

# Understanding Lateral Violence in Nursing

Norma Sheridan-Leos, RN, MSN, AOCN®, CPHQ®

The concept of lateral violence (LV) also is known as horizontal violence, bullying, or aggression (Griffin, 2004). Other terms in the literature relating to this concept are horizontal hostility, verbal abuse, or “nurses eating their young” (see Figure 1). The phenomenon has been described in nursing literature for more than 25 years (Farrell, 1997; Roberts, 1983). The literature defines LV as nurses overtly or covertly directing their dissatisfaction inward toward: (a) those less powerful than themselves, (b) themselves, and (c) each other (Griffin). The lack of a universal term to encompass these actions makes integrating research on LV difficult (Bartholomew, 2006). LV manifests itself in a variety of unkind, antagonistic interactions that occur among nurses at the same organizational hierarchy (Alspach, 2007); these interactions may be overt or covert (Bartholomew; Griffin). Because most communication is nonverbal, covert behaviors have the biggest impact (Bartholomew).

LV is an act of aggression that is perpetrated by one nurse against another. The common manifestations of LV have been described by Griffin (2004) as nonverbal innuendo, verbal affront, undermining activities, withholding information, sabotage, infighting, scapegoating, backstabbing, failure to respect privacy, and broken confidences (see Table 1). Typically, LV is verbal or emotional abuse, but it also can become physical abuse (Longo & Sherman, 2007). LV is an issue throughout nursing and practice settings (Stanley, Dulaney, & Martin, 2007; Woelfle & McCaffrey, 2007).

## Origins of Lateral Violence

As sensitivity and caring (Bartholomew, 2006) are the focus of the nursing

profession, LV occurring at all is ironic (McKenna, Smith, Poole, & Coverdale, 2003; Woelfle & McCaffrey, 2007). Although other theories describe why LV occurs, the most cited theory to describe the origins of LV can be found in the oppressed-group model (Roberts, 1983). The model suggests that nurses are an oppressed and powerless group dominated by others (DeMarco & Roberts, 2003). Oppression exists when a powerful and dominant group controls and exploits a less powerful group. Nursing has been described as an oppressed group because the profession is mostly women, and nurses report to mostly male physicians and administrators (Farrell, 1997). Cherished nursing characteristics, such as sensitivity and caring, are viewed as less important or even negative when compared to those of medical practitioners, who often are seen as the central culture in health care (Woelfle & McCaffrey).

The literature supports this view, stating that nurses lack autonomy, control over their work, and self-esteem and subscribe to submissive-aggressive syndrome to affect change (Freshwater, 2000). Submissive-aggressive syndrome is a term that describes when nurses feel they have lost their power (submissiveness), and react by overpowering others through aggressiveness (Bartholomew, 2006). Roberts (1983, 2000) has described the application of Freire's (1971) oppression theory to nursing. The theory explains that members of an oppressed group display common behavioral characteristics, such as low self-esteem and self-hatred (Roberts, 1983; Woelfle & McCaffrey, 2007). LV among

nurses evolves from feelings of low self-esteem and lack of respect from others in the work environment (Longo & Sherman, 2007). Oppression theory proposes that nurses perceive themselves as powerless and oppressed in the healthcare setting. As an oppressed group, nurses feel alienated and have little control of their practice. This leads to a cycle of low self-esteem and feelings of powerlessness (DeMarco & Roberts, 2003). Rather than confronting the issue (and risking retaliation by leadership in the healthcare system), the oppressed group manifests their frustration on other nurses lateral to them.

LV behaviors are not directed at the individual nurse but rather are a response to the practice environment. The practice environment is seen as “emotionally, spiritually, and psychologically toxic” (Alspach, 2007, p. 12). These toxic work environments often are a result of downsizing, aggressive management styles, and increasing internal and external competition (Rowell, 2005). Nurses exhibiting LV believe it is a safer manifestation of stress. The nurse committing the LV is unable to effectively confront the oppressors, so the anger is directed at a safer person; however, LV causes the recipient of the behavior to become a victim and, feeling hurt and vulnerable, reinforces powerlessness (Longo & Sherman, 2007). The victim of LV is practicing in what they perceive is an oppressive healthcare setting; the fear of retribution from those considered more powerful prevents the individual nurse from taking action that could break this cycle. Nurses in such a workplace lack the solidarity to effect change (DeMarco &

---

Norma Sheridan-Leos, RN, MSN, AOCN®, CPHQ®, is self-employed as an oncology consultant of Oncology Quality Solutions and is a full-time doctoral student at Texas Woman's University in Houston. She is the recipient of the 2007–2008 Vivian L. Smith Distinguished Doctoral Scholarship.

Digital Object Identifier: 10.1188/08.CJON.399-403