem to resonate with the particular aims of the research but, later, it proved to be beneficial when analyzed with other data culminating from the research questions.

Table 3.1

Participant Demographics

Participant	Gender	Age range	Ethnicity	Years in critical care practice	Charge nurse preparation
Billy	Female	35-40	Caucasian	15	6 months
Star	Female	35-40	African American	16	6 months
George	Female	40-45	Caucasian	22	2 years
Renee	Female	40-45	African American	21	6 months
Celeste	Female	45-50	African American	10	1 year
Tony	Male	30-35	Caucasian	5	1 month
Block	Male	35-40	African American	4	3 months
Max	Male	45-50	Caucasian	7	3 months
Harry	Male	45-50	Caucasian	13	2 years

Recruitment procedures included a purposive sampling of potential participants through the professional networking platform LinkedIn (Appendix A). Self-selected, prospective participants were contacted via email with a follow-up phone discussion. After verbal confirmation to join the study was received, each prospective contributor was emailed a detailed invitation to confirm their intent to participate. This instrument provided each potential candidate with a brief overview of the researcher's overall intent and direction of the study (Appendix B).

Polit and Tatano Beck (2012) indicated that establishing trust, ensuring confidentiality, and obtaining permission are vital components of any research endeavor. In this study, the creation of trust began at the onset of each semi-structured interview, with a 20-30 conversation about the phenomenon under investigation. Pietkiewicz and Smith (2014) supported this action by suggesting that warm-up conversations reduced the participants' tension in preparation for discussions laden with potentially sensitive or personal matters.

The participants self-selected their pseudonyms for this study to secure their anonymity. As a result of the in-depth nature and small number of research participants in qualitative studies, investigators need to take extra precautionary measures to safeguard identities (Polit & Tatano Beck, 2012). For this reason, only general descriptions of work and training conditions, coworkers, and other identifying information were utilized during the data collection process.

Polit and Tatano Beck (2012) suggested that informed consent was based upon a potential participant's evaluation of the potential risk and benefits of participation, as such, critical information must not only be communicated but also understood. Acquiring permission from the participants was conducted in two phases. During Phase 1, each participant received an informed consent form (Appendix C) via email to review, explicitly communicating the study's procedures, expectations, and protocols. To inform the presence of a mutual understanding, Phase 2 consisted of a review of the informed consent form, along with any procedural clarifications. Once completed, the participant and the researcher electronically signed, and each retained a copy of the informed consent form for their respective records.

In acknowledgment of this study and its potential impact, all participants were provided the opportunity to express concerns or reservations at any time during the interview. Furthermore, the participants were informed, if at any time they should experience discomfort during the video interview or when recalling events, the researcher would redirect inquiries or, if necessary, end their participation. This safeguard was put into place in the event that a participant could not complete an interview; however,

despite the emotional attachments and displays of emotional connection demonstrated by some of the participants, this measure never required activation.

Instruments Used in Data Collection

According to Creswell and Creswell (2018), qualitative studies frequently utilize the researcher as the first data collection tool. In honor of this concept, and with adherence to the qualitative tradition, this study utilized the primary researcher and the interview protocol (Appendix D) as the data collection instruments.

When the researcher serves as an in instrument of data collection, he or she is permitted to discover the spontaneity and uniqueness of the participants' lifeworlds, thus enabling the researcher to achieve a more direct contact with the phenomenon as it was lived rather than as it was conceptualized (Bendell, Sutherland, & Little, 2017; Creswell & Creswell, 2018). In essence, the researcher brings forth and bears witness to a human being's account of subjective experiences (Silverman, 2006; Willis, Sullivan-Bolyai, Knafl, & Cohen, 2016). This study sought to immerse the primary researcher into the lived experiences of the participants in an effort to garner the richest descriptions of their experiences.

Bevan (2014) suggested that the interview was, by far, the most dominant method of data collection in phenomenological research. Such inquiry begins by exploring a phenomenon from the perspective of those who have experienced it firsthand (Matua & Van Der Wal, 2015). For this study, an interview protocol was developed to elicit descriptive or lifeworld accounts of each participant's encounters. Combined with analytic memos, the interview protocol comprised three, broad opening questions, followed by six research-driven inquiries. Descriptive questions are generally broad,

open-ended, and presented in the participant's common language, allowing for opportunities of expression from his or her vantage point (Bevan, 2014). Von Eckartsberg (1986) revealed:

> It is through thematized verbalization of the reflected experience that we gain access to the phenomena experienced, in its natural attitude and meaning. If we accept the supposition that vocabulary is shared through culture and community whereby the experience is identified, then interviewing is an appropriate means of explicating lifeworld experience. (p. 138)

The study sought to directly interface with each of the participants through intentional and methodologically guided conversations.

Procedures for Data Collection and Analysis

After obtaining consent, 90-minute, semi-structured, one-on-one video interviews were conducted and captured on two independent digital MP_3 devices. In light of the COVID-19 pandemic and associated social distancing procedures, video conferencing on the Zoom video platform provided the most effective and safe means of conducting the live interviews.

A descriptive interview protocol was deployed (Appendix D) to facilitate a productive and meaningful exchange with each of the 90-minute, semi-structured interviews. A series of open-ended questions was utilized to assist in focusing the participants on their experiences. According to Creswell and Creswell (2018), qualitative interview protocols include (a) basic information about the interview; (b) introductions; (c) opening questions; (d) content questions; (e) probing questions, such as "tell me more," "I need more detail," and "could you explain your response more?"; and

(f) closing in. Following each question, there was a moment of member checking, performed to confirm alignment between with the participants' lived experiences and the interpretation of said experiences.

Interview recordings were imported into the coding and data analysis software platform, NVivo, for transcription and storage. Each of the files was labeled with various identifiers or tags. This process staged each file for retrieval and future coding. The transcriptions were completed within the NVivo and stored as files or cases. These cases served as the primary repository for all coding and analytic memos specific to each individual participant. This structure permitted the analyzation and coding of the live experience of each participant prior to comparison with the other cases.

After establishing the case structures, a secondary framework for data sorting and storage was constructed. This arrangement consisted of four primary sections for analytic memos and interview data gathered from all of the established cases, they were: Introduction Questions (IQ), Research Question 1 (RQ1), Research Question 2 (RQ2), and Research Question 3 (RQ3). These sections or nodes served as points of aggregation for specifically tagged data, which eventually allowed for the comparison and contrast of all of the participants' lived experiences in reference to each other.

Under each node, sub-nodes correlating with the study's first two levels of coding were established. The first coding sub-node was tagged *in vivo*, and the second was *concept*. Saldaña (2016) suggested that in vivo coding prioritizes and honors the voice of the research participants. The in vivo sub-node contained the literal statements of each charge nurse, intentionally recorded and stored with all of the participants' professional vernacular intact. The concept sub-node contained words and short phrases, all of which

symbolically represent the broader meanings of the in vivo codes. Conceptual processes consist of smaller observable actions and ideas that culminate into more comprehensive schemes (Saldaña, 2016).

Transcripts were read cyclically and compared to their respective recordings to garner a familiarity with not just the words but with the emotions, expressions, and mannerisms captured in the analytic memos. During this comparison, superfluous and/or redundant elements of speech were redacted for clarification, rendering precise representations of each participant's case and description of lateral violence among colleagues.

To establish a meaningful connection with the data and the participant responses, in vivo coding was performed in the first cycle. The nurses communicated in a language specific to the culture of healthcare. In vivo coding and the verbatim principle allowed the researcher to derive meaning directly from the words and phrases of the participants within a particular culture or subculture (Saldaña, 2016).

The concept coding was conducted in the second cycle. Saldaña (2016) suggested that concepts imply ideas rather than observable objects or behaviors. Concepts also refer to processes such as surviving or coping (Saldaña, 2016). After acquiring knowledge from the literal perspectives of the participants, concept coding supported the goal of progressing toward idea formation specific to the study population.

Finally, axial coding was performed in the third cycle. Axial coding's primary purpose is to identify the dominant and most representative themes in the data (Saldaña, 2016). Axial codes informed by concept codes are sharpened to achieve the best fit within a study (Saldaña, 2016). The selected coding methods served to reduce data to its

fundamental or essential form. The intention was to yield the most representative codes and the emergent themes for the study.

Considerations for this descriptive phenomenological study were the collection of naïve descriptions of the participants' experiences, analysis of said experiences, and the rendering of the universal essence or eidetic structures of lateral violence among nurses. The investigator must seek out the substance of the phenomenon divested of any preconceptions in order to maintain its richness, breadth, and depth (Smith et al., 2012). In honor of the phenomenological procedural traditions for data collection and analysis, the processes of bracketing, reflexive journaling, phenomenological reduction, and imaginative variation were all incorporated into this study.

Smith et al. (2012) defined bracketing as a process that allows researchers to concentrate their perceptions on the object of study. Bracketing or epoché describes the suspension of a researcher's subjectivities, beliefs, and preconceived notions about the phenomenon under investigation (Durdella, 2019; Saldaña 2016). This integral step informed the study in two explicit ways: (a) by supporting the formation of a lasting awareness and intentional separation from preconceived notions associated with lateral violence and (b) to create a conduit through which the participants could openly articulate experiences of lateral violence, unencumbered by researcher bias.

Reflexive journaling was performed before, during , and after each interview. Audio-recorded analytic memos provided the study with in-the-moment descriptions of each participant's reactions, expressions, and feelings.

With the study's fundamental constructs in place, the methodological tradition of phenomenological reduction was engaged. This data analysis action organizes

information into tangible, meaningful statements of lived experiences (Durdella, 2019). This reduction was achieved through the examination of each individual participant case, while conceptually clustering and memoing each research question's response to its corresponding node. As part of the reduction process, axial coding was performed to illuminate the most representative codes. In axial coding, redundant findings are removed, similar codes are combined, and data are reorganized around newly formed categories (Saldaña, 2016).

The exploration of meaning from the segmented elements of data introduced the phenomenological process of imaginative variation. In this fundamental step, Durdella (2019) expounded the utilization of one's imagination, varying the frames of reference, and the approaching of a phenomenon from divergent perspectives, positions, and roles. This study's research questions invoked imaginative variation through their descriptions of lateral violence among registered nurses, as witnessed by the provisional critical care leaders. Emergent themes were subjected to peer review by two doctoral candidates, the investigator's dissertation chair, and the dissertation committee member for validity and congruency with the research and associated questions.

All relevant research-related data are stored electronically on a dedicated computer with a back-up, encrypted cloud data-storage device. Analytic memos, audio recordings, transcripts, and all research-related materials are archived and secured in a double-locked safe in the researcher's home. After all participant-related procedures and study findings were made available electronically to the participants upon request. All materials are being retained for the Institutional Review Board (IRB)-designated duration of 3 years after publication of this manuscript, and all will be summarily destroyed once

that period has passed. Monitoring of the project activities was facilitated through biweekly updates with all research participants and the dissertation committee.

Chapter 4: Results

Serving as inspirational role models, nursing leaders employ a sense of clarity that permeates the environmental, behavioral, and cultural experiences of subordinate nurses (Wilson et al., 2013). This study set forth to determine the degree to which provisional critical care nurse leaders, or charge nurses, acknowledge and describe peer behaviors consistent with normalized lateral violence, trauma, and psychological woundedness. Sequestered from the lived experiences of critical care charge nurses, this study captured their descriptive essences of observed lateral violence.

With respect to the COVID-19 pandemic and associated social distancing recommendations, video interviews were performed via the Zoom online platform. The participants were comprised of nine New York State critical care registered nurses. Under the pseudonyms Bob, Max, Harry, Renee, Block, Tony, Celeste, Star, and George, these self-selected contributors were audio recorded and video interviewed with a semi-structured, qualitative research protocol (Appendix D) that provided rich and descriptive accounts of lateral violence in their respective critical care workplaces.

Audio recordings were transcribed, checked for accuracy, and electronically deposited as files or cases into the qualitative data analysis software platform NVivo. The cases operated as the primary repositories for all coding and analytic memos specific to each individual participant. Data stores or nodes were later designed as segregated aggregation points for codes stemming from all the cases. In the phenomenological research tradition, the processes of segregation, coding, clustering, and thematizing

served as the primary vehicles of thematic data analysis (Durdella, 2019; Peoples, 2020). Aligning with this pedagogy, 1,117 segregated codes (Appendix E) informed the development of the concepts, the conceptual clusters, and the emergent themes.

This study acknowledges a *concept* as an abstract unit of meaning that reveals a feature or trait of the phenomenon under investigation (Peoples, 2020). By way of segmentation, these concepts form the basic building blocks of data transformation from the participants' interviews into arranged theorized patterns of the participants' stories (Durdella, 2019). Data analysis revealed 30 separate, unique, and comparable concepts (Appendix F). Similar concepts were assembled to give rise to conceptual clusters.

This study identifies *conceptual clusters* as an assemblage of multiple concept codes. Within these clusters, all concepts shared notable similarities and parallels. Simultaneously, however, each concept was distinct enough to represent a separate expression of the data. As a result of this analytical structuring, eight distinct conceptual clusters surfaced (Appendix F). Clusters sharing like qualities were subsequently united to form emergent themes.

Within this study, the analytical task of phenomenological reduction yielded the construction of cases, nodes, concepts, and conceptual clusters, each specifically designed for the purpose of data stratification. This division also set into motion the progression and formation of *emergent themes.* Operating as a compilation of the conceptual clusters, the emergent themes represent the most salient convergences of the participants' descriptions of lateral violence among their colleagues. For the purpose of this study, thematically organized data were examined by (a) descriptive responses to the three research questions and associated interview questions, (b) situating the narratives

from each participant, (c) unanticipated findings that occurred during the data collection, and (d) a summarization of the results.

Research Questions

This descriptive phenomenological study was designed with two specific intentions: (a) exploring the paradox existing between nursing, as a healing occupation, and the normalized violence occurring therein; and (b) acquiring descriptive accounts of charge nurses who may or may not have recognized psychological trauma in colleagues, transformed pain, or transcended woundedness from lateral violence in the workplace. With these guiding intentions, two introductory questions and three primary research questions were designed. Each research question was addressed by two specific interview questions, each question was presented in the commonly used language of the participants (Appendix D). Three salient themes emerged from the research questions: (a) acknowledgment of colleague moral injury, (b) transformational intent, and (c) transcending normalized practices (Appendix F).

Research Question 1. *What actions by colleagues inform charge nurses of laterally violent behaviors as defined by this study?* This query was designed to elicit details from the participants about their recognition of lateral violence in the workplace specifically perpetrated by colleagues. The following concepts were acquired through two specific interview questions, noted in Table 4.1 and Table 4.2.

Concepts. These concepts were clustered through the process of imaginative variation to give rise to an overarching major theme.

Accusatory – one's predisposition to charge others with fault or offense.

Aggressive –one's predisposition to confrontational readiness.

Defeated – the behavior of an individual exhibiting an overwhelming loss of emotional protective mechanisms.

Dismissive –one's predisposition to regard situations or others as unworthy.

Direct observations – when a charge nurse is informed of the presence of lateral violence by way of seeing, hearing, or bearing witness.

Direct reports – when a charge nurse is alerted to acts of lateral violence by subordinate nurses.

Emotionally labile –observable, unpleasant fluctuations of moods.

Evasive – the actions of an individual attempting to escape a potential, or actual, unpleasant person or situation.

Intuition – when a charge nurse is alerted to acts of lateral violence through instinctive feelings rather than conscious reasoning.

Investigation – when a charge nurse is alerted to acts of lateral violence through a self-directed process of systematic study or examination.

Oppressive – the behaviors of individuals who purposely and unreasonably burden others.

Persecutory –one's predisposition to seek the punishment of others.

Retaliatory –one's predisposition toward seeking actions of revenge.

Territorial –behaviors exhibited by a person actively defending an actual or perceived zone of influence.

Conceptual clusters. Similar concepts were assembled to give rise to conceptual clusters.

Charge nurse alerted to lateral violence – any activity that informs a charge nurse to the presence of lateral violence.

Perpetrator behavior – the manner in which an individual conducts oneself when dispatching acts of lateral violence.

Victim behaviors – the manner in which an individual conducts oneself when exposed as the recipient of acts of lateral violence.

Emergent theme. Operating as a compilation of the conceptual clusters, the emergent themes represent the most salient convergences of the participants' descriptions of lateral violence among their colleagues.

Acknowledgement of moral injury – as charge nurses are made aware of lateral violence, the phenomenon simultaneously empowers them to detect and experience situations that are a direct affront to viscerally embedded values (Peter, Simmonds, & Liaschenko, 2018).

The concepts, conceptual clusters, and emergent themes, acquired through the participants' answers to two specific interview questions, are shown in Table 4.1 and Table 4.2.

Table 4.1

Interview Question 1: Give some examples of times when you suspected that acts of lateral workplace violence were occurring among your colleagues.

Excerpts from transcripts	Concepts	Conceptual cluster	Emergent theme
George: If there was a conflict between nurses and it didn't involve me, people would bring it to my attention to help solve. *George:* But other coworkers would come and tell me these two aren't getting along. You know, I think a lot of the violence or conflict was very subtle even passive aggressive.	Direct reports	Charge nurses alerted to lateral violence	Acknowledgment of colleague's moral injury
Celeste: It didn't even have to be an apparent or obvious moment; you could just feel it happening. *Celeste:* I think sometimes when you're in a hospital and you're working as a nurse, you just feel the signs of lateral violence more than you see them.	Intuition		
George: I would check on [them] often if I knew they received a patient that was going to be a challenge for them. New nurses would tell me if others were giving them a hard time. *Star:* It was a union facility and that nurse had been there so long. The facility wanted things documented. And most people aren't willing to write statements, so we had to keep following up with questions and request for statements.	Investigations		
Star: [She] knew that situation was intimidating for anybody, but she would just send the new nurse in the room and tell them "go ahead!" just to watch them fail. *Harry:* They deserve respect. They worked hard. They deserve the respect and the help and teamwork of their coworkers! So, I watched a lot of people leave because they didn't feel it was fair to be victim of this passive-aggressive behavior.	Direct observation		

Table 4.2

Interview Question 2: After witnessing those episodes of lateral workplace violence, how would you describe the behaviors of those involved? The victims and the perpetrators.

Excerpts from transcripts	Concepts	Conceptual clusters	Emergent theme
George: People didn't want to work weekends because they were treated poorly by the same group of people. *Star:* They were miserable. They often ask for a transfer off the floor. *Block:* [She] ended up trying to apply to other places. *Block:* Rather than just trying to find a middle ground between the two or having the person acknowledge that person was wrong or how to do better, they would just switch the preceptor.	Evasive	Victim behavior	Acknowledgment of colleague moral injury
Block: [He] just had a total meltdown. He was in tears. *Block*: I did not feel that they had enough confidence in me. I felt that they second guessed a lot of things that I did. I was a heartbeat away from just giving the fuck up!	Defeated		
Block: That is fucking ridiculous! This guy never, never came to me and acknowledged me as a person, as a man even! *Tony:* Their first emotion that you see is anger. They get angry, act angry, respond angrily. *Renee:* You get angry to the point where you should probably walk away. You just felt violated, angry, and remorseful at the same damn time.	Emotionally labile		
Block: Whether she'll ever get out of this tangled mess; they just accused her of having an undiagnosed learning disability. Who does that?! *Max:* Competence can be questioned. Lifestyle characteristics, social living arrangement. Nurses even make accusations based on social media content.	Accusatory	Perpetrator behavior	
Harry: I would actually watch [her] go and you can actually see her mentally preparing herself to work, like she was walking into a fight, like she was walking into, like, an MMA octagon or something in that nature. *Harry:* Shift-to-shift report was really brutal. This nurse would actually have to brace herself before getting a report from certain people.	Aggressive		

George: And then that was the end of it. In the other nurses eyes, I was a terrible nurse.	Dismissive
Max: They just shrug me off and go on about their business.	
Block: I just felt ostracized, left out.	
Celeste: Always getting either the harder patients or being put in a corner.	
Block: I'm the only Black person on the unit. And no one knows how it feels. You're always being looked at. You're always being double checked. You're always being micromanaged.	Oppressive
Tony: When I'm in charge, I'm in charge dammit! But the senior nurses were trying to micromanage my fuckin' charge nurse role	
George: I see other charge nurses purposely give assignments to new nurses that force them to struggle and require a lot of extra work; not necessarily giving them things that were unsafe, just unfair.	Persecutory
Star: I heard about a lot of it from people who were the victims, and [I] certainly experienced it myself when I was a preceptee. Having my preceptor choose a particularly terrible assignment because it was going to be a "good learning opportunity." That was the one of the key phrases for "this is going to suck."	
Max: So harsh words were generally met with harsher words.	Retaliatory
Max: When the offending person leaves, [they] turn to colleagues who are present, after the other person departs, and then display, again, equal kinds of bad behavior.	
Renee: New nurses were forced to meet with management at the behest of the aggressors, or they may lose their job. Or worst-case scenario, something tragic will happen because people were focused on emotions and not patient care.	
Billy: There's this attitude of only the strong survive, you know, and the weak get weeded out.	Territorial
Block: I felt that they didn't want to give her the keys to the castle. They wanted her to beg and plead.	
Celeste: Theses nurses act like they have proprietary rights to patient care and education, and they will push you around if you let them	

Research Question 2: *What corrective actions do charge nurses recommend in the reduction or elimination of laterally violent behaviors exhibited by colleagues?* This query was designed to elicit details from the participant about measures aimed to mitigate pervasive lateral violence in the workplace. The following concepts were acquired through two specific interview questions, noted in Table 4.3 and Table 4.4.

Concepts. These concepts were clustered through the process of imaginative variation to give rise to an overarching major theme.

Charge nurse responses – actions taken or not taken by provisional leaders in the workplace.

Organizational responses – actions taken by the administrative, governing structures of the workplace as a whole.

Unit leadership responses –actions taken or not taken by the immediate leadership of a section of the workplace, such as a manager or coordinator.

Conceptual clusters. Similar concepts were assembled to give rise to conceptual clusters.

Mechanisms of cultural change – the extrinsic and intrinsic forces affecting the socialization of a specific group.

Emergent theme. Operating as a compilation of the conceptual clusters, the emergent themes represent the most salient convergences of the participants' descriptions of lateral violence among their colleagues.

Transformational intent – the act of revolution may present itself in various phases of completion. Acknowledging the need for change and measures taken toward

said change, are both indicative of intentionality. This theme was designed to acknowledge the presence, or lack, of the rudiments of transformation.

The concepts, conceptual clusters, and emergent themes, acquired through the participants' answers to two specific interview questions, are shown in Table 4.3 and Table 4.4.

Table 4.3

Interview Question 3: Describe your thoughts on how lateral workplace violence is addressed in critical care.

Excerpts from Transcripts	Concepts	Conceptual cluster	Emergent theme
Star: So, I think they try to turn off the issue because people were unwilling to actually speak up.	Organizational responses	Mechanisms of cultural change	Transformational intent
Star: It was called the Horizontal Violence Committee at the hospital, and they would often meet and present scenarios and try to educate people on how to deal with situations and also raise an awareness of attitudes, behaviors.			
Billy: I don't know that it is addressed. I think it's an accepted behavior. Unfortunately, you know, I think it's almost like a rite of passage for nurses to have to go through that and eat their young. There's this attitude of only the strong survive, you know, and the weak get weeded out.			
George: I think some of the managers were scared of the senior staff or were friends with the senior staff that were allowed to be, you know, laterally violent to their coworkers.	Unit leadership responses		
Celeste: I went and talked to my manager the next morning and that nurse made a bunch of accusations about all the stuff that I had supposedly left undone. I was called back to the office and reprimanded.			

Table 4.4

Interview Question 4: If given the opportunity, describe how you would address lateral workplace violence as a charge nurse.

Excerpts from transcripts	Concepts	Conceptual cluster	Emergent theme
George: But we had to consistently document that they were overstepping their bounds and not able to learn, but certainly not while setting them up for failure or the patient to be, you know, in harm's way. *Star:* I would hope that my work environment is comfortable enough so that people just take a moment, come back and address the person to say, you made me feel this way when you did X, Y, and Z. *Billy:* I can't be the best nurse that I can be when nurses are hostile. So, providing education to those nurses that are doing the bullying, you know how that affects not just the nurse that they're doing it to, but the patients that they're doing it to and then having an open line of communication for those employees that are being bullied. So that they have an outlet to look somewhere or to somebody to turn to, because a lot of people don't know how to stick up for themselves, especially when they're just not confrontational. So, we may have to confront issues for them! *Block:* Lateral violence, I would say is the same every time. I think there needs to be a change, and we will have to be the ones to change it.	Charge nurse responses	Mechanisms of cultural change	Transformational intent

Research Question 3: *What behaviors indicate that a charge nurse has shifted personal behaviors to support colleagues affected by lateral violence as defined by this study?* This query was designed to elicit descriptions from participants, indicative of personal transformation and the intentional healing others. The following concepts were acquired through two specific interview questions, noted in Table 4.5 and 4.6. These concepts were clustered through the process of imaginative variation to give rise to an overarching major theme.

Concepts. These concepts were clustered through the process of imaginative variation to give rise to an overarching major theme.

Abstention – instances in which one decides to neither support or condemn an action or behavior.

Academic support – the act of endorsing, reinforcing, and nurturing an individual's transition from practical knowledge to professional application.

Direct confrontation – decisive acts that challenge or oppose the actions or behaviors of others.

Indirect confrontation – nonassertive acts that challenge or oppose the actions or behaviors of others.

Moral support – the act of endorsing, reinforcing, and nurturing an individual's fundamental guiding principles.

Professional support – the act of endorsing, reinforcing, and nurturing an individual's sense of belonging to the profession of nursing.

Conceptual clusters. Similar concepts were assembled to give rise to conceptual clusters.

Calibrating personal narrative – intentional and individualized behavioral adjustments made by charge nurses in response to undesirable, established social norms.

Charge nurses healing wounded colleagues – the restorative actions of charge nurses imparted to colleagues suffering from varied forms of emotional and/or psychological distress.

Emergent theme. Operating as a compilation of the conceptual clusters, the emergent themes represent the most salient convergences of the participants' descriptions of lateral violence among their colleagues.

Transcending normalized practices – when an individual seeks to rise above the abstract boundaries of a professional group, in search of alternative behaviors that align with personal values. As individuals socialize into professional groups, they generally seek conformity by mimicking behaviors, mannerisms, and moral stances. The transcending of normalized practices occurs.

The concepts, conceptual clusters, and emergent themes, acquired through the participants' answers to two specific interview questions, are shown in Table 4.5 and Table 4.6

Table 4.5

Interview Question 5: Describe a time you assisted colleagues in coping after being exposed to lateral violence.

Excerpts from transcripts	Concepts	Conceptual cluster	Emergent theme
George: I would check on them often if I knew that I gave them a patient that was going to be a challenge for them. Well, I know that I rescued a few preceptees in my day. And, so, I guess I did that quite a bit of rescuing because I am the person whom preceptors had to get through in order to get off of orientation.	Professional support	Charge nurses' healing wounded colleagues	Transcending normalized practices
Block: You have these nurses or this new slew of nurses who feel speed is the way to get things done, particularly during emergency situations, because speed is what causes mistakes			
Block: When you go into a unit and you see and you feel that there's no command or you can feel it, you can see it. It's like stark, stark difference from where you're on a unit where everyone helped each other.			
George: They just needed somebody to be patient and talk to them and come at them with an open mind.	Moral support		
Billy: I kind of took her under my wing [to] guide her and, you know, just to kind of say, "you know, don't worry about what other people are thinking."			
Block: People make mistakes all the time, as long as you can recognize that.			
Tony: Somebody was actually emotional to the point where they were they were in tears about something that had occurred, and all you could do, I think at that point in time, is to sit there and listen to the individual and because they want to go. We talked about earlier. The initial response of having that anger. You know, they want to be able to vent their anger out any way that they can. And, you know, it just was an individual and a shared crying and maybe in a chair listening just to be there for that support and to hear what they had to say.			
Celeste: We have to keep [them] confident in what they know. There are so many assaults to their character and knowledge base. If they have a concern, then it should be a learning moment for the both of us, and they should be able to talk to me about it so that we can both learn and grow.			
Harry: I made it a personal point to support that nurse and support them in a positive manner such that their morale was a little bit more filled back up again. I always protect people who don't, who can't, or won't protect themselves. That's just part of my nature.			

Block: I use this as a time to talk to her and try to educate her on knowing the medication *Max:* Part of it also involved a little bit of education to try to help the nurse understand what the provider was wanting them to understand but wasn't taking the time to properly educate them about . . . . And once the education process was there and allowing the nurse to take on some additional knowledge, they felt a bit more comfortable in the situation. *Max:* Addressing any knowledge deficits that were there to allow the nurse to feel as if they were once again confident in their own skills and abilities. Give them the opportunity to allow them to seek me as a resource, which could also help to diffuse the situation.	Academic support

Table 4.6

Interview Question 6: Tell me about an encounter that informed your approach toward a colleague who had perpetrated an act of lateral workplace violence.

Excerpts from transcript	Concepts	Conceptual cluster	Emergent themes
Star: I knew her intention wasn't malicious. Because I knew her attitude and her behavior, I was comfortable talking to her.	Direct confrontation	Calibration of personal narrative	Transcending moralized practices
Renee: Once the aggressive nurse heard her say that she really felt bad and was saying that wasn't her intention. She realized she was making her feel bad. So, I would encourage dialogue.			
Billy: I just told her "I'm here, I'm a person with feelings, and don't fuck with me! You're not going to throw me under the bus!"			
Max: There have been times when I have simply alerted the person that their actions were questionable and that I would certainly be speaking to a supervisor.			
Max: Stay in your lane, kind of thing, to put it in the common vernacular. That's not your place!			
Tony: I told him that I was uncomfortable [with] how he had made [feel]. Feelings of anger and avoidance.			
Renee: You know, I just came right out with it, I didn't sugar coat anything. I asked "what is your problem? What did I do? As registered professional nurse how have I angered you to make you feel like you have to combat me at any given moment or try to sabotage my work ethics?"			
Harry: I actually told her straight up that her conduct was completely unacceptable and that I wasn't going to be treated in that manner and that no one deserves to be treated in the manner that she was treating everyone.			
Star: I think once the aggressive nurse was made aware of her behaviors and how she made the other nurse feel, because the nurse did describe to her that she went home plenty of nights crying and feeling like she wanted to quit.	Indirect confrontation		
Celeste: I try to do so without a personal attack to the best of my ability. Sometimes I would just report the behavior to a manager for them to handle.			

Celeste: Sometimes you make things worse when you address it. It may just be a matter of leaving well enough alone. Some battles are worth fighting and some battles are not. *Tony:* Things needed to be discussed, but I didn't have the time or the patience to confront that asshole! *Block:* You know, before I was striving to be one of them, and now that I'm in there, all I want to do is stay the fuck away from them!	Abstention

Situated narratives. With all of the interviews strategically stored as cases and prepared for thematic analysis, the interview recordings, transcripts, and analytic memos were cyclically reviewed to support connections with the lived experiences of the critical care nurses and their descriptions of lateral violence in the workplace. Tables 4.7 through 4.15 demonstrate the individual reiterations or situated narratives of each participant. The responses were thematically identified to demonstrate each participant's contribution to the emergent themes. The meaning of each participant's experience was highlighted through direct quotes from the interviews.

Table 4.7

Situated Narrative of Participant Billy

Emergent theme and associated research question	Excerpt from transcript
Charge nurses alerted to lateral violence RQ1	*Observations:* Some nurses would tuck their tail between their legs and, you know, stay clear of [them] at all times. *Intuition:* I'm constantly worried about looking behind my back. And is this person going to fuck with me or do anything to me to get me fired?
Descriptions of lateral violence perpetrator RQ1	*Aggression:* And it didn't matter what you said to her, it didn't matter. She would continue to keep kicking you when you were down. And there was absolutely nothing that you could do or say to her that would change her behavior until years later, she ended up getting fired for that behavior.
Descriptions of lateral violence victims RQ1	*Defeated:* Some would put their tail between their legs and, you know, stay clear of people at all times. *Emotionally labile:* And they would rather cry or be angry; that's how you knew they were drowning.
Lateral violence addressed through . . . RQ1	*Charge nurse response:* I feel with nurses in critical care, violence will ALWAYS be the same unless we come together and change it. Accepted culture or not, I won't stand for it.
Charge nurse's support responses to victimized colleagues RQ3	*Moral support:* A lot of people don't know how to stick up for themselves, especially when they're just not confrontational people. We have to teach them, you know, maybe ways or strategies of dealing with cruel people.
Charge nurse's responses to victimized colleagues RQ3	*Abstention:* I don't know if violence is really addressed. I think it's an accepted behavior. Unfortunately, you know, I think it's almost like a rite of passage for nurses, you know, to have to go through that. There's this attitude of only the strong survive, you know, and the weak get weeded out. I don't know that they're necessarily doing it on purpose, like I said, it's like an accepted culture. Sometimes it's just best to stay out of the way

Table 4.8

Situated Narrative of Participant Star

Emergent theme and associated research question	Excerpt from transcript
Charge nurses alerted to lateral violence RQ1	*Observation:* Let me give an example of a nurse who had been on the trauma unit for 7 years. When she was with new nurses, she'd often try scare tactics. And she knew that situations were intimidating for anybody, but she would just send the new nurse in the rooms alone and unprepared.
Descriptions of lateral violence perpetrator RQ1	*Oppression:* One nurse, in particular, knew that certain situations were intimidating for anybody, but she would just send the new nurse in the room and tell them to "go ahead!" and watch them suffer. *Territorial:* That's how I learned to fight it. And [they] can do it the same way. Got to get thick skin if you're going to survive. That's what nursing is about. She felt like if they didn't have thick skin, then they shouldn't be on the trauma unit.
Descriptions of lateral violence victims RQ1	*Defeated:* They were miserable. They often requested for a transfer off the floor. *Evasive:* Eventually [they] just avoided the person or asked others to intervene with the aggressive person.
Lateral violence addressed through . . . RQ2	C*harge nurse response:* I sometimes think just bringing it to people's attention makes them more aware and makes them more cautious of the things. I don't feel like the things that people do are intentional all the time. So, just bringing an awareness may make a change. And that's what I would try to incorporate. People just making the aggressor aware of how they make the victim feel.
Charge nurse's support responses to victimized colleagues RQ1	*Moral support:* I actually encourage people to have a conversation with the nurse that they were threatened by, they described it as hazing. *Professional support:* I knew her intention wasn't malicious. Because I knew her attitude and her behavior, I was comfortable talking to her. So, we both sat down in a room to establish a dialogue.
Charge nurse's responses to victimized colleagues RQ3	*Direct confrontation:* I think once the aggressive nurse was made aware of her behaviors and how she made the other nurse feel, she was remorseful and changed her behavior.

Table 4.9

Situated Narrative of Participant George

Emergent theme and associated research question	Excerpt from transcript
Charge nurses alerted to lateral violence RQ1	*Direct reports:* If there was a conflict between nurses and it didn't involve me, people would bring it to my attention to help solve. But other coworkers would come and tell me "these two aren't getting along." *Intuition:* You know, I think a lot of the violence or conflict was very subtle, even passive aggressive.
Description of lateral violence perpetrator RQ1	*Persecutory:* I see other charge nurses purposely give assignments to new nurses that force them to struggle and require a lot of extra work, not necessarily giving them things that were unsafe, just unfair.
Description of lateral violence victims RQ1	*Defeated:* Some people left. They just didn't want to be the victims anymore. Many of the people that were victims of lateral violence were in their second or third career. *Evasive:* But I did hear from preceptees who didn't want to go to work weekend nights or weekend days because, at that point, there were people on days that were just as nasty.
Lateral violence addressed through . . . RQ2	*Unit leadership:* But I had to consistently document and report to management that they were overstepping their bounds and not able to learn, but certainly not setting them up for failure. I think it was tolerated and hidden, and it was dished out to the newer nurse because they hadn't been there very long. I refuse to behave in this manner, so I protected
Charge nurse's support responses to victimized colleagues RQ3	*Academic support:* They just needed somebody to be patient and talk to them and come at them with an open mind. Teach and talk about critical thinking and patient scenarios. *Professional support:* And, so, I guess, I did quite a bit of rescuing because I am the person who preceptees had to get through in order to get off orientation.
Charge nurse's responses to victimized colleagues RQ3	*Indirect confrontation:* A lot of it was attributed to personality conflicts, or the preceptee not being willing to learn. Either way, I protected them by teaching them to advocate for themselves.

Table 4.10

Situated Narrative of Participant Renee

Emergent theme and associated research question	Excerpt from transcript
Charge nurses alerted to lateral violence RQ1	*Intuition:* You know, they want to vent their anger out any way that they can. Many times the behavior was not obvious. I think that because of the color of your skin, people assume that you will be confrontational, or they may feel like you may not give them the answer that they want. A lot of it was just crap.
Description of lateral violence perpetrator RQ1	*Oppressive:* I watched [her] sit there and meticulously try to create my demise, create my downfall, almost like she wanted me dead. Her attitude and her negativity towards me was not only felt by me, but by others around her who did not agree.
Description of lateral violence victims RQ1	*Emotionally labile:* Stressed, anxious, angry, constantly apprehensive. Not a great combination for patient care.
Lateral violence addressed through . . . RQ2	*Unit management:* So you don't have time to speak and discuss the behavior of someone who's in charge because you have to take care of a critical patient. And the violence continues on that basis, in the open, suddenly, and unopposed. This is a management problem.
Charge nurse's support responses to victimized colleagues RQ3	*Moral support:* I would work with the victimized nurses. Asking [them] to stay over a little bit, even approving overtime to have conversations. If they could. And because these are things that need to and should be addressed, you cannot work faithfully or effectively if these issues are not addressed and taken care of and nipped in the bud.

Table 4.11

Situated Narrative of Participant Celeste

Emergent theme and associated research question	Excerpt from transcript
Charge nurses alerted to lateral violence RQ1	*Intuition:* I sometimes think when you're in a hospital, and you're working as a nurse, you know to look for those signs, the one's the aggressive people give off. I think we miss it simply because we're not used to looking for it. But I do notice. *Observation* I saw a lot of preceptees asking other people questions simply because of that fear of senior staff. Fear of being wrong, fear of rejection, fear of being ignored, fear of looking stupid or being, you know, just ridiculed.
Description of lateral violence perpetrator RQ1	*Dismissive:* I remember sitting there after a long night of doing charge and being completely ignored in the morning. And then they proceeded to go into our rooms where we make the assignments and give out the day's assignments without even talking to me.
Description of lateral violence victims RQ1	*Evasive:* And I saw a lot of preceptees asking questions of people other than their preceptors simply because of fear, fear of being wrong, fear of rejection, fear of being ignored, fear of looking stupid, fear of being, you know, just ridiculed.
Lateral violence addressed through . . . RQ2	*Charge nurse response:* We need to teach people how to communicate with each other. Because the first person that you should really address if you're having conflict is the one that you have the conflict with. Folks don't know how to go to each other and just communicate without being aggressive.
Charge nurse's support responses to victimized colleagues RQ3	*Academic support:* There's other people like me who are there to support them and teach them to still remain confident in what they do know. I'm not one to educate by fear.
Charges nurse's responses to victimized colleagues RQ3	*Direct confrontation:* When I see folks being picked on because that's really what it boils down to, I step in. There's nothing worse than watching somebody becoming a victim.

Table 4.12

Situated Narrative of Participant Tony

Emergent theme and associated research question	Excerpt from transcript
Charge nurses alerted to lateral violence RQ1	*Observation:* You know, just people's egos, the demeanor, the way people carry themselves. They put on this poker face, and you know it's not consistent with their emotions or the way they carry themselves. They just have that look of frustration on their faces. *Investigation:* I try to try to appease everybody's feelings. And, you know, when you make rounds, you can see it in their body language. If they've got an issue or not.
Description of lateral violence perpetrator RQ1	*Aggressive:* I had a more-senior nurse trying to micromanage my charge nurse role. I mean, she was just yelling at me like I was her stepchild.
Description of lateral violence victims RQ1 :	*Emotionally labile:* And, usually, nurses would just come in and help, no problem. But, that day, he was just so distant that I didn't choose him to be my partner and the look of frustration on his face was just overpowering. Their first emotion that you see is anger, more than anger, its rage.
Lateral violence addressed through . . . RQ2	*Unit leadership:* I don't think violence is addressed at all. I think it's just case by case, individual by individual. You can eliminate some violence as a charge nurse and try to get individuals to talk about their situation, but you may really need the manager. *Charge nurse response:* I think that it's important for the charge nurses to recognize that and try to turn the outlook away from the situation and just to focus on the patient.
Charge nurse's support responses to victimized colleagues RQ3	*Moral support:* It wasn't a lot of talking on my part. And, just like I said, listening to what they needed to get off their chest was more beneficial than disciplining them.
Charges nurse's responses to victimized colleagues RQ3	*Direct confrontation:* When I confronted my coworker, I was uncomfortable, but the feelings of anger and avoidance were making me even more uncomfortable.

Table 4.13

Situated Narrative of Participant Block

Emergent theme and associated research question	Excerpt from transcript
Charge nurses alerted to lateral violence RQ1	*Observation:* It was actually the first time I saw someone essentially get bullied in the ICU. The young nurse didn't look forward to going to his preceptor. He was constantly getting down on himself when he could not complete a task. He had a total meltdown; in tears and quit that day.
Description of lateral violence perpetrator RQ1	*Dismissive:* I felt ostracized, and instead of using the opportunity to educate me, they sat there and made fun of and talked about me. Frequently, I would be the recipient of dirty looks.
Description of lateral violence victims RQ1	*Emotionally labile:* I remember the new guy. He didn't look forward to going to his preceptor and frequently had total meltdowns. We would find him in tears, getting down on himself when he doesn't do a good job, or he doesn't get something. He would almost be like . . . constantly paranoid.
Lateral violence addressed through . . . RQ2	*Unit leaders*hip: Lateral violence, I would say, is the same every time. Management needs to do something. I think there needs to be a change, and I feel like the word the verbiage [they] use to describe it is very lighthearted and less abrasive than what it really needs to be to accurately describe the problem, the real problem, trying to understand, trying to talk to somebody when you know you have a problem with them.
Charge nurse's support responses to victimized colleagues RQ3	*Moral support:* Giving people a sense of security or giving, you know, someone a safe place to gain some level of understanding; letting them know that we all make mistakes. What makes you a critical care nurse is that you can think on your toes, not work on your toes.
Charges nurse's responses to victimized colleagues RQ3	*Direct confrontation:* People are not always aware of their behaviors, which is no excuse. So, we just have to keep fuckin' reminding them.

Table 4.14

Situated Narrative of Participant Max

Emergent theme and associated research question	Excerpt from transcript
Charge nurses alerted to lateral violence RQ1	*Observation:* Many times, people choose not to acknowledge each other; that's one way of dealing with conflicts. They might return the behavior in kind and be equally as violent in return if provoked. Sometimes there is a period in which they will isolate themselves, presumably to process emotion and then return to the floor looking composed. There have even times when an individual has broken down in tears. So, an emotional display, such as crying, could really signify anger.
Description of lateral violence perpetrator RQ1	*Territorial:* I noticed in their home life or when they are outside of work, they don't have that power. So, as soon as they came into the job, they felt that because of their own personal experiences, and because their own knowledge, that they had power and needed to show it.
Description of lateral violence victims RQ1	*Defeated:* So, an emotional display in terms of crying would be anger. There are times when people choose not to acknowledge each other; that's one way of dealing with it. There have even been even times when an individual has broken down in tears.
Lateral violence addressed through . . . RQ2	*Unit leadership response:* We can talk about the dynamics between colleagues that seem to inhabit the nursing profession. When faced with intolerable behavior, I simply would alert them to the fact that the actions were questionable, and I would be speaking to a direct supervisor in the morning.
Charge nurse's support responses to victimized colleagues RQ3	*Academic support:* Part of change also involves providing a little bit of education to try to help the new nurse understand what is expected of them. And once the education process has taken place, allowing the nurse to take on some additional knowledge, they felt a bit more comfortable in critical situations.
Charges nurse's responses to victimized colleagues RQ3	*Abstention:* I see less of an opportunity to deal with lateral violence simply because everyone is doing their best to work together. Some people don't believe that the charge nurse is invested with the same sort of leadership as a proxy supervisor.

Table 4.15

Situated Narrative of Participant Harry

Emergent theme and associated research question	Excerpt from transcript
Charge nurses alerted to lateral violence RQ1	*Observation:* I would do my best to help them, but those individuals that I want to say, unfortunately received the worst treatment, were new the individuals. And they just didn't deserve to be treated in such a despicable manner.
Description of lateral violence perpetrator RQ1	*Territorial:* I worked with a veteran nurse who was absolutely horrible, not just to new nurses, but to everybody. But she was, for some reason, regarded as an amazing caretaker. She seemed to go on an absolute warpath against not just me but other new nurses that were on the unit.
Description of lateral violence victims RQ1	*Emotionally labile:* I would actually watch [her] mentally preparing herself to go into report like she was walking into a fight, like she was walking into like an MMA octagon or something. She would cry in the middle of talking to me, then trying to laugh her pain away.
Lateral violence addressed through . . . RQ2	*Organizational response:* Lateral violence can be addressed in dramatically different ways, depending on which facility you are actually standing in at the time. I have worked in facilities that could not care less. And I worked in other facilities that were very much proactive.
Charge nurse's support responses to victimized colleagues RQ3	*Moral support:* If we train ourselves to see information, despite the fact that it was offered in a hurtful manner, we can see past the people delivering said information. Listening skills during intense situations help nurses to process aggressive communication without sacrificing their personal integrity.
Charges nurse's responses to victimized colleagues RQ3	*Direct confrontation:* A direct conversation with all parties independently is a great place to start. It needs to happen because, I mean, we work very long shifts, and we end up seeing our coworkers, sometimes more than we actually see are our own damn families.

Unanticipated findings. Over the course of this study, the participants openly and often vividly connected with the introductory questions. Testimonies from these three opening queries were initially designed to begin discussions with the participants. However, the responses from the charge nurses yielded rich dialog with potential thematic connotations. After an iterative analysis with subsequent coding, unanticipated concepts were discovered and clustered through the process of imaginative variation to give rise to a fourth emergent theme as noted in Tables 4.16 through 4.18.

Concepts. These concepts were clustered through the process of imaginative variation to give rise to an overarching major theme.

Duration of training – the quantity of time invested by an organization into the basic preparation of a critical care charge nurse.

Lateral violence description – a charge nurse's applied meaning of aggressions occurring among peers rather than adversaries.

Nursing moral obligation – intrinsically driven behaviors associated with the principles of right and wrong.

Nursing task obligation – extrinsically driven behaviors strictly associated with the completion of an assigned duty.

Perception of training –the charge nurses' applied meaning and awareness of critical care preparation.

Rigor of training –the charge nurses' observations of the accuracy, exhaustiveness, and precision of critical care instruction.

Conceptual clusters. Similar concepts were assembled to give rise to conceptual clusters.

Cultural acclimation – the transformative process by which one becomes accustomed to the behaviors and influences shared by a particular group.

Lateral violence sensitivity – the degree to which one is aware of hostilities between individuals of equal status.

Mission setting – the actions by which one chooses to represent personal, deeply held beliefs and values.

Emergent theme. Operating as a compilation of the conceptual clusters, the emergent themes represent the most salient convergences of the participants' descriptions of lateral violence among their colleagues.

Charge nurse identity – As critical care nurses endure various rites of passage into the clinical arena, they are also faced with the task of assuming the mantle of leadership. This learning experience serves as the crucible in which qualities, such as conformity, awareness, and guiding principles, are forged. Temperaments emerging from charge nurses' training inextricably inform their distinctiveness and sensitivity to the healing needs of others.

Tables 4.16 through 4.18 demonstrate the concepts and conceptual clusters stemming from the answers to the introductory questions.

Table 4.16

Introductory Question 1: Tell me how you were trained to serve as a charge nurse in critical care?

Excerpts from transcripts	Concepts	Conceptual clusters
Billy: I've been a nurse for 15 years. So, first, obviously, you know, you get trained to the bedside. Then I was a new grad at the time, so I didn't get introduced to the charge role for about a year. There was never really an opportunity for me to be a charge nurse at the time, but when the time came, the training was really just 2 days' worth of orientation. *Star:* I received 6 months of training as a charge nurse in critical care while doing a travel assignment upstate. I have been a nurse for 16 years. *George:* I had prior charge experience, so they let me do charge class immediately after I was off my orientation in the ICU, meaning that I was through my basic orientation. This went on for about 2 years. *Renee:* I was hired without critical care experience. I came in with educator experience, management experience, and home-care experience, women's health experience. So. critical care was definitely a new element for me. Orientation lasted for about 6 months. *Celeste:* I went straight from being a graduate RN straight into the critical care unit. I remember being trained as a charge nurse probably a year and a half into being a critical care nurse. *Tony:* They made it mandatory that individuals get trained as charge nurse, and I was very resistant to that. My training process was barely a damn month! It just really included a sit down with the coordinators for a few hours. *Block:* I have been an RN for 4 years. [They] do the training and then they have you shadow them for 2 to 3 months before I had to go for charge. And it was not until they literally had no one for charge at night. That's when I was voluntold to do charge. *Max:* Orientation for charge entailed a simple 4-hour class and about 3 months of observation from management, or at least it did for me. *Harry:* As far as the training is concerned, there is kind of a boilerplate training that everybody gets in critical care. My charge training lasted for about 2-3 years.	Duration of training	Cultural acclimation
George: I had to have intensive modality training before I could go to charge class for the hospital. *Renee:* I had a core training of advanced cardiac life support, pediatric advanced life support training. I had lots of training, but despite the good critical care training, I still struggled to delegate and make out the assignments. *Starr:* Teaching consisted of medications, specific patient populations, telemetry cardiac drips, conscious sedation, and how to deal with radiation patients suffering from laryngeal or throat cancer. *Billy:* You know, I worked for state facilities, teaching hospitals. So, there was a lot of, you know, residents. They really counted on the nurses to give them lots of pointers as far as taking care of people. At the same time, there was a tremendous amount of education given to me. I learned things that just couldn't be taught from a book. But training was really only like 2 days' worth of just logistics and tasks. *Block:* And it wasn't like they gave me any notice beforehand. It was, like, one day I came in, and shit, I'm being told that I'm charge for the night!	Rigor of training	

Max: I think entails a simple 4-hour class, or at least it did for me. A lot of it was just reviewing policies and procedures of the unit. *Tony:* And, I mean, it was just a few hours, the training process. [They] showed us the computers and other technology that we would have to use as charge nurses to help transfer patients in and out. There was no leadership involved. I just tried to mold the specific behaviors that I saw, that were more desirable, into my own. I taught myself. *Celeste:* You know, it seemed kind of quick to transition into the charge nurse role. I remember being very concerned whether or not I could do the role and feeling just overwhelmed as to whether or not my colleagues would listen, because I feel like there was a lot of challenges. I saw other charge nurses being challenged by their colleagues. I could take care of my own patients, but I was not prepared to tend to the entire unit. It seemed very soon and sudden because I was a new nurse. No one wanted to train me at first. I didn't take it personally, per se, because I saw it happening to others . Unfortunately, nurses have this view of proprietary information and they purposely delay orientation for everyone. *Harry:* There's a lot of processes that we go through in critical care nursing that are actually fairly complicated. When you think of a charge nurse, you think of somebody who is a highly skilled at the bedside practice and is able to contribute to the care of a critical patient. I was fortunate to have been trained by people with the same frame of thought.	
Renee: The training that I received was phenomenal. I was ready to take care of critical patients. *Billy:* My training was great, probably because I was so new. *Celeste:* It seemed very soon and sudden because I was a new nurse. No one wanted to train me at first. I didn't take it personally, per se, because I saw it happening to others . Unfortunately, nurses have this view of proprietary information and they purposely delay orientation for everyone. *Block:* Well, my training for charge, in general, took a lot of fighting. I believe, convincing them in a sense. I had to work harder or better just to prove that I can understand the clinical work in front of me. I had to go through several different evaluations, one from the manager, another one from the charges that were actually invested in my progression. *Harry:* First of all, the environment is the real trainer. It's not really the coursework per se. *Tony:* [They] made it mandatory that those individuals get trained as charge nurse, and I was very resistant to that. I wanted nothing to do with that shit! *Max:* The charge role can simply be seen as someone who directs traffic. And, in that sense, there is not an overt sense of leadership about the role other than making sure that people go where they need to be. *Star:* I needed to feel prepared to competently care for my patients. As long as that happened, I was straight. I learned a long time ago not to allow places to push you out of orientation too fast. *George:* I had prior charge experience, so they let me do a charge class after I was off my orientation in the ICU, meaning that I was in a good place and completing my basic orientation.	Perception of training

Table 4.17

Introductory Question 2: As a charge nurse, how would you describe your duty to the nurses you oversee?

Excerpts from transcripts	Concepts	Conceptual clusters
Star: I am essentially the nursing supervisor. Overseeing some of the work the nurses do and the patients that they care for, depending on the type of patient that they had. Often it would be helping them manage and prioritize their time. Acting like a damn babysitter sometimes. *George:* I had to do a certain number of shifts with a preceptor, making sure I made the right choices, but after approval and about 2 years, I was able to be a charge nurse on my own and support the unit. *Tony:* They showed us the computer technology that we would have to use as charge nurses to help transfer patients out and see who's coming in and just the flow on the flow of the day and what our responsibilities. I was like a damn traffic controller *Max:* I think largely the duties simply entail making sure that staffing assignments are appropriate and changing staff assignments to meet the needs of changing patient situations. *Billy:* It really just consisted of making out assignments and making sure that, you know, the assignments were safe for the amount of people that you had and reporting to the supervisors when they came around. *Block:* My roles included ensuring that [they] were doing all their duties in the clinical setting. Making sure that their mentors were available, making sure that they understood the devices in front of them, make sure that staffing was correct so that the ratio of patients to nurses was appropriate. *Renee:* When I'm in charge, I have to track what nurse was going to cover what. Also over seeing medical staff, such as LPNs, and CNAs. *Harry:* You got to make it happen now! You know, you got to get the chest tubes lined up, get those initial labs in. You've got to get him on the monitor. You got to make sure that the drips are right. You got to make sure that there wasn't a mistake from pharmacy.	Nursing task obligation	Mission setting
George: I touch base with all the nurses to learn about their patients and make sure that they weren't drowning, and that they were able to keep up with their patients' changing conditions. *Star:* If upper management felt like [they] were too slow or needed some assistance, I would help them instead of just letting them burn out. *Billy:* So making sure that those nurses were comfortable in the assignments that they had was a priority for me. *Block:* You weren't overloading people, like just giving a fresh new nurse, a complicated patient. You have to balance their progression with the patient's level of illness. *Tony:* So, you know, I think that's probably one of my biggest downfalls as a charge nurse. When I'm in charge, I feel like this is a burden; I just feel like this obligation to make myself extremely available to all my fellow coworkers. *Harry:* Some of us are a little bit more willing to take it on the chin, so to speak, and actually get the work done. And no matter what else is going on, that's really what we need to keep our eyes on. That's the prize at the end of the ride. The good patient outcome.	Nursing moral obligation	

Table 4.18

Introductory Question 3: How would you describe lateral violence?

Excerpts from transcripts	Concepts	Conceptual clusters
George: I saw charge nurses give another nurse a patient to challenge them, or they would give a senior nurse an assignment that was less difficult because they were friends.	Lateral violence description	Lateral violence sensitivity
Star: The best way to describe it for me is by using the old saying nurses eat their young. Back in the early 2000s, I would say there were a lot of older nurses in the hospital setting. They weren't too nice to new nurses.		
Billy: She didn't come! She didn't come to fuckin' help me! That lateral violence, or whatever you call it, is like hazing, because later on, I heard people say, you know, she what she said? Just let them drown because that's the only way that they're going to learn.		
Block: Lateral violence. To me, I would say, is when a person has power, where they can change or influence the future of another person and they use that power to purposely and professionally hurt people.		
Max: Lateral violence. People feel as if they're not allowed to offer any input; they feel for lack of a better term, browbeaten by colleagues or supervisors, which do not allow them to fulfill the role of collective management or shared management of unit issues. It can also be emotional in the sense that there can be belittling that takes place of people either personally or professionally. Signs of lateral violence could also be silence or a failure to interact in a similar fashion with one person versus another group of people, even when professionally required.		
Tony: I feel that microaggression is what happens when people don't agree with decisions.		
Renee: But she would purposely try to put me into impossible situations. People that knew me very well and knew my work ethic, they went to bat for me and reported her. I attribute the lateral violence to the fact that I was the only African American female. Lateral violence is just another form of discrimination.		
Celeste: But I think nurses, unfortunately, tend to undermine each other. And sometimes they're not taught how to professionally interact with each other when there's conflict. That's what lateral violence really is.		
Harry: I've often wondered if at our very core, the reason why [it's] a part of our culture is because we, as nurses, have to bottle up so much negativity. And it's just an outlet that has just become, unfortunately, a common practice.		

Summary of Results

Tables 4.19 through 4.22 show the findings for each research question, based on the level of congruency between the participants' answers. The results are identified with one of the following value ranges to indicate the degree of saturation for each response:

- *10–30%* indicates less than four participants converged on a finding
- *30–55%* indicates that four to five participants converged on a finding
- *55–89%* indicates five to eight participants converged on a finding
- *100%* indicates that all nine participants converged on a finding

Table 4.19

Summary of Findings for Introductory Questions 1-3: Tell me how you were trained to serve as a charge nurse in critical care? How would you describe your duty to the nurses you oversee? How would you describe lateral violence?

Theme	Summary of findings	General narrative
Charge nurse identity	100% of the nurses identified strongly, both positively and negatively, with their roles as charge nurses and equated their efficacy with the duration and tribulations associated with their social preparation. Positive, as well as negative, experiences informed the nurses' subsequent presence or lack of leadership qualities. While some considered it a privilege to be accepted into the charge nurse role, others felt slighted in their preparation. 67% of the charge nurses were motivated by directives to complete tasks while addressing deeply held moral standards. Alerted, cognizant, and professionally injured, 89% of the charge nurses rendered an accurate description of lateral violence that is congruent with the current literature. 30% of the participants provided alternate perspectives of lateral violence.	While pointing vigorously toward the monitor, George stated: I had to have intensive modality training before I could even go to charge class for the hospital! I had to do a certain number of shifts with a preceptor, making sure I made the right choices. Billy calmly stated, after a long and intentional pause: I've been nurse for 15 years. So, first, obviously, you know, you get trained to the bedside, and I was a new grad at the time, so I didn't get introduced to the charge role for about a year, but by then I was ready. Block clearly did not equate his training with acceptance or reverence. Rigidly posturing and word searching, he recalled: They first open training where they have you shadow them for two to three months. And it was not until they literally had no one for charge at night, that's when I was voluntold. Not because I was good or ready for that matter but because there was absolutely no one else to do it, and that's just bullshit! Some participants suggested that the charge role was thrust upon them without safety, preparation, or resources. Tony expressed his disgust through pursed lips when recalling his orientation experience: They made it mandatory for individuals to get trained in charge. I was very resistant to that! They made it mandatory that those individuals get trained in charge. Nurses and I was very resistant to that. And I mean, it was barely a few hours of training before I had to just do it! With crossed arms and a calm, tempered voice, Max suggested: The charge role can simply be seen as someone who directs traffic. And in that sense, there is not an overt sense of leadership about the role other than making sure that people go where they need to be. Tony aggressively latched onto the question, while simultaneously displaying his angst by stating, They showed us the computer technology that we would have to use as charge nurses to help transfer patients out and see who's coming in and just the flow, on the flow of the day. I was like a damn traffic controller. George emphatically expressed his deep-seated concern for his colleagues: I touch base with all the nurses to learn about their patients and make sure that they weren't drowning, and that they were able to keep up with their patients changing conditions.

With raised fist and voice, Billy shouted, eyes wide: She didn't come! She didn't come to fuckin' help me! That lateral violence or whatever you call it, is like hazing, because, later on, I heard people say, 'you know what she said? Just let them drown because that's the only way that they're going to learn.'

While desperately attempting to compose himself, Block expressed, through tears, Lateral violence. [long pause] To me [another long pause] I would say, is when a person has power, power to change or influence the future of another person, and they use that power to purposely and professionally hurt people.

In a clear and direct tone, Max stated: Lateral violence in this particular instance or this particular definition more likely takes a psychological form of. People feeling as if they aren't allowed to voice their concerns. People feeling as if they're not allowed to offer any input; they feel for lack of a better term, browbeaten, by colleagues or supervisors.

With a furrowed brow and drum-like tone, Renee reported: I attribute the lateral violence to the fact that I was the only African American female. Lateral violence is just another form of discrimination that we have to endure.

Biting his bottom lip and shaking his head, Harry somberly exclaimed, I see it, feel it every day, dude. It's under my skin. I've often wondered if at our very core, the reason why [it's] a part of our culture is because we, as nurses, have to bottle up so much negativity. And it's just an outlet that has just become, unfortunately, a common practice.

Table 4.20

Summary of Findings for Research Question 1: What actions by colleagues inform charge nurses of laterally violent behavior as defined by this study?

Theme	Summary of findings	General narrative
Acknowledgment of colleague moral injury	100% of the participants were able to articulate notifying measures taken by themselves or others. These warnings provided the charge nurses with situational awareness and acknowledgement of laterally violent behaviors.	Taking a brief moment to separate multiple occurrences from the point he was attempting to make, Max intentionally stated: There have been even times when an individual has broken down in tears. So, an emotional display in terms of crying could be anger. Quite often, there is there at least a cooling off period that involves talking with other colleagues and then, of course, other colleagues have the choice to either take sides if they feel that a poor interaction has taken place.
	40% of the participants described having strong intuition, leading them toward understanding without the need for conscious reasoning.	Block was extremely animated with his description of a colleague and their transition into a state of what he referred to as professional paralysis. Was it just his expressions or his overall change? I would say he had a bubbling personality. He was very friendly to other people. Slowly he started to get very quiet. He started to second guess himself. He was almost paralyzed professionally. He would get nervous upon the beginning of his shift. He would almost be like [pause, searching for words] almost paranoid, very paranoid about making sure ALL of his actions were correct. He began to constantly punish himself when he did not do a good job or understand something.
	100% of the participants were able to describe behaviors of victims and perpetrators of lateral violence. This acknowledgement aided the participants in their personal selection of values and associated behaviors.	Entering her response to this question, Celeste offered multiple apologies for being long-winded, despite encouragement to keep pressing onward. Hesitantly, she stated: I think sometimes when you're, when you're in a hospital and you're working as a nurse and, you know, to look for those signs of, like, when a patient is crashing. Those are things you expect. Unfortunately, I think nurses do not expect lateral violence, so sometimes I think we miss it simply because we're not used to looking for it. But I do notice, for example, preceptor/preceptee confrontations happened a lot, which prompted how I personally would precept people. I'm not one to educate by fear. I find that when you're in the mode of being afraid of your preceptor, you won't ask questions that are pertinent, and you have a tendency not to retain information in the same way. So I sensed it a lot more with regards to the preceptor/preceptee relationship.
		Carefully choosing each word, Harry described the comfort his intuition gave him and how he extended said comfort to others; . . . . Knowing that you've made it, that you're able to endure and see that positive outcome. When you're able to make all of these different strings fluttering in the wind, suddenly wind together. And boom! You got yourself something you can work with. In nursing, like any other difficult task, it really does take a real [will] to do it. And sometimes the bedside nurse is able to accomplish that while in charge as well. Sometimes the bedside nurse can't even get out of the room to make phone calls that are necessary. So, as far as the charge nurse is concerned, being keenly aware of what's going on, not only in that room but in the entire unit, is where our best qualities come out.

Table 4.21

Summary of Findings for Research Question 2: What corrective actions do charge nurses recommend in the reduction or elimination of laterally violent behaviors exhibited by colleagues?

Theme	Summary of findings	General narrative
Transformational intent	22% of the participants were able to describe their personal commitment to the charge nurse role, which included actual, as well as potential, corrective measures. 78% of the participants clearly stated their disassociation from administration functions associated with the charge role. These participants regarded the charge role as an imposition or an unwanted obligation, especially if they were slighted during initial charge training. This was illustrated by the participant responses in which all corrective actions were reassigned to the immediate management or the organizational leadership.	Holding his head low, expressing feelings of guilt, Tony somberly recalled: So, you know, I think that's probably one of my biggest downfalls as a charge nurse. I feel like this is a burden. I just feel like this obligation to make myself extremely available to all my other coworkers. You know, even sometimes as charge, we have to be saddled with a two-patient assignment as well. And you know that I catch myself all the time in a difficult spot because, I want to be there for everybody and help everybody. And then at the same time, I got my own shit to do! While placing the responsibility squarely on the shoulders of the organization, Star sternly remarked: Well, eventually what happens is that people end up complaining, but not actually writing statements or doing anything . . . anything . . . REAL about it. They started a fire by calling it horizontal violence. Committees would start in the hospital, and they would often meet and present scenarios and try to educate people on how to deal [with] situations and raise an awareness of attitudes and behaviors. But, again, because people were unwilling to actually speak up on violence when it happens and so fixing it doesn't go too far. Convinced of her response, Renee emphatically supported the presence of a manager: If you have a good manager, an excellent manager, they will be able to address situations immediately, so it starts with leadership. So, if leadership allows this behavior to continue, it will continue. Fortunately, for me, I had an amazing manager. You know what I'm saying? So you don't have time to speak and discuss behaviors when you are in charge, because you have to take care of your own critical patient. That's is what a manager is for. Wide-eyed and speaking energetically, Billy slowly digressed by reporting: I can't be the most effective charge nurse that I can be if people are cutting each other at the knees. So, providing education to those nurses that are doing the bullying, not only affects the nurses that they're doing it to, but the employees that are being bullied; we need to create outlets where people can turn to, somebody for help. You know that they can trust that they can go to for teaching, because a lot of people don't know how to stick up for themselves, especially when they're just not confrontational. We have to stand for them, advocate for them.

Table 4.22

Summary of Findings for Research Question 3: What behaviors indicate that a charge nurse has shifted personal behaviors to support colleagues affected by lateral violence as defined by this study?

Theme	Summary of findings	General narrative
Transcending normalized practices	100% of the nurses articulated supporting and healing measures extended to colleagues affected by lateral violence. 57% of the nurses instinctively accommodated wounded colleagues and accompanied them onto a trajectory of healing. 57% of the nurses implemented confrontation as a technique to reach laterally violent colleagues. The remaining half either indirectly addressed hostile colleagues through management or complete abstention from potentially violent situations.	Apologizing for the use of harsh language, Billy swiftly rummaged through her vocabulary, searching out words that best described her experiences: So, I was friends with everybody. You know, I wasn't the one that got bullied, people respected me. So, I kind of took [her] under my wing. And guided her and, you know, just to kind of say, you know, don't worry about what other people are thinking. You do your job the way that you can. And if you don't know something, it's okay for you to not know something but stand up for yourself! Don't let people fuck with you! Celeste struggled with antithetically positioned descriptions. Conflicted but extremely confident, she suggested: So, I would prefer that people just come to me or I need to go to them. However, there's times when I haven't because it's one of those things where sometimes you make things worse when you address it and sometimes you make things better when you address it. And some battles are worth fighting and some battles are not. You've got to select your sanity first. It's like the evil you know versus the evil you don't. Methodically, almost brooding while contemplating a response, Max cleared his throat addressing the shifting of priorities: There have been times when I have simply alerted the person that their actions were questionable and that I would certainly be speaking to a supervisor. Individuals will take up the mantle of charge nurse leadership. Some people don't believe that the charge nurse is invested with the same sort of leadership as a proxy supervisor. And so, in that sense, if they don't perceive you as a leader other than as a traffic controller, is it? Whereas, I said before, you also have to be sensitive to the fact that if they feel that you're overstepping your bounds in terms of your role, then that can also be perceived as lateral violence. Harry expressed his perception on lateral violence control. Indirect resolution doesn't always work. Utilizing a multitude of hand gestures, he described the following: It really depends on the scenario. I mean, some people have told me that I am overly aggressive. I'm not. I really am not. I've done a lot of thinking about this. Some people just don't like to be looked in the eye and spoken to directly. So, as far as those particular scenarios are concerned, person-to-person conversation is the correct tool to use to resolve lateral violence. Personally, I'm not sure that there is a tool that could be effective at resolving lateral violence.

Chapter 5: Discussion

Introduction

Lateral violence persists as a result of situational complexities and an established work-force culture resistant to the notion that nurses can exist as both victims and perpetrators (McPhaul & Lipscomb, 2004; Tee et al., 2016). Converging on the psychological woundedness and residual trauma imparted by lateral violence, this study sought to uncover the descriptive essence of provisional critical care nurse leaders observing this phenomenon. This chapter provides a discussion of the research findings, study limitations, and recommendations for additional research, policy development, and best practices.

Implications of Findings

A combination of structured introductory and research questions guided this study, producing four emergent themes: (a) charge nurse identity, (b) acknowledgment of colleague moral injury, (c) transformational intent, and (d) transcending normalized practices. Each of these thematic expressions contains the rudiments of recalibrating measures specific to the phenomenon of lateral violence within the profession of critical care nursing. Accompanying each of the emergent themes is a discourse revealing the implications for the areas of nursing practice, nursing leadership, and social justice.

Emergent Theme 1: **Charge nurses identity.** This study set forth to determine the degree to which provisional critical care nurse leaders, or charge nurses, acknowledge peer behaviors consistent with normalized lateral violence. From the introductory

questions (Appendix D), the theme charge nurse identity emerged as result of three convergent conceptual clusters: (a) duration of training, (b) rigor of training, and (c) perceptions of training. Informing each charge nurse's constituents of self, these reflections expounded the various leadership stances of the participants. Nurses describing robust training experiences concurrently reported a connection to their organizations and direct reports. Conversely, nurses recalling truncated or minimized orientation encounters described the charge nurse's role as an unwanted burden or obligatory saddling. Conti-O'Hare (2002) asserted that becoming a wounded healer arises from a personal transformation, or awakening, generating wisdom and a marked insight to help others. Reflecting on Fitzpatrick et al. (2016), professional development was inextricably connected to clinical nurses and their unanswered struggle to become leaders. This empirical evidence revealed the intermediary function of leadership preparation and nurses' slighted perceptions of self-efficacy. This study asserts that a charge nurse's identity carries implications for the edification of nursing practice, nursing leadership, and social justice.

Practicing in critical care demands that nurses remain constantly primed to confront crisis, and even death, at a moment's notice. Critical care nurses struggling with marginalization or identities informed by wounded behaviors may fail to recognize their ascribed duty to respond to patient conditions.

Critical care nurses operating as preceptees are typically trained or precepted by other nurses. When training is truncated, trivialized, or traumatic to the nurse learner, negative leadership perceptions inform and propagate maladaptive behaviors. The cascading effect of wounded behaviors produces a numbing effect on the perception of

lateral violence, directing new leaders to adopt and continue the psychological injuring of others.

Creating a socially just environment presents a challenge for charge nurses. As charge nurses advance in their training, their sense of inclusion directly informs the degree by which they are motivated to act. Nurses who experience isolation or marginalization within their environments, may find motivation to only complete duties or specific task associated with the charge role. However, charge nurses who are included in the growth of the unit obtain vested interest, and work to satisfy their moral obligation to lead others. It can be implied that nursing practice informed by isolation and lateral violence does not engender a sense of shared leadership responsibility.

Emergent Theme 2: **Acknowledgment of colleague moral injury.** In the investigation of peer actions consistent with normalized lateral violence, this study sought to determine the degree to which charge nurses acknowledge the subsequent behaviors. The theme, acknowledgment of colleague moral injury**,** emerged as the participants provided their descriptions of lateral violence as a direct assault on their viscerally embedded values of caregiving. Rationalized from responses to the associated interview questions (Appendix D), conceptual clusters were assimilated: (a) charge nurses alerted to lateral violence, (b) description of perpetrator behavior, and (c) description of victim behavior. Recognition of woundedness is the fundamental, sentinel step of the healing process for those who have either witnessed, or been affected, by psychological trauma. Tee et al. (2016) reported a myriad of negative emotions associated with nurses experiencing psychological trauma, such as humiliation, confusion, anger, anxiety, and depression, culminating into suicidality. Identification of these deep-seated issues begins

with an initial recognition of the contributing forces. Implicit in this awakening is the notion that nurses must understand their own vulnerability as a key concern when dealing with traumatic situations Conti-O'Hare (2002). Emphatically emphasized in this study were concise recollections of lateral violence, regardless of age, gender, race, or professional preparation. This study asserts that acknowledgment of colleague moral injury carries implications affecting nursing practice, leadership, and social justice.

Charge nurses influence practice outcomes for subordinate nurses, the organization, and ultimately the patient. Consistent with a charge nurse's duty to act is the associated obligation to assess and respond to patient care changes. Charge nurses must consistently scan the horizon for variations in the environment and respond with appropriate interventions. When minimal attention is paid to morally injured nurses, the perpetuation of laterally violent behaviors interfere with charge nurses' control of the patient care area, potentially undermining vital patient care processes.

Charge nurses serve as the intermediaries between subordinate nurses and formal leadership, such as managers and other administrators. The mechanisms of communication include a general assessment of the patients, staff, and emergent concerns. Evaluating the influence of nursing behavior on patient care is a vital charge nurse function. Furthermore, the reporting of said behaviors can only occur when charge nurses are sensitized to the presence of morally wounded behavior.

The protective qualities of moral injury identification serve the greater good of the clinical area. Morally injured nurses generate a palpable tension in the workplace for their colleagues. This pressure is subsequently amplified by the preexisting intensity of the critical care environment. As novice nurses experience this burdening atmosphere, they

become heavily invested in the circumvention of aggressive colleagues. As these neophytes eventually leave the critical care setting, or the profession ,as a direct result of their maltreatment, the remaining morally inured staff perceive their clandestine behaviors as cathartic, as they presumably shield their patients by ridding the profession of unworthy or unsafe nurses.

Emergent Theme 3: Transformational intent. In the investigation of normalized lateral violence, the theme, transformational intent**,** materialized as the participants expressed their designs for cultural change while identifying the provocateurs of said change. Expanded from responses to the interview questions (Appendix D), the following subthematic clusters were assimilated: (a) organizational responses, (b) unit leadership responses, and (c) charge nurse responses. Freeman et al. (2013) posited that nurses in the critical care setting were able to see beyond the workplace violence while creating meaning and satisfaction in their work. Conti-O'Hare (2002) emphasized the appropriateness of nurses utilizing a healing paradigm to facilitate the healing of psychological trauma within others. The participants of this study could not easily articulate the dimensions of obligation associated with the charge nurse role. Many of the participants deferred to the nursing unit management or the organization to address imbedded and accepted forms of lateral violence. The participants referred to themselves as traffic controllers or babysitters. If the nurses identified with the charge role as a needless or cursory function, then decisions to engage culturally systemic lateral violence were predicated on this perception. This study asserts that transformational intent carries implications for the framing of nursing practice, leadership, and social justice.

The decision to positively impact one's environment is deeply personal as well as challenging. Disrupting the status quo can come with many rewards; however, the road on which this journey is traversed can be professionally hazardous and filled with unanticipated repercussions. Course corrections in practice, even if on a personal level, can engender attitudes of resentment and hostility from others, which must be anticipated as well as recalibrated.

As a measure of leadership efficacy, adaptability describes the innate trait of balancing speed while coordinating change. Healthcare organizations have been charged with the daunting task of attending to the human condition while concurrently remaining viable. During turbulent times, health organizational leaders may face toxic workplace conditions that erode away resources while simultaneously establishing normalcy. The intent to transform the environment may remain obscured by employees in fear of retaliatory behavior from colleagues.

One of the tenets of a socially just environment is the notion of representation. Every person, every voice, and every grievance should be acknowledged and respected. In the nursing arena, transformational intent resonates with diversity in thought, practice, and general performance.

Emergent Theme 4: Transcending normalized practices. From its inception, this study was driven to understand how critical care nurses acknowledged lateral violence and peer behaviors consistent with that violence. In doing so, the final theme, transcending normalized practices**,** arose from evidence indicating that the participants' intent was to challenge the normalized, abstract boundaries of the nursing culture. Additionally, the participants described their search of alternative behaviors such that

alignment with personal values could be achieved. With responses from interview questions 6, 6a, and 6b (Appendix D), conceptual clusters were integrated: (a) charge nurses' responses to victimized colleagues, and (b) charge nurses' responses to aggressive colleagues. Brann and Hartley (2017) examined the deployment of courses focusing on workplace violence prevention. Content retention and participation were both significant, with reproducible results across both awareness and knowledge. Students participating in this course demonstrated a collective readiness for change. According to both Conti-O'Hare (2002) and Jackson (2004), nurses served as instruments of healing when they facilitated opportunities for others to realign disharmony, gain the capacity to recover from woundedness, and rise above conventional notions of tolerable behavior. This study asserts that transcending normalized practices recalibrates nursing practice, leadership, and the concepts of social justice.

As nurses strive to become efficient practitioners of healthcare, they must also contend with the preconceived notions of others. Theses prejudices levy a heavy burden on presumptively independent nurses. When work culture resists change, defies diversity, and rejects new perspectives, the philosophy of transcending the social norm becomes evident, while individuals engaging in transformative behaviors become vulnerable.

Nursing leaders ultimately control the clinical environment. In light of the critical care atmosphere, attention to clinicians and their collective input can be staggering. The inclination to lead in a standardized, deontological fashion can provide an avenue of retreat from change. Recalibrating ideologies has the potential to become a competing entity in a place that prides itself on establishing stability.

Designing, spearheading, and replicating affirmative transformation, these are the underlying principles of cultural change and transcendence. As it applies to nursing, decades of socialization and cultural indoctrination stand between the normalized practices of lateral violence and the formation of a social justice evolution. Calibration of any instrument requires that an honored and accepted standard be present in which to compare that which needs to be changed. In the case of lateral violence and nursing, culture is the mechanism in need of adjustment and the standardized tool of regulation remains obscured.

Limitations

The limitations to this study were experienced as a result of the COVID-19 pandemic. Nurses have been branded as front-line healthcare workers as they operate at the intersection of health and human suffering. COVID-19 has catalyzed local, national, and global responses to an agony that transcends all boundaries. Even sacred institutions, such as family and religion, have not been spared the pernicious and destructive nature of the COVID virus. The participants in this study, at the time of their interviews, were all practicing as critical care nurses in the state of New York. As one of the original epicenters of the virus, critical care nurses were clinically bound to areas where COVID victims were suffering and the healthcare system was powerless to help them. Conditions. such as extended work hours, poor patient outcomes, and emotional exhaustion, presented barriers to participant access and engagement. Protocols for social distancing precluded direct contact with the charge nurses. Though video conferencing was available, the degree of participant observation was stunted by the venue.

The researcher's proximity to the subject of lateral violence and the potential for bias presented a significant, potentially limiting threat to this study. Establishing, correcting, and providing safeguards for this investigation were paramount, given the nature of the subject. The ubiquitous influence imposed by potential researcher bias required an intentional and equally persistent strategy. The mechanism deployed in this study was the phenomenological exercise of bracketing. As a fundamental dimension of bracketing, intentionality was conveyed at every participant interaction. Bracketed feelings, thoughts, and expressions were exhaustively confronted before and after every participant interview.

Recommendations

Conventional preparation fails to empower nurses with mechanisms situated to mitigate pernicious psychological violence (Christie & Jones 2014; Liu & Chiang, 2017). This study set out to determine the degree to which charge nurses acknowledge and describe peer behaviors that are consistent with normalized lateral violence, trauma, and psychological woundedness. Data collected from the lived experiences of nine provisional nursing leaders, or charge nurses. served as a basis for the recognition and interpretation of this phenomenon. The following recommendations serve as the frameworks for identification, transformation, and transcendence designed to detect, address, and recalibrate the psychologically wounding behaviors caused by lateral violence in the critical care division of professional nursing.

Nursing policy development and practice. At the time of this writing, the virulent nature of lateral violence is concealed by silence and division. In order to address

lateral violence, these two pillars of obscurity must be met with clamor and inclusion on both local and national platforms.

Locally, nurses possess access to various fraternities, networks, and labor unions such as Sigma Theta Tau, LinkedIn, and 1199SEIU (United Healthcare Workers East). Unifying under a banner of intolerance through these organizations could propel the message of lateral violence elimination and encourage hospitals and other healthcare organizations to assume an offensive stance, while aligning policies to detect and mitigate this phenomenon. In the development of this study, negligible empirical data was found from nationally generated sources, because a majority of the evidence was located within international studies. It remains unclear whether or not the stigma of lateral violence deters local healthcare facilities from studying the phenomenon. What is apparent is the lack of cohesion between entities perfectly suited to inform, codify, and initiate policies to protect nurses from lateral violence in the workplace. It was earlier implied that when minimal attention is paid to morally injured nurses, the perpetuation of laterally violent behaviors interferes with a charge nurse's control of the patient care area, potentially undermining vital patient care processes. Uncovering the phenomenon of lateral violence on the local level initiates the conversation for national involvement.

On a national stage, organizations, such as the Society of Critical Care Medicine (SCCM) and the American Association of Critical Care Nursing (AACN), could combine their investigative prowess and influence to seek the inclusion of novice nurses into their ranks. This recruitment measure could provide membership as well as opportunities for education. New critical care nurses are currently excluded or provided with minimal inclusion into these organizations; however, acquiring their interest when they are

impressionable may bear tangible results. Continual education units (CEUs) could be acquired from lateral violence learning modules, which could be applied to yearly re-registration requirements for the nursing participants. These nationally guided interventions could set the stage for policy creation given that no such entity currently exists. As it applies to nursing violence, the threat to positive patient outcomes has been exhaustively explored. It appears prudent to solicit national organizations for their inclusion in this endeavor.

Future research. Given the pervasive nature of lateral violence among nurses, potential opportunities for further investigation are ample. This study focused on the lived experiences of critical care registered nurses and their descriptions of lateral violence amongst their colleagues. As a specific facet of the nursing community, critical care in itself represents intensive care units, emergency departments, and postanesthesia care units. This study resonates with all nursing specialties and with any nursing population from nursing students to advanced practice nurses. It is recommended that future studies be conducted on various specialties and populations such as pediatric care, geriatric care, in rural settings, as well as urban settings. Given the breadth and depth of this study, it is further recommended that theses adaptations be applied to isolate the perceptions of men and women, respectively, on the phenomenon of lateral violence. These perspectives could advance the profession's working knowledge of lateral violence and its various presentations.

Although this study is grounded in the examination of nurses practicing in the field of healthcare, the essence of the research lies in the study of toxic workplace culture. Future studies could be performed within an industry and with any population.

This study further asserts that the acknowledgement of moral injury influences nursing practice, transformational intent frames nursing leadership, and the transcension of normalized practices recalibrates social justice. As an integral dimension of this study, each of these implications possess specific recommendations for challenging the normalcy associated with lateral violence.

Acknowledgment of moral injury and nursing practice. Critical care units are on the frontline of life and death. Recognition of morally injured colleagues is paramount in the eradication of lateral violence. Becoming cognizant of lateral violence's presence is the first step in creating corrective measures.

Acknowledgement of moral injury permits leaders to seek, retain, and cultivate talent while identifying hidden outcries for help. When considering the theory of the walking wounded, charge nurses who exhibit behaviors of the wounded healers protect the psychological well-being of their colleagues through the recognition of their pain and influence upon their healing.

Transformational intent frames nursing leadership. The participants in this study indicated their intent to change the negative work culture. They further indicated that when training was truncated, trivialized, or traumatic, that negative leadership perceptions informed and propagated maladaptive behaviors. This individual intent and motivation to change resonates with the human resource frame of leadership. Bolman and Deal (2017) reported that the human resource frame of leadership places people at the center of any organization. Listening to aspirations, goals, and communicating with openness, empowers individuals through participation (Bolman & Deal, 2017). As recently implicated, the cascading effect of wounded behaviors produces a numbing

effect on the perception of lateral violence, directing new leaders to adopt and continue the psychological injuring of others. The human resource frame validates worth and ensures autonomy, making it an ideal approach to the phenomena of lateral violence.

Transcension of normalized practices recalibrate social justice. Previously stated, morally injured nurses generate a palpable tension in the workplace for their colleagues. As these new nurses leave the critical care setting or the profession as a direct result of their maltreatment, the remaining morally inured staff perceive their clandestine behaviors as cathartic, as they presumably shield their patients by ridding the profession of unworthy or unsafe nurses. The act of rising above this behavior, healing instead of curing, leading instead of following, represents mechanisms of recalibration. Nursing leadership must work to establish new renditions of normal. Supporting nurses in professional peril and making them a part of the culture, teaches others to engage justly, and calibrate behaviors to support the organization and the patient.

Conclusion

Lateral violence is deeply embedded within the continuum of the professional nursing culture and has been well described since before the start of the 1990s. In the absence of a universal definition, studies have exploited terms, such as horizontal hostility, incivility, bullying, and microaggression, to describe the violence experienced, as well as perpetrated, by nurses.

Converging on the residual trauma and woundedness imparted by psychological injuries occurring in the workplace between nurses, this study sought to determine the degree to which provisional leaders or charge nurses acknowledged and described peer behaviors consistent with normalized lateral violence and psychological woundedness.

To capture the lifeworld, descriptive essence of critical care charge nurses, the following research questions were deployed:

1. What actions by colleagues inform charge nurses of laterally violent behavior as defined by this study?
2. What corrective actions do charge nurses recommend in the reduction or elimination of laterally violent behaviors exhibited by colleagues?
3. What behaviors indicate that a charge nurse has shifted personal behaviors to support colleagues affected by lateral violence as defined by this study?

A descriptive phenomenological methodology was applied to illustrate the acknowledgement, personal transformation, transcension of psychologically wounded behaviors of critical care nurses. This approach provided succinct depictions of emergent narratives and lifeworld accounts of the participant's experiences.

This study was performed in the county of Onondaga, within the city of Syracuse, New York. Participants were sequestered from across the New York State region. At the time of the study, the New York State Education Department, Office of the Professions (2020) reported that 323,126 registered nurses were licensed throughout the state.

Aligning with the aim of the study and the phenomenological tradition, this study included a participant cohort of nine critical care charge nurses, all working within the New York State area. All participants within this study met the following criteria for inclusion:

1. Licensure as a registered nurse through the New York State Office of Professions

2. At the time of the interview, working with 3 or more years of experience in a critical care setting
3. Charge nurse experience in the critical care setting

This study utilized the primary researcher, a semi-structured interview protocol, and a 90-minute interview as the data collection instruments. With respect to the COVID-19 pandemic and associated social distancing recommendations, video interviews were performed via the Zoom online platform. Audio recordings were imported into the coding and NVivo data analysis software platform, for storage and transcription. As the primary repository for all future coding and analytic memos, NVivo was used to create the primary sorting and coding structures for the study.

Data analytical procedures for this descriptive phenomenological analysis included the processes of bracketing, reflexive journaling, phenomenological reduction, and imaginative variation. These processes yielded 1,117 segregated verbatim codes, which informed 30 individual concepts, eight conceptual clusters, four emergent themes.

A combination of structured introductory and research questions guided this study, producing four emergent themes: (a) charge nurse identity, (b) acknowledgment of colleague moral injury, (c) transformational intent, and (d) transcending normalized practices. Each of these thematic expressions contained the rudiments of the recalibrating measures specific to the phenomenon of lateral violence in the profession of critical care nursing.

This study revealed that 100% of the participants identified strongly with their roles as charge nurses and equated their efficacy with the duration and tribulations associated with their social preparation. Positive as well as negative experiences informed

the nurses subsequent presence or lack of leadership qualities. While some considered it a privilege to be accepted into the charge role, others felt slighted in their preparation. More than half of the charge nurse participants were driven strictly by directives to complete tasks while the remaining participants were motivated by deeply held moral standards. Of all participants, 89% rendered an accurate description of lateral violence, congruent with the current literature. All of the participants were able to articulate notifying measures taken by themselves or others. These warnings provided the charge nurses with situational awareness and acknowledgement of laterally violent behaviors. All of the participants were able to describe behaviors of victims and perpetrators of lateral violence. This acknowledgement aided the participants in their personal selection of values, associated behaviors, and mechanisms of personal correction. Only 22% of the participants described a personal commitment to the charge nurse role, which included actual, as well as potential, corrective measures. Subsequently, 78% of the participants clearly stated their disassociation from administration functions associated with the charge role. Theses participants regarded the charge role as an imposition or an unwanted obligation, especially if they were slighted during initial charge nurse training. This was illustrated by the participant responses in which all corrective actions were reassigned to the immediate management or the organizational leadership. All of the nurses articulated supporting and healing measures extended to colleagues affected by lateral violence. Of all participants, 57% instinctively accommodated wounded colleagues and accompanied them onto a trajectory of healing. More than half of the nurses described direct confrontation as a technique used to connect laterally violent colleagues. The remaining

half of the participants either indirectly addressed hostile colleagues through management or completely abstained from contact with potentially violent situations.

Each of the thematic expressions garnered from this study contained the rudiments of the recalibrating measures specific to the phenomenon of lateral violence in the profession of critical care nursing. Accompanying each of the emergent themes were implications in the areas of nursing practice, nursing leadership, and social justice.

Regarding nursing practice, the cascading effect of wounded behaviors produces a numbing effect on the perception of lateral violence that could potentially encourage new leaders to adopt and continue the psychological injuring of others. Furthermore, critical care nurses struggling with marginalization or identities informed by wounded behaviors may fail to recognize their ascribed duty to respond to patient conditions. Disrupting the status quo can come with many rewards; however, the road on which this journey is traversed, can be professionally hazardous and filled with unanticipated repercussions. Course corrections in practice, even if on a personal level, can engender attitudes of resentment and hostility from others, which must be anticipated as well as recalibrated.

Implications for nursing leadership begin with the training of charge nurses. When nursing leadership permits training to be truncated, trivialized, or traumatic to the nurse learner, negative leadership perceptions inform and propagate maladaptive behaviors. Charge nurses serve as the intermediaries between subordinate nurses and formal leadership, such as managers and other administrators. Evaluating the influence of nursing behavior on patient care is a vital charge nurse function. Furthermore, the reporting of said behaviors can only occur when charge nurses are sensitized to the presence of morally wounded behavior. As nursing leaders control the clinical

environment, attention to clinicians and their collective input can be staggering. The inclination to lead in a standardized, deontological fashion could have a negative impact on change. Recalibrating leadership ideologies has the potential to become a competing entity in a place that prides itself on establishing stability.

The tenets of a socially just environment include the notions of inclusion and representation. In the nursing arena, transformational intent resonates with diversity in thought, practice, and general performance. As charge nurses advance in their training, their sense of inclusion is linked to the degree to which they are motivated to engage the practice setting. It can be implied that nursing practice informed by isolation and lateral violence does not engender a sense of shared leadership responsibility. The protective qualities of moral injury identification serve the greater good of the clinical area. Morally injured nurses generate a palpable tension in the workplace for their colleagues. As novice nurses experience this burdening atmosphere, they begin leave the critical care setting or the profession as a direct result of their maltreatment.

In response to lateral violence, nursing policy development should begin with the inclusion of various fraternities, networks, and labor unions. Unifying under a banner of intolerance through these organizations could propel the message of lateral violence elimination and encourage hospitals and other healthcare organizations to align policies to detect and mitigate lateral violence. Exposing the phenomenon of lateral violence on the local level initiates the conversation for national involvement.

On a national stage, organizations, such as the SCCM and the AACN, could combine their investigative prowess and influence to seek the inclusion of novice nurses into their ranks. This recruitment measure could provide membership as well as

opportunities for education. New critical care nurses are currently excluded or provided minimal inclusion into these organizations, however; acquiring their interest when they are impressionable may bear tangible results. CEUs could be acquired from lateral violence learning modules, which could be applied to yearly reregistration requirements for the nursing participants. These nationally guided interventions could set the stage for policy creation given that no such entity exists. As it applies to nursing violence, the threat to positive patient outcomes has been exhaustively explored.

Given the pervasive nature of lateral violence among nurses, potential opportunities for further investigation are ample. This study resonates with all nursing specialties and with any nursing population from nursing students to advanced practice nurses. It is recommended that future studies be conducted on various specialties and populations such as pediatric care, geriatric care, in rural settings, as well as urban settings. Given the breadth and depth of this study, it is further recommended that theses adaptations be applied to isolate the perceptions of men and women nurses respectively on the phenomenon of lateral violence. This study further asserts that the acknowledgement of moral injury influences nursing practice, transformational intent frames nursing leadership, and the transcension of normalized practices recalibrates social justice. As an integral dimension of this study, each of these implications rendered recommendations for challenging the normalcy associated with lateral violence in nursing.

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Appendix A

Recruitment Posting

My name is Johaun T. Jackson. I am a doctoral candidate in the Ed.D. program in Executive Leadership at Ralph C. Wilson, Jr. School of Education at St. John Fisher College. I am seeking the participation of Critical Care Nurses in the New York State area in a study investigating the healing perspectives of provisional critical care nurse leaders (charge nurses).

Participation in this study is voluntary. It will involve an interview approximately 90 minutes in length, to take place via a Zoom © conference. With your permission, the interview will be audio recorded to facilitate the collection of information and later transcribed for analysis.

All information you provide is considered completely confidential. Your name will not appear in any thesis or report resulting from this study. Data collected during this study will be retained in a locked cabinet in my home office and destroyed after a period of 3 years.

Please be assured that this study has been reviewed and received ethics clearance through the Institutional Review Board at St. John Fisher College. However, the final decision to participate is yours. For all interested, please indicate so by responding to this post with your email address. You will be contacted within 24 hours with further details.

Appendix B

Email Invitation

July 2020

Dear Critical Care Nurse,

My name is Johaun T. Jackson. I am a doctoral candidate in the Ed.D. program in Executive Leadership at Ralph C. Wilson, Jr. School of Education at St. John Fisher College. I am seeking your participation in a study investigating the healing perspectives of provisional critical care nurse leaders (charge nurses), as they apply to nursing workplace culture. I would like to provide you with more information about this study and what your involvement will entail should you decide to participate.

Title of the Study: Recalibrating Normalcy: Healing perspectives of Critical Care Registered Nurses

This study seeks to determine the degree to which provisional critical care nurse leaders or charge nurses, acknowledge and describe peer behaviors consistent with culturally normalized lateral workplace violence. I am requesting your participation in this study because as a critical care nurse, your leadership perspective is vital to the development of this research.

You will be invited to engage in an in-depth, audio-recorded, one-to-one interview lasting approximately 90 minutes, in an agreed-upon location and at a time of your convenience. In light of the current COVID-19 pandemic and all associated social distancing protocols, interviews will be conducted in a video conference format. At the conclusion of the interview, you will be asked to review the associated transcripts and provide corrections if needed.

All information gathered from the audio-recorded interviews will be maintained in strict confidence. All recordings will be locked on an encrypted cloud data storage device. Throughout the entire study, you and all other participants will be assigned a pseudonym, known only to the researcher. All digital audio files will be transcribed by software by the researcher on a dedicated, password-protected

computer. All data will be stored in a double-locked cabinet located in the researcher's home office. All participant-related data will be destroyed after the Internal Review Board's designated period of 3 years.

Although no risk is anticipated to you as a participant, the topic could potentially invoke feelings and or memories. Should this occur during any time of the interview, you may request the researcher to stop the interview, during which time you may withdraw from the study without penalty.

Please be assured that this study has been reviewed and received ethics clearance through the Institutional Review Board at St. John Fisher College. However, the final decision to participate is yours.

Results from the data will be available to any requesting participant through an electronic version of the dissertation. Should you wish to participate in this study, please indicate so by responding to me via email. If you have any additional questions, contact me at (___) ___-____ or by e-mail: _____@sjfc.edu. You can contact my supervisor C. Michael Robinson, Ed.D. by phone: (___) ___-____ or by email: _____@sjfc.edu.

Thank you for considering participation in this study, I look forward to your response.

Respectfully,

Johaun T. Jackson RN, MSN
Doctoral Candidate
St. John Fisher College
School of Education
Rochester, New York

Appendix C

Informed Consent Form

St. John Fisher College Institutional Review Board

Statement of Informed Consent for Adult Participants

Recalibrating Normalcy: Healing Perspectives of Provisional Critical Care Nurse Leaders

SUMMARY OF KEY INFORMATION:

- You are being asked to be in a research study of lateral violence amongst Registered Nurses. As with all research studies, participation is voluntary.
- The purpose of this study is to examine the connection between cultural normalcy and lateral violence witnessed by charge nurses.
- Approximately five people will take part in this study. The results will be used for the expansion of the current body of Nursing knowledge on the subject of lateral violence.
- If you agree to take part in this study, you will be involved in this study for one month.
- Should you decide to participate, you will be asked to engage the primary researcher in one, 90-minute interview. In respect to current COVID-19 guidelines, the study will take place, electronically on the web-based conference platform Zoom ©.
- Although no risk is anticipated to you as a participant, the topic can potentially invoke feelings and or memories. We believe this study has no more than minimal risk. As a result of the study procedures, we anticipate sitting for a time greater than one hour.
- Though you may not benefit directly from you participation. We hope that your inclusion in the study will advance the body of knowledge and the professional health benefits of provisional critical care nurse leaders and those for whom they supervise.

DETAILED STUDY INFORMATION:

You are being asked to be in a research study of the connections between cultural normalcy and lateral violence witnessed by critical care charge nurses. In respect to current COVID-19 and social distancing protocols, this study is being conducted via an on-line, one-on-one discussion on the Zoom © platform. This study is being conducted by Johaun T. Jackson and C. Michael Robinson, Ed.D. of the St. John Fisher College School of Education. You were selected as a participant because of your knowledge and experience as a charge nurse. Please read this consent form and ask any questions you have before agreeing to be in the study.

PROCEDURES:

If you agree to be in this study, you will be asked to do the following:

1. Declare your intent to participate in the study by responding to an e-mail request from the primary researcher.
2. Read and sign consent for the study
3. Participate in one, 90-minute audio recorded interview with the primary researcher.

During the 90-minute, audio recorded interview, you will be asked questions specific to nursing culture and lateral violence, with respect to your experience as a charge nurse. After your interview, the primary researcher will review all of the meeting transcripts with you to ensure accuracy.

COMPENSATION/INCENTIVES:

You will not receive compensation for your participation. However, we hope that your participation in the study will advance the body of knowledge and the professional health benefits of charge nurses.

CONFIDENTIALITY:

The records of this study will be kept private and your confidentiality will be protected. In any sort of report the researcher(s) might publish, no identifying information will be included.

Identifiable research records will be stored securely and only the researcher(s) will have access to the records. All data will be stored electronically on a dedicated computer with a back-up, encrypted data storage device. Writings, field notes, and other physical research-related materials will be archived and secured in a double-locked safe in the researcher's home. All study records with identifiable information, including approved IRB documents, recordings,

transcripts, and consent forms, will be destroyed by professional shredding service, and/or deleted after 3 years.

VOLUNTARY NATURE OF THE STUDY:

Participation in this study is voluntary and requires your informed consent. Your decision whether or not to participate will not affect your current or future relations with St. John Fisher College. If you decide to participate, you are free to skip any question that is asked. You may also withdraw from this study at any time without penalty.

CONTACTS, REFERRALS AND QUESTIONS:

The researchers(s) conducting this study are Johaun T. Jackson and C. Michael Robinson. If you have questions, you are encouraged to contact the researcher Johaun Jackson at _____, ____ NY _____, (___) ___-____, _____@sjfc.edu. and C. Michael Robinson, Dissertation Chair, (___) ___-____ _____@sjfc.edu.

The Institutional Review Board of St. John Fisher College has reviewed this project. For any concerns regarding this study/or if you feel that your rights as a participant (or the rights of another participant) have been violated or caused you undue distress (physical or emotional distress), please contact C. Michael Robinson, Ed.D. by phone: (___) ___-____ or by email: _____@sjfc.edu. The following national resources are also available:

National Hotlines for survivors of violence and Trauma
http://www.traumainformed.org/hotlines-for-survivors-of-violence-and-trauma/

STATEMENT OF CONSENT:

I am 18 years of age or older. I have read and understood the above information. I consent to voluntarily participate in the study.

Signature:_____ Date: _____

Signature of Investigator:_____ Date: _____

Retain this section only if applicable:
I agree to be audio recorded and transcribed _____ *Yes* _____*No* *If no, I understand that the researcher will exclude me from the study without penalty.*

Please keep a copy of this informed consent

Appendix D

Interview Protocol

Research Questions (RQ)/Interview Task (IT)	Interview Questions (IQ)/Rationale for Task (RT)
1. (IT) Welcome participant; ensure comfort and environmental control.	1. (RT) Establishing rapport.
2. (IT) Describe study in full detail, allow for questions, obtain written consent, and provide participant with a copy of consent.	2. (RT) Establishing confidentiality.
3. (IT) Opening questions.	3a. (RT) Establishing participant comfort with questions. 3b. (IQ) Tell me about how you were trained to serve as a charge nurse in critical care? 3c. (IQ) As a charge nurse, how would you describe your duty to the nurses you oversee? 3d. (IQ) How would you describe lateral violence?
4. (RQ1) What actions by colleagues inform charge nurses of laterally violent behavior as defined by this study?	4a. (IQ) Give me some examples of times when you suspected that acts of lateral workplace violence were occurring among your colleagues? 4b. (IQ) After witnessing those episodes of lateral workplace violence, how would you describe the behaviors of those involved? The victims and the perpetrators.
5. (RQ2) What corrective actions do charge nurses recommend in the reduction or elimination of laterally violent behaviors exhibited by colleagues?	5a. (IQ) Describe your thoughts on how lateral workplace violence is addressed in critical care. 5b. (IQ) If given the opportunity, describe how you would address lateral workplace violence as a charge nurse?
6. (RQ3) What behaviors indicate that a charge nurse has shifted personal behaviors to support colleagues affected by lateral violence as defined by this study?	6a. (IQ) Describe a time you assisted colleagues in coping after being exposed to lateral violence. 6b. (IQ) Tell me about an encounter that informed your approach to colleagues who perpetrate or have been victims of lateral workplace violence.
7. (IT) Conclude interview; thank participant and allow for expression of feelings related to the interview.	7. (RT) Refinement of the researcher's interpretations. Confirmation of alignment with the participants' lived experiences.

Appendix E

Aggregated In Vivo Codes

Participant	Introduction	RQ1	RQ2	RQ3	Individual Nodes
Billy	18	14	14	8	54
Star	16	17	10	15	58
George	20	36	28	27	111
Renee	25	19	44	18	106
Celeste	53	38	10	19	120
Tony	42	41	16	11	110
Block	36	78	70	47	231
Max	52	37	21	27	137
Harry	56	48	28	58	190
Aggregates	318	328	241	230	1117

Appendix F

Emergent Themes

Emergent theme	Conceptual clusters	Concepts
Charge nurse identity (introduction questions)	Cultural acclimation	Duration of training Perception of training Rigor of training
	Mission setting	Moral obligation Task obligation
	Lateral violence sensitivity	Lateral violence description
Acknowledgement of colleague moral injury (RQ1)	Charge nurse alerted to lateral violence	Direct reports Intuition Investigation Observation
	Description of lateral violence perpetrator (behaviors/actions)	Accusatory Aggressive Dismissive Oppressive Persecutory Retaliatory Territorial
	Description of lateral violence victim (behaviors/actions)	Discouraged Defeated emotionally labile Evasive
Transformational intent (RQ2)	Lateral violence addressed	Charge nurse responses Organizational responses Unit leadership responses
Transcending normalized practices (RQ3	Charge nurse's support responses to victimized colleagues	Academic support Moral support Professional support
	Calibrating personal narrative	Abstention Direct confrontation Indirect confrontation