Summer 6-12-2017

An Exploration of Nurse Educators' Knowledge, Attitudes and Practice of Horizontal Violence Measured through Dimensions of Oppression

Brenda Berner Petersen
brenda.petersen@student.shu.edu

An Exploration of Nurse Educators' Knowledge, Attitudes and Practice of Horizontal Violence Measured through Dimensions of Oppression

By

Brenda Berner Petersen

Dissertation Committee

Deborah A. DeLuca, M.S., J.D. (Chair)

Terrence F. Chaill, Ed.D., FACHE

Genevieve Zipp, Ed.D.

Submitted in partial fulfillment of the requirements for the degree of

Doctor of Philosophy in Health Sciences

Seton Hall University

2017

"An Exploration of Nurse Educators' Knowledge, Attitudes and Beliefs of Horizontal Violence Measured through Dimensions of Oppression"

By

Brenda Petersen

Dissertation Committee:

Deborah A. DeLuca, Chair
Terrence F. Cahill
Genevieve Pinto Zipp

Approved by the Dissertation Committee:

Date: June 12, 2017

Date: June 12, 2017

Date: June 12, 2017

Submitted in partial fulfillment of the
requirements for the degree of Doctor of Philosophy in Health Sciences
Seton Hall University
2017

ACKNOWLEGEMENTS

As I reach this milestone of achieving a terminal degree following a ten-year journey, which included many barriers, hurdles and roadblocks, I am deeply aware of the support that has surrounded me along this passage to completion of my research. I would not have made it through the struggle to reach this final stage without those who surround me with their knowledge, strength, care and support. First and foremost, I acknowledge my Chair and Committee.

Dr. DeLuca, from the first time I met you and had the opportunity to sit in front of you in the classroom, I was struck by your brilliance and listened intently to every lecture you provided; learning in those moments how to think like a scientist. But how do I truly say thank you to someone who opened my mind and stretched my thinking through quantum theory? But I will try, nonetheless. I thank you Dr. DeLuca for the times you shared your knowledge and expertise and helped me expand my mind. I thank you for every minute you devoted to me, for your mentoring and for all you did to teach me to become a better writer, a better thinker. I thank you for every minute you shared yourself with me and cared for me along this long path to this final milestone in my academic career, as I achieve a terminal degree. I thank you for supporting me, guiding me, teaching me, listening to me, motivating me and most of all for believing in me as you gave of yourself to me as my Advisor and my Dissertation Chair.

Dr. Cahill, thank you for your endless calm and reassuring support as you asked me the questions that helped me explore all avenues of this research proposal

and defense. Thank you for always encouraging the deeper dive. Your leadership traits are those I seek to emulate. Your knowledge of leadership theory has deepened my understanding of the elements that lead to successful organizational leadership through an inter-professional, evidence-based framework. I deeply appreciate the time you devoted to my success and the support you provided, as well as your leadership of the program that I am proud to have completed.

Dr. Zipp, thank you for joining my committee and providing me with valuable feedback and support. Thank you for your example of leadership and scientific enquiry. Thank you for all you have done to support me in this scientific exploration.

With deep thanks I acknowledge my Delphi Committee. Thank you for sharing your valuable time and expertise. Thank you for your contribution in review of the NEKAP-HV© instrument. This research would not have been possible without your support.

I would not have been able to complete this work without the loving and constant support of my husband, John Norman Petersen, Jr., my touchstone, my strength. You were excited when I was excited and every time I hit a barrier, and every time I wanted to give up, your steady strength and endless support held me up and kept me moving forward. Your faith in me gave me faith in myself when I wanted to give up. Your love for me when I didn't always feel good about myself showed me what love really means. You have been by my side since we were 19 years old and I can never truly express how amazing it has been to take this road with you, knowing you would never give up on me. My true north, my husband, I thank

you. To my adult "children," Tyler Jeffrey Petersen, Victoria Alice Petersen and Erik Lars Petersen, you are my reason. My reason for living, my reason for working so hard, my reason for being. There has been no greater accomplishment in my life than the three of you and it is you who give me strength to hold on and you who inspire me to always strive for excellence. Thank you Tyler, Victoria and Erik for sharing this journey with me. I love you.

To my sister, Janice Edna Berner Daku. Your unconditional love and quiet strength have always been my guide. You have been so excited for me and so supportive of me every step along this journey and there are not adequate words to express my gratitude to you for believing in me, for encouraging me, for listening to me and most of all for loving me, sister, my sister.

To the rest of my dear family and dear friends, I am truly, deeply, richly blessed to have so many wonderful people in my life who have encouraged me and motivated me and cared for me. Your support and enthusiasm means more than I can say and I thank you for believing in me and for loving me.

DEDICATION

This dissertation of my research is dedicated in loving memory to my beloved parents Alice Emfinger Berner and Norman Berner, and my beloved brother Jeffrey Norman Berner. Mom and Dad, you taught me how to be strong. Daddy, as a WWII Veteran and member of "the greatest generation," you earned a Bronze Star for bravery and you were truly the strongest, bravest and most honorable man. I learned the definition of faithfulness by watching you. Mommy, as one of the first Physician Assistants in the State of New Jersey, you were a trailblazer and taught me to be a strong woman. You loved me unconditionally and you were so deeply proud and excited about my academic journey, and the memory of that has kept me moving forward. I strive every day to do my best to honor both of you in all I do.

To my sweet, loving, quiet brother, Jeffrey, you were taken from us far too soon but in the 12 years that you were my big brother on this earth, you taught me to be kind. You taught me to be a fighter. You taught me that life is far too short and so very fragile and that I need to cherish every moment – through despair and joy – to cherish this life.

I wish you were all still here beside me and could be here to share this with me because I know how proud you would be. But mom and dad, I am so grateful you lived long enough to see me qualify for this degree and I am so grateful you were beside me through my coursework. I am so grateful that I was given to you as your child. Your strength literally runs through my veins

"I have long wondered what role we play in this."

"The power should be held by the team."

"Oppression is perpetuated by healthcare systems, media, some physicians and even some nurses"

"A physician can yell, scream and throw a fit like a toddler and the nurse is supposed to take it."

"Nurses are still giving up their chairs to physicians"

"It's a gender issue"

"I believe nurses are oppressed"

"Nurses do this to themselves"

"Still battling in some states for full prescribing rights."

"If we ignore their concerns we silence their voice."

"We are all inter-dependent. In this era of IPE the silos should be gone, the hierarchy flattened and the patient in the center of the circle."

Anonymous comments from a national sample of nurse educators

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABSTRACT

There is a paradox in the profession of nursing. Although nursing is known as the caring profession, evidence demonstrates that nurses do not care well for their own. Literature demonstrates that the phenomenon of horizontal violence (HV) is an international problem in the nursing profession, which negatively affects the nurse workplace environment. HV is broadly described as aggressive destructive behavior and intergroup conflict that occurs between nurses. Where behaviors of HV exist, the workplace becomes a toxic environment or nurses (Woefle & McCaffrey, 2007).

This dissertation provides the results of a research study exploring nurse educator's knowledge, attitudes and practices of HV measured through dimensions of oppression. Nurses have been widely argued to exhibit oppressed group behaviors (Roberts, 1983; Roberts, 1986; Roberts, DeMarco, & Griffin, 2009).and empirical evidence demonstrates that HV is a widespread problem in the nursing profession, with a cycle of behaviors that are embedded during nurse role socialization (Randle, 2003; Longo, 2007). This study explores the phenomenon of HV in nursing using a national sample of nurse educators.

CHAPTER I

Introduction

Background of the Problem

There is a paradox in the profession of nursing. Although nursing is known as the caring profession, evidence demonstrates that nurses do not care well for their own. Literature demonstrates that the phenomenon of horizontal violence (HV) is an international problem in the nursing profession, which negatively affects the nurse workplace environment. HV is broadly described as aggressive destructive behavior and intergroup conflict that occurs between nurses. Where behaviors of HV exist, the workplace becomes a toxic environment (Woefle & McCaffrey, 2007).

Five dimensions of oppression applied in the nursing literature are (1) assimilation, (2) marginalization, (3) low self-esteem, (4) submissive-aggressive syndrome; and (5) horizontal violence (Roberts, 1983; Mathey & Bobay, 2007). Roberts describes characteristics of Friere's (1971) model and states that oppressed group behavior stems from the ability of the dominant group to identify the norms and values as the "right" values for the subordinate group. Typically, within oppressed groups, the dominant group looks and acts differently compared to the subordinate group and the characteristics of the subordinate group become negatively valued.

For this study on horizontal violence, the pedagogy of oppression is operationally defined as groups who are controlled by forces outside of themselves that have greater prestige, power and status (Roberts, 1983; Friere 1971). HV is defined as acts of overt or subtle aggression between colleagues that may be emotional

or verbal; and rarely physical (Stanley, Martin, Michel, Welton & Nemeth, 2007). Making sarcastic remarks, using belittling words or gestures, minimizing or ignoring a colleague's concerns and withholding information are common examples of HV within nursing (Longo, 2007).

The evidence reveals that HV is significant problem that has a negative impact on the novice nurse during professional role socialization as a registered nurse (Woefle & McCaffrey, 2007). A growing evidence base both domestically and internationally has identified the phenomenon of horizontal violence within nursing as an endemic problem that remains poorly understood. Horizontal violence has a negative impact on the nurse work environment as well as the healthcare delivery system. When HV is prevalent - the workplace environment becomes toxic to nurses. HV has a significant negative impact not only on nurses, but also on the healthcare institution and patients.

HV is described as a cyclical and global phenomenon (Farrell, 2001) with negative social behaviors that become entrenched within the profession of nursing (Randle, 2003). Socialization of the novice nurse into the profession occurs through acts of HV (Randle, 2003) and through this socialization process, the cycle of HV is maintained, and HV becomes a professional behavioral norm (Sofield & Salmond, 2003).

Statement of the Problem

Cyclical behaviors characteristic of HV are passed on from the more experienced nurse to the novice nurse (Farrell, 2001). This cycle is believed to

perpetuate HV as these characteristic behaviors become culturally embedded within the nursing profession when negative behaviors are passed on from one generation of nurses to the next. The literature suggests that HV proliferates through an existing culture in nursing whereby there is an acceptance of nurse-to-nurse abuse as a professional norm (Farrell, 2001; Sofield & Salmond, 2003; Randle, 2003). International and domestic research demonstrates that HV is a global problem within the professional culture of nursing as a result of embedded characteristic behaviors that are passed on throughout professional role socialization (Roberts, 1983; Roberts, Demarco & Griffin, 2009).

HV results in 33% to 61% of new registered nurse graduates leaving the profession or changing their place of employment within their first year of practice (Cox, 2001; Farrell, 2001; McKenna, et al, 2003; Duchscher & Myrick, 2008; Beecroft, Kunzman & Krozek, 2001; Duchscher & Myrick, 2008; Tinsley & France, 2004). With the migration of the novice nurse out of the profession, the cost to employers is significant. The cost of replacing a staff nurse is $65,000, while the cost of replacing one specialty nurse as exceeds $145,000 (Pendry, 2007).

There is a migration of novice and experienced registered nurses out of the profession, who would prefer to stay at the bedside but who leave due to HV (Feblinger, 2009). Costs are incurred due to work absenteeism, treatment for depression and anxiety, decreased work performance and increased turnover (Gerardi & Connell, 2007). Organizations face financial losses when intelligent highly talented professionals exit to escape workplace dysfunction.

In addition to the financial cost, there is a correlation between negative behaviors and patient safety. The Joint Commission, an independent, not-for-profit organization which certifies and accredits more than 17,000 health care organizations and programs in the United States, issued a Sentinel Event Alert (Issue 40, 2008) regarding associated characteristic horizontal violence behaviors, and states that negative behaviors in healthcare undermine a culture of safety and can foster medical errors, contribute to poor patient satisfaction and also contributes to otherwise preventable adverse patient outcomes. Cost to the patient, the nurse, the family, and the hospital from the ultimate compromised care, as well as the potential for legal action due to patient harm can be staggering. Although the Joint Commission requires organizations it accredits to have zero-tolerance policies for negative intergroup behavior, evidence demonstrates that over half of the events of are never reported (Stagg et al, 2012, Vessey et al., 2010).

The Commission reported in a root cause analysis of sentinel events that nearly 70% of the events are connected to communication problems between healthcare professionals (Rosenstein & O'Daniel, 2008). A sentinel event is a "never event" i.e., a preventable medical mistake that should have been prevented. The seminal Institute of Medicine report "To Err is Human" published in 2000 identified that 45,000 to 98000 patients die each year from preventable medical error and more recently medical errors are identified as the third leading cause of death. Breakdown in communication is at the root of 70% of sentinel events and poor communication between nurses occurs in organizations where HV exists.

Purpose of the Study

The purpose of this study is to develop and test a newly designed quantitative self-report tool. This tool provides applied relevance to the existing science on HV by providing a measure of the five dimensions of oppression from which HV has emerged. Each dimension serves as a construct. Variables measure nurse educators' knowledge, attitudes and practice behaviors using the dimensions of oppression as a theoretical framework (Friere, 1971; Roberts, 1983).

More specifically, the purpose of this study is to explore nurse educators' knowledge, attitudes and practice of horizontal violence and to determine which factors if any have a predictive relationship in the knowledge, attitudes and practice of horizontal violence by nurse educators. Nurse educators are the first to socialize new nurses into their professional role.

Published studies have looked at experience of nurses with HV, and demonstrate the problem is highly prevalent in the nursing profession both domestically and internationally. We know that HV is a widespread endemic problem. We do not understand why the behavior occurs. In the under-researched area of HV in nursing domestically there are no published peer-reviewed studies identified which have utilized nurse educators as a sample, despite the fact that research demonstrates that nurses first experience HV while in nursing school (Longo, 2007, Randle, 2003).

HV is an area of emerging research domestically (Vessey, DeMarco, Gaffney, Budin, 2009). Matheson & Bobay (2007) discuss the fact that although more than 20

years have passed since Roberts (1983) initial observations of oppressed group behaviors in nursing; oppressed group behaviors have not been studied as a distinct phenomenon. Research has demonstrated the need to continue to study, as well as define, the dimensions of oppression (Matheson & Bobay, 2007; Friere, 1971)

In order to better understand HV, the interlinked dimensions of the pedagogy of oppression that form the basis of HV must be assessed. Existing tools only measure one dimension of oppression; i.e., horizontal violence or low self-esteem (Randle, 2003). This study addresses a gap in the literature on horizontal violence and oppression in nursing, specifically within nursing education.

Variables

The dependent variables are nurse educators' knowledge, attitudes and practice of HV measured on dimensions of oppression. Independent variable measured is years of experience.

Research Questions

The overarching research question being explored is what are nurse educator's knowledge, attitudes and practice (K, A, P) of horizontal violence (HV) utilizing oppression pedagogy (see Figure X). Oppression pedagogy includes the dimensions of assimilation, marginalization, low self-esteem, submissive-aggressive behaviors and horizontal violence that will serve as constructs. Research questions 1 a. – e. through 3 a. – e. will be analyzed through descriptive analysis therefore there is no hypothesis.

To explore nurse educator knowledge of HV as measured through dimensions of oppression, the research questions are:

RQ 1a: What is Nurse Educator (NE) Knowledge (K) of HV as measured on dimension of assimilation?

RQ 1b: What is NE K of HV as measured on dimension of marginalization?

RQ 1c: What is NE K of HV as measured on dimension of low self-esteem?

RQ 1d: What is NE K of HV as measured on dimension of submissive-aggressive behavior?

RQ 1e: What is NE K of HV as measured on dimension of HV?

To explore nurse educator attitude of HV as measured through dimensions of oppression, the research questions are:

RQ 2a: What is NE Attitude (A) of HV as measured on dimension of assimilation?

RQ 2b: What is NE A of HV as measured on dimension of marginalization?

RQ 2c: What is NE A of HV as measured on dimension of low self-esteem?

RQ 2d: What is NE A of HV as measured on dimension of submissive-aggressive behavior?

RQ 2e: What is NE A of HV as measured on dimension of HV?

To explore nurse educator practice of HV as measured through dimensions of oppression, the research questions are:

RQ 3a: What is NE Practice (P) of HV as measured on dimension of assimilation?

RQ 3b: What is NE P of HV as measured on dimension of marginalization?

RQ 3c: What is NE P of HV as measured on dimension of low self esteem?

RQ 3d: What is NE P of HV as measured on dimension of submissive-aggressive behavior?

RQ 3e: What is NE P of HV as measured on dimension of HV?

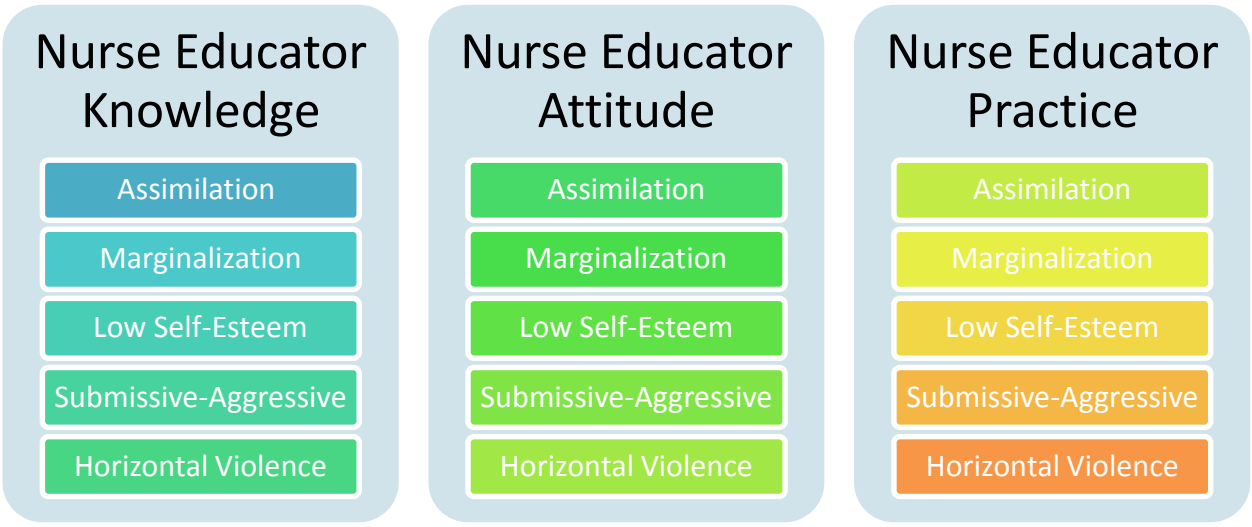

Figure 1. Image to reflect Research Questions 1 a. – e. through 3 a. – e.

Research Hypothesis

Correlational analysis will consider whether or not relationships exist between NE knowledge and attitude, NE attitude (A) and practice (P) and NE knowledge (K) and Practice (see Figure X). If the result is positive, the null hypothesis is rejected that there is no relationship, and the researcher will accept the hypothesis that a positive correlation exists. In correlational design, researchers do not manipulate an independent variable and there is no effort to control for other possible factors that may vary. For this reason, a significant correlation does not show that one factor causes changes in another (i.e., causality). A significant correlation shows that two factors are related but it does not provide an explanation for how or why they are related. The correlational research questions are:

RQ 4 a. What is the relationship between NE K and A?

H 4 a. There is a relationship between NE K and A

RQ 4 b. What is the relationship between NE A and P?

H 4 b. There is a relationship between NE A and P

RQ 4 c. What is the relationship between NE K and P?

H 4 c. There is a relationship between NE K and P?

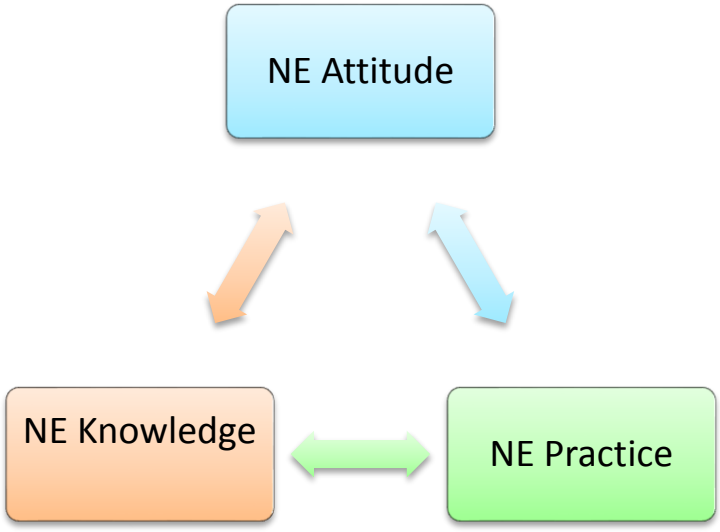

Figure 2: Nurse Educator KAP model.

Significance of the Study

The evidence demonstrates that the negative acts of HV are embedded in the socialization of the novice nurse into the profession of nursing and become the professional norm. HV is a problem that exists around the world in the profession of nursing with empirically evidence that HV adversely affects the novice nurse psychologically and physiologically. HV has a negative impact on retention of nurses and the cost to healthcare systems is significant.

HV threatens patient safety (JCAHO, Sentinel Event Alert 40, 2008). Joint commission identifies interpersonal communication between health care providers as a critical aspect of quality care with breakdown in communication contributing to the majority of medical errors and HV as corollary to this problem. Joint Commission has called for its accredited agencies to have zero-tolerance policies for HV with mandatory reporting guidelines; however, HV commonly goes unreported.

More than 3 million nurses are the backbone of the healthcare delivery system in the United States. The need to retain competent, confident nurses in a healthcare environment that is rapidly changing, complex and frequently unsafe, is critical to the quality of this healthcare delivery system. HV is a widespread problem in the profession of nursing that is not going away. There is a need for nurse researchers to look deeper into the phenomenon of HV. There is an exodus of both novice and expert nurses from the profession when the need for competent, confident nurses will continue to increase significantly over time, in the technologically driven, complex and rapidly changing healthcare delivery industry. Without studying HV on a deeper level, we will never find a way to end the negative cycle of HV embedded within the profession of nursing. We must end the cycle of nurse-to-nurse HV. This study adds to the body of evidence on HV and addresses a significant gap in the literature.

Operational Definitions

Nurse Educator Knowledge, Attitude & Practice are operationally defined as:

Knowledge – Expertise that includes cognitive and affective domains (American Nurses Association Scope & Standards of Practice, 2016; Blooms Taxonomy).

Attitude – A way of thinking and feeling (Webster, 2015)

Practice – The "who, what, where and how of nursing" (ANA, 2016).

Oppression: Friere's Pedogogy of Oppression (Friere, 1971) posits that groups are controlled by forces outside of themselves that have greater prestige, power and status and oppressed behavior stems from ability of dominant group to identify their norms and values as the "right" values (Roberts, 1983). The dimensions of oppression include assimilation; marginalization, low self-esteem, passive-aggressive behavior, and horizontal violence (Friere, 1971; Roberts, 1983):

Assimilation is defined as group behavior that includes customs and attitudes acquired through communication or observation. Individuals are fully assimilated to a new group when traits from the old group are indistinguishable from the new cultural group.

Marginalization occurs when members of a group feel unimportant or like their opinion does not matter.

Low self-esteem and self-hatred occur when individuals feel devalued.

Submissive aggressive behavior results in individuals feeling unable to speak up and confront issues which concern them (submissive) and when they do speak up to confront an issue, they do it in an ineffective, confrontational manner (aggressive).

HV is defined as subtle or overt acts of aggression between group members and intergroup conflict. An example of a subtle act of HV is ignoring the concerns of another or withholding information. An example of overt acts are extreme criticism or ridicule.

Conceptual Framework

Nursing is widely argued to be an oppressed group (Roberts, 1983). With tenets in oppressed group behavior, the understanding of HV first emerged through the work of Freire (1971) as he observed native Brazilians who had been taken over and dominated by Europeans (Roberts, 1996). HV emerges within the oppressed group when the dominant powerful group determines what is valued or rewarded. This causes the oppressed group to feel defective or substandard. Oppression results within a social system when dominant groups control, perpetuate and normalize unequal roles and relationships (Duchscher & Myrick, 2008). The five dimensions of oppression in nursing from the literature (Roberts, 1983; Matheson & Bobay, 2007) are (1) assimilation, (2) marginalization, (3) low self-esteem, (4) submissive-aggressive syndrome; and the final dimension of oppression that is (5) horizontal violence.

The conceptual frame for this study is Friere's Pegagogy of Oppression (1971) from which HV has been defined through his research in Brazil. Friere's oppression pedagogy posits that HV occurs when groups feel powerless due to oppression. Seminal work by Roberts in 1983 posits that nursing is an oppressed group, as nurses often feel powerless due to the controls of the hierarchy of healthcare that places physicians and hospital administrators at the top. Although we know empirically that

HV exists and is a widespread phenomenon, there has been no scale identified to apply Friere's theory directly.

Bandura's social learning theory also underpins this research. Bandura describes the theories of human behavior that examine the impact of external influences to evoke behavior and then maintain the behavior. The work of Bandura and others posit that the most powerful influence on human behavior resides not within the organism, but within environmental forces (Bandura, 1977 p. 6). Bandura further describes that experiences predict behavior. The social learning view is explained in terms of continuous and reciprocal interaction that learned behavior and acquisition is acquired through modeling the behaviors of others.

In fact, it is widely recognized that most human behavior is learned observationally through modeling and that people learn by example. Application of Bandura's Social Learning Theory demonstrates the predictive nature of learning through modeling behavior such as when people applaud when they observe others clapping. Bandura's theory is particularly relevant to this research as it correlates to power as an influence to behavior. Bandura identifies that characteristics of behavior modeling are more effective to the observer when those who have high status, competence or power then have greater effect in prompting others to behave in similar ways. Bandura cites the force of this model when researchers found that pedestrians were more likely to cross a street when the light was red when someone with high-status for example, wearing executive clothing were observed doing so, versus a negative perspective when someone with patched clothes and scuffed shoes crossed

the street on a red light. This observational research shows that status enhances social modeling of observed conduct. Bandura specifically describes the impact of modeling to develop competencies when students observe skillful instructors, and Bandura emphasizes that learning is fostered by modeling and instruction, but also through the feedback that individuals receive through their own transactions with the environment (Bandura, 1977, p. 91).

Friere's pedagogy of the oppressed (1971) is also a theoretical framework for this research. Central to this conceptual framework is the nurse educator who comprised the sample group. Nursing students learn professional skills through direct instruction by nurse educators and direct observance of instructors within healthcare practice settings. This research explores nurse educators' knowledge, attitudes and practice of horizontal violence measured through dimensions of oppression. The NEKAP-HV instrument is designed to measure nurse educators' knowledge, attitudes and practice of horizontal violence through the lens of Friere's oppression framework. Horizontal violence as the final dimension of Freire's pedagogy has been researched; however, this is the only tool identified that has been developed in nursing to measure the other dimensions of Friere's oppression theory as applied to nursing (Matheson & Bobay, 2007). Those include the dimensions of assimilation, marginalization, low self-esteem, passive-aggressive behavior and the final dimension of horizontal violence.

NEKAP-HV Conceptual Model

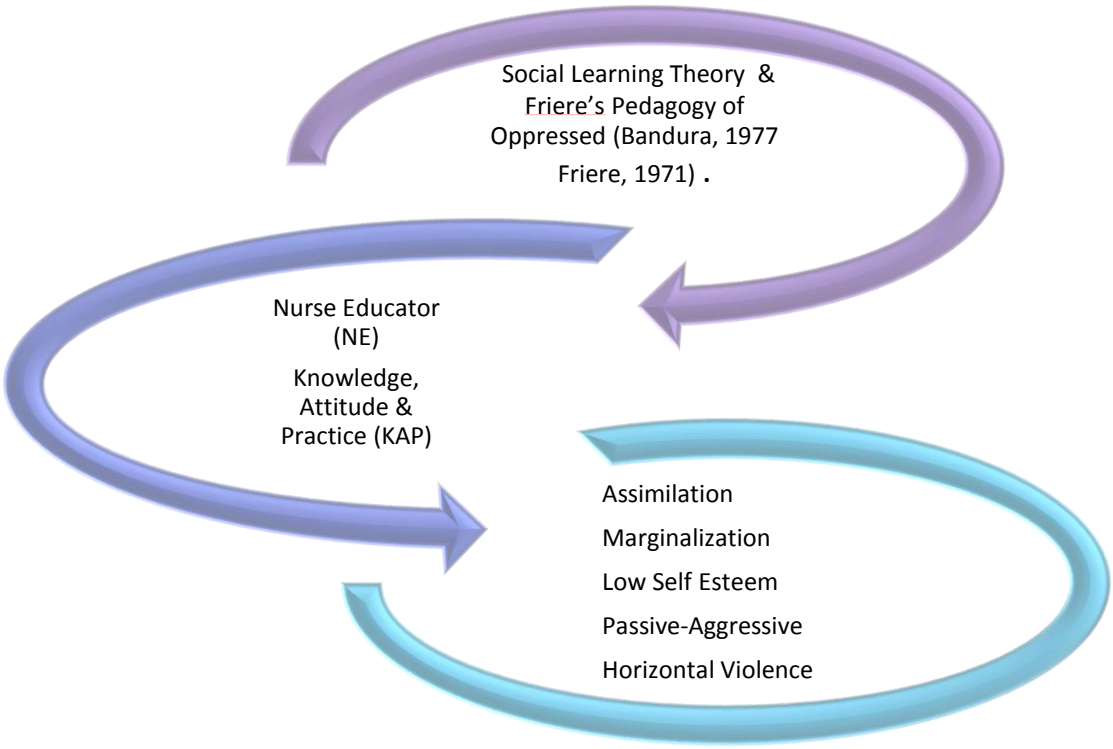

Figure 3. Conceptual Model NEKAP-HV© (Petersen, 2017; Friere, 1971, Roberts, 1983; Matheson & Bobay, 2007).

CHAPTER II

Related Literature

Evidence of HV in nursing first emerged in international literature (McKenna et al. & Randle et al.). This was followed by domestic research that has demonstrated that HV is a common method of socialization of students and new nurses (Longo, 2007; Stanley, et al, 2007). Researchers across the globe have concluded that HV is part of the organizational culture embedded within the profession of nursing (McKenna, et al, 2003). We know from the literature that HV is an endemic problem within the profession of nursing. Empirically we know that HV begins in nursing school and HV exists around the globe. HV has a negative impact on the socialization of the novice nurse into the professional practice role. HV has a negative impact on nurse well-being and erodes self-esteem. It has a negative psychological and physiological impact on nurses. It has a significant negative impact on retention of nurses with resultant negative financial impact on healthcare delivery systems. We know from the Joint Commission that HV has a negative impact on patient safety.

Literature demonstrates that the phenomenon of horizontal violence is a significant issue that negatively affects the professional nurse workplace environment. Horizontal violence (HV) is also referred to as lateral violence or disruptive behavior (Rosenstein, Russell & Lauve, 2002; Weber, 2004; McKenna, Smith, Poole & Coverdale, 2002; Longo, 2007). HV is described as aggressive destructive behavior that occurs between nurses and these behaviors exist in what are described as toxic

work environments (Rowell, 2005, Woefle & McCaffrey, 2007). Within the profession of nursing, HV is referred to anecdotally as "nurses eat their young."

Characteristic disruptive behaviors that are associated with HV have a negative impact on the nurse workplace environment as well as retention. It is reported that 30% to 50% of novice nurses leave a position, and sometimes the profession all together due to the physiological and psychological distress experienced from HV (Weber, 2004). HV is a common experience in the transitional professional role socialization experience from student nurse to novice nurse, and finally to expert nurse. Characteristic HV behaviors among nurses occur across all clinical settings (Woefle & McCaffrey, 2007).

Although similarities exist between bullying and HV, bullying differs from HV. Bullying is defined as repetitive behavior that occurs at least twice a week, continue for a minimum of 6 months; and consists of behaviors that occur in situations where the person is targeted, finding it difficult to defend themselves to end the abuse (Felblinger, 2009). HV may be overt or subtly covert and includes behaviors such as belittling gestures or sarcastic comments; ignoring or minimizing the concerns of another or verbal abuse. Bullying has tenets in victimization theory while HV has tenets in the theory of oppressed group behavior. Although problems associated with workplace bullying have been identified as a problem in nursing as well, HV will be the focus of this research.

Research has shown that nurses first experience the phenomenon of horizontal violence as they begin their journey of professional role socialization during nursing

school. Behavioral patterns associated with horizontal violence are often an element of professional role socialization within nursing (McKenna, Smith, Poole and Coverdale, 2002; Foster, Mackie and Barnett, 2004; Dunn, 2003; Rosenstein, et al., 2002; Randle, 2003; Longo, 2007). Professional role socialization is a process whereby professional attitudes, values and beliefs become internalized and the individual develops a sense of occupational identity through assimilation of characteristic professional behaviors (Nesler, Hanner, Melburg & McGowan; Clayton, Broome & Ellis, 1989). Student and novice nurses assimilate their professional role through social learning by directly observing more experienced nurses within clinical settings (Bandura, 1977; Randle, 2003a; Randle, 2003b; McKenna, et al, 2002).

This learning model perpetuates negative social behaviors as negative behaviors become entrenched within the profession as the novice nurse is socialized into the profession through acts of HV. HV is described as possessing a generational nature that is cyclical; i.e., behaviors characteristic of HV are passed on from the more experienced nurse to the novice nurse. This cycle is believed to perpetuate HV as characteristic behaviors are passed on from one generation of nurses to the next, and the cycle of HV is thereby maintained.

There is a suggestion that HV proliferates through a culture that exists in nursing whereby there is an acceptance of nurse-to-nurse abuse as a professional norm. Researchers have theorized that this process demonstrates a hierarchical structure that preserves the status quo and thereby prevents an end to the cycle of HV (Kohnke, 1981; Farrell, 2001). International and domestic research demonstrates that

HV is a global problem within the professional culture of nursing because of embedded characteristic behaviors passed on from the more experienced nurse to the novice, throughout professional role socialization.

With tenets in oppressed group behavior, the understanding of HV first emerged through the work of Freire (1971) as he observed native Brazilians who had been taken over and dominated by Europeans (Roberts, 1996). HV emerges within the oppressed group when the dominant powerful group determines what is valued or rewarded. This causes the oppressed group to feel defective or substandard. Oppression results within a social system when dominant groups control, perpetuate and normalize unequal roles and relationships (Duchscher & Myrick, 2008). It has been widely argued that nursing is an oppressed group as it is controlled by forces outside of the profession; within the hierarchy of medicine. Hierarchical power structures within medicine have created a long tradition where the novice members of the organization are oppressed. Hospitals and physicians are the alphas in this hierarchy with nurses at the bottom of the totem pole (Weber, 2004).

Freire postulates that the ability of the dominant group to enforce their norms and values upon the oppressed group results in characteristic oppressed group behavior of intergroup conflict and horizontal violence (Roberts, 1983). Applying this perspective to the nursing profession, it is recognized that problems related to HV have a significant impact on nurse professional role socialization into the dynamic culture of today's healthcare delivery system within the hierarchy of medicine (Duchscher & Myrick, 2008). Concepts from Firere's theory of oppression (1971) run

throughout the available literature on HV and nursing has been widely argued to be an oppressed group (Roberts, 1983). Oppressed group behavior rises from a dominant groups' ability to control a lower, more submissive group. Roberts (1983) argued that dependent and submissive behaviors evolve throughout the history of nursing, in response to the domination of nursing by the more powerful groups of doctors and hospital administrators (Matheson & Bobay, 2007). Friere's theory of oppression includes five dimensions (1) assimilation, (2) marginalization, (3) self-hatred and low self-esteem, (4) submissive-aggressive syndrome and (5) the final dimension is horizontal violence.

Concepts from oppression theory have emerged throughout the HV nursing literature both internationally and domestically. HV and oppression within nursing have been reported in the literature for more than 20 years with nursing seen to have a long tradition of hierarchical power structures and struggles. The evidence on HV demonstrates that the result is nurses who perceive a lack of control over their profession that leads to self-destructive aggression within in the oppressed group, and horizontal violence. HV drains the nurse of energy and undermines the strength of organizations (Woefle & McCaffrey, 2007). The Joint Commission, an independent, not-for-profit organization which certifies and accredits more than 17,000 health care organizations and programs in the United States, issued a Sentinel Event Alert (Issue 40, 2008) regarding intergroup conflict (HV) in healthcare. This Alert states that disruptive behavior undermines a culture of safety and can foster medical errors, contribute to poor patient satisfaction and also contributes to otherwise preventable

adverse patient outcomes (The Joint Commission, 2008; 2012; Rosenstein, et al. 2002).

There is a strong link between quality healthcare delivery and HV. Clinical outcomes of patient safety, errors, adverse events and quality of care are all negatively impacted by behaviors associated with HV (Rosenstein & O'Daniel, 2005; Institute for Safe Medication Practices, 2004). Healthcare organizations are expected to be patient focused, deliver the highest standard of quality care, and to be fiscally responsible. However, there has been very little analysis of the collective conditions, patterns of thought and professional behaviors that perpetuate oppressive workplace environments for nurses, and which establish breeding grounds for HV (Feblinger, 2007; Duchscher & Myrick, 2008, Thompson, 1987).

HV is identified as a global problem. National, international and state nurse and physician organizations have adopted position statements that call for recognition and eradication of HV within the healthcare professional workplace environment (Rosenstein, et al., 2001). However, while healthcare quality and safety organizations and professional organizations have begun to recognize this problem, there is a dearth of literature on the phenomenon of HV domestically. The first studies related to HV were conducted in the United Kingdom, New Zealand and Australia. Foster and colleagues (2004) note that horizontal violence in the profession of nursing is a phenomenon that has existed for decades but have only recently been studied, and are just beginning to be understood. The evidence demonstrates that intergroup conflict in the form of HV has been identified as an endemic problem in the profession of nursing

internationally while a growing body of evidence demonstrates the significance of the problem domestically (Sofield & Salmond, 2003; Aiken et al., 2001; McKenna, et al., 2004; Randle, 2003a; Randle, 2003b; Rosenstein, et al., 2002; Longo, 2007).

Although limited, literature reveals that HV is a common experience in the professional role socialization process toward becoming a professional registered nurse. Domestic evidence demonstrates that characteristic behaviors of HV such as verbal abuse are widespread (Sofield & Salmond, 2003). Despite the fact that oppression theory has emerged as a common theme in the global literature on HV, no studies have been identified which have tested this theory as a conceptual frame. There are no published studies using nurse educators as a sample; although it has been demonstrated empirically that HV is first experienced in nursing school (McKenna, et al.,; Longo, 2007). This study addresses this gap in the literature by using nurse educators as a sample. Limited domestic evidence available on HV is fraught with methodological weaknesses and there is a clear need for further research on this topic to add to the limited body of knowledge.

Assessment and measurement of HV is challenging (Sofield & Salmond, 2003; Vessey, DeMarco & DiFazio, 2010) due to differing perspectives of the phenomenon (Stanley, Martin, Michel, Welton & Nemeth, 2007). HV is often seen historically as a "right of passage." Although HV is widely viewed as a negative socialization process, some nurses report that it is simply part of the job in the fast-paced, high-stress complex healthcare environment (Dunn, 2003; Sofield & Salmond, 2003).

While one nurse may perceive certain behaviors as HV, another nurse may simply see it as the "nurse being stressed out" (Stanley, Martin, Michel, Welton & Nemeth, 2007. ; Some propose that the demands of the profession drain nurses emotionally, physically and spiritually, ultimately leaving them with little energy left to provide support to their colleagues. HV is accepted as a common persistent problem in nursing (Vessey et al 2011). There is a migration of both novice and experienced registered nurses out of the profession who would prefer to stay at the bedside but who leave due to HV (Feblinger, 2009).

Costs are incurred as a result of work absenteeism, treatment for depression and anxiety, decreased work performance and increased turnover (Gerardi & Connell, 2007) Organizations face financial losses as a result of intelligent highly talented professionals who exit to escape workplace dysfunction. HV results in 33% to 61% of new registered nurse graduates leaving the profession or changing their place of employment within their first year of practice (Cox, 2001; Farrell, 2001; McKenna, et al, 2003; Duchscher & Myrick, 2008; Beecroft, Kunzman & Krozek, 2001; Duchscher & Myrick, 2008; Tinsley & France, 2004). The cost to employers to replace a staff nurse is $65,000, while the cost of replacing one specialty nurse as exceeds $145,000 (Pendry, 2007).

Nurses must be confident and competent to render safe effective care; but new graduates consistently express a sense of demoralization as a direct result of the dissonance between what they perceive the profession of nursing will be when compared with the ultimate reality that they actually experience after entry into the

profession (Duchscher & Myrick, 2008). Novice nurses describe intellectually oppressive practice environments that lead them to exit the hospital workplace environment or the profession (Duchscher & Myrick, 2008).

Although the majority of the preeminent literature on the topic of HV was first published in peer reviewed international journals, there is considerable precedent for continued US research and scholarship because our healthcare systems are different as well as the way that we educate nurses. However, the international literature of HV provides the sentinel standard of understanding for HV in the US and also informs how we are addressing it as a community of educators and practitioners in the scholarly literature. International literature on HV is important in our understanding of the topic of HV in the US as these studies preceded domestic research on HV.

What we know from international studies on HV is that there is a cycle of characteristic HV behavior embedded within the culture of nursing and that HV is first experienced in nursing school. We know that HV Negatively impacts professional role socialization for nurses through as it lowers nurse self-esteem and it also negatively impacts retention of new nurses with up to 50% of new nurses leaving the profession as a result of HV. While the international literature on HV is imperative to consider, as these studies were the first on the phenomenon of HV, there are methodological weakness of these studies such as small samples and non-validated tools; as well as a Question about generalizability in the US where both the system for the education of nurses and the healthcare delivery system differs.

Cyclical behaviors characteristic of HV are passed on from the older more experienced nurse to the novice nurse (Farrell, 2001). This cycle is believed to perpetuate HV as these characteristic behaviors become culturally embedded as they are passed on from one generation of nurses to the next. The literature suggests that HV proliferates through a culture which exists in nursing whereby there is an acceptance of nurse-to-nurse abuse as a professional norm. HV has been empirically demonstrated to negatively impact the novice nurse and lowers self-esteem, causes anxiety, depression, sleep disorders, gastrointestinal disorders, suicidal thoughts and behaviors

International and domestic research demonstrates that HV is a global problem within the professional culture of nursing as a result of embedded characteristic behaviors that are passed on throughout professional role socialization. Interpersonal conflict is common in nursing according to McKenna, Smith & Poole (2003). In this study 34% experienced statements made by other nurses that they perceived as abusive and humiliating and these experiences affected confidence and self-esteem. Psychological consequences included fear, anxiety, sadness, depression, frustration, mistrust and nervousness. Physical consequences included weight loss, fatigue, headaches, hypertension and angina. HV occurred across all clinical settings with self-reported data seen as a limitation of this study.

In a seminal study by McKenna et al. (2003) which utilized the Impact of Event Scale that measures levels of distress over 7 days; results of the nurse respondents were similar to symptoms of post-traumatic stress disorder. This study

found that new graduate nurses experienced horizontal violence across all clinical settings. The preponderance of evidence from international research on the topic of HV reveals that there is a cycle of characteristic HV behavior which is embedded within the culture of nursing which negatively impacts professional role socialization for nurses and Interpersonal conflict is common in nursing (McKenna, Smith & Poole, 2003).

In the McKenna et al study 34% of new graduate nurses experienced statements made by other nurses that they perceived as abusive and humiliating. This affected their confidence and self-esteem. The significant psychological consequences included fear, anxiety, sadness, depression, frustration, mistrust and nervousness. Physical consequences included weight loss, fatigue, headaches, hypertension and angina.

Randle (2003) conducted a study on the impact of HV using a sample of student nurses looking at their professional role socialization process where behaviors and group norms are adopted. Randle used the Professional Self-Concept Nursing Inventory and the Tennessee Self-Concept scale and found that both general and professional self-esteem deterioration occurred. This researcher found that the majority of students start their nurse training with normal self-esteem but leave with below average self-esteem. 95% of the student nurses in this study perceived themselves as anxious, depressed and unhappy as they assimilated their nursing identity.

This researcher concluded this to be the result of HV and that these changes in self-esteem imply that the process toward becoming a nurse has a negative effect on self-esteem which is dramatic. 95% of students perceived themselves as anxious, depressed and unhappy as they assimilated their nursing identity as the result of HV. A common theme in student narratives was the hierarchy which is embedded within healthcare; and that having power over someone became integral to the novice nurses' self-esteem. Students may ignore and accept HV perpetrated against them by more experienced nurses in an effort to gain a sense of belonging. Students also began to assimilate the same tactics of HV into their own practice as they identified these behaviors with becoming a nurse. And we can once again see here how HV becomes cyclical and embedded within the profession.

The impact on retention of new graduate nurses is significant as well with up to 50% of new graduates leaving their first position within the first 6 months because of HV. (Beecroft, Kunzman & Krozek, 2001; McKenna, Smith, Poole & Coverdale, 2003)

Students start their nurse training with normal self esteem but leave with below average self esteem (Randle, 2003). Randle found that 95% of students perceived themselves as anxious, depressed and unhappy as they assimilated the role of a nurse 50% of new nurses leave position within first 6 months post graduation (Beecroft, Kunzman & Krozek, 2001; McKenna, Smith, Poole & Coverdale, 2003). These authors describe the cycle of characteristic HV behavior which are embedded within the culture of nursing (McKenna, Smith, Poole & Coverdale, 2003).

In a review of the domestic literature, Longo (2007) conducted a study (n47) using a survey to describe the experience of HV by nursing students in the U.S. Longo (2007). The behavior most frequently reported was being put down by a staff nurse with 53% of respondents reporting this behavior. Longo found that 40% of nursing students reported being humiliated; 32% reported having a sarcastic remark made about them; 34% observed an act of horizontal violence between a staff member and a classmate. Although more than half of the students in this study reported experiencing HV, 49% of students also reported that they did not report HV occurrences to their instructor. 72% of respondents agreed with the statement that "nurses eat their young." Longo (2007) identifies limitations of this study related to small sample size with no discussion of the reliability and validity of the survey tool.

Stanley, Martin, Michel, Welton & Nemeth (2007) developed and tested the Lateral Violence in Nursing Survey (LVNS) using a questionnaire designed to measure perceived incidence and severity of lateral violence(LV). Lateral violence is synonymous with HV. The survey instrument was developed and piloted at a tertiary medical center by a multicenter in the US. The survey was administered online to nursing staff participants (*n*=663). Although 75% of respondents reported that they were treated with respect and courtesy by their co-workers, 65% reported that they frequently observed LV and almost half believed that it was a very serious or somewhat serious problem at their medical center. The literature demonstrates that a significant barrier to elimination of characteristic behaviors of HV is the fact that it commonly goes unreported. Stanley et al found that 26% of respondents did not feel

safe reporting it for fear of retribution. In this study 14% reported that LV had contributed to their decision to leave a nursing position. Qualitative statements and extensive narrative revealed perceived oppression (Stanley, Martin, Michel, Welton & Nemeth (2007) as new staff and young nurses were undermined in their integration on the unit. Nurses were unwilling to intervene when witnessing HV and nurses were unwilling to correct negative behaviors. This study by Stanley et al (2007) included qualitative statements with extensive narrative perceptions that many situations were perceived to be oppressive.

Especially noteworthy is the described treatment of new staff and young nurses by staff who undermined their integration on the unit or who were unwilling to intervene to correct negative behaviors. The Stanley et al study found that rude behavior is common and participants believe that new nurses are tested to see if they can make it. One of my students described the experience as "it's like they push you off the edge and you are hanging by your fingertips. If you are able to pull yourself up over the edge, then you are accepted."

Stanley, et al (2007) report study limitations of a non-random convenience sample in this pilot study which increase the possibility of sampling errors. As a result, the probability exists that the sample is not representative of the population. There is also concern of socially desirable responses by the employed nurses that may have occurred as the survey was conducted internally within their healthcare system.

In an effort to add to the limited body of knowledge in the area of HV, a study by Sofield & Salmond (2003) was conducted which found that verbal abuse, a

characteristic of horizontal violence, is an almost universal experience in nursing with 91% of respondents (*n*=461) reporting its occurrence. Sofield & Salmond (2003) conclude that verbal abuse in healthcare is pervasive and accepted. It is suggested in this study that nurses lack the skills to respond to and cope with verbal abuse and that the problem is perpetuated when no action is taken following incidents of verbal abuse. These researchers conclude that nurses accept verbal abuse because they feel powerless to change it. This sense of powerlessness as well as these behaviors of acceptance of negative behaviors exhibit the tenets of oppressed group behavior.

Nursing has been widely argued to be an oppressed group. Roberts is the seminal author on oppression in nursing and states that oppressed group behaviors exist in nursing because nursing falls below physicians and administrators within the hierarchy of medicine. Nurses often feel powerless within this system. The study by Sofield and Salmond suggests an organizational culture exists, leading to a passive response by nurses who experience verbal abuse. The qualitative data from this study demonstrates that the organization allows verbal abuse to continue as it is often accepted and ignored. Nurses report a general non-responsiveness by administration to verbal abusive incidents.

Disruptive behavior in the form of HV undermines a culture of safety (Joint Commission Sentinel Event Alert No. 40 (2008) and 70% of sentinel events connected to problems with communication between healthcare professionals. HV results in 33% to 61% of new registered nurse graduates leaving the profession or changing their place of employment within their first year of practice (Cox, 2001; Farrell, 2001;

McKenna, et al, 2003; Duchscher & Myrick, 2008; Beecroft, Kunzman & Krozek, 2001; Duchscher & Myrick, 2008; Tinsley & France, 2004).

There is a migration of both novice and experienced nurses out of the profession due to HV (Feblinger, 2009) and the cost to employers is significant with $65,000 to replace and train a staff nurse, while the cost to replace a specialty nurse exceeds $145,000 (Pendry, 2007). The phenomenon of HV measured through dimensions of oppressed group behavior have not been developed and validated and oppressed group behaviors have only been studied independent of each other.

HV has an impact on patient safety. Disruptive behavior in the form of HV undermines a culture of safety (Joint Commission Sentinel Event Alert No. 40 (2008) and 70% of sentinel events connected to problems with communication between healthcare professionals. Preventable medical error remains the third leading cause of death in this country and HV undermines patient safety.

Chapter III

METHODS

Research Design

This study is non-experimental as there is no attempt to control variables. This study is descriptive in nature, in addition to correlational. In correlational design, we do not manipulate an independent variable and there is no effort to control for other possible factors that may vary. For this reason, a significant correlation does not show that one factor changes another (i.e., causality). A significant relationship shows that two factors are related, but it does not provide an explanation for how or why they are related.

This dissertation study used a newly created validated survey instrument and this research is non-experimental design, cross-sectional and descriptive. The design is correlational intending to explore relationships between domains of knowledge, attitudes and practice behaviors along the dimensions of assimilation, marginalization, low self-esteem, submissive aggressive syndrome and horizontal violence.

Instrument Development

An instrument was developed to assess the affective domain of nurse educator knowledge, attitude and practice of horizontal violence (NEKAP-HV©) (Polit & Beck, 2008). Responses are rank ordered on a Likert type scale. With no demonstrated reliability or validity, this questionnaire was reviewed by an expert panel for construct validity. Variables are based upon descriptions of which have emerged from the research on HV in nursing. Five constructs of oppression theory.

Variables are based upon descriptions of HV which have emerged from the research on HV in nursing. The five constructs of Friere's (1971) model are measured through the domains of nurse educator's knowledge, attitudes and practice.

This instrument uses a comparative Likert scale with all items rated on the same dimension, to provide simplicity, clarity and economy. The questions are supported by what is known from the literature in nursing on horizontal violence. Items were written to be short and brief while conveying meaning; and were developed to be as simple and clear as possible.

Assessing Validity - Primary Investigator Tool Creation

Concepts as items on questionnaire

Variables on the NEKAP-HV© instrument are based upon descriptions of HV which have emerged from the research on HV in nursing. The five constructs of Friere's 1971 model are measured through the domains of nurse educator's knowledge, attitudes and practice.

Construct Number One – Assimilation

Construct definition: Assimilation is defined as group behavior that includes customs and attitudes acquired through communication or observation. Individuals are fully assimilated to a new group when traits from the old group are indistinguishable from the new cultural group (Friere, 1971; Roberts, 1983).

Variable: It is natural within healthcare systems for physicians to hold all the power (Roberts, 1996). (Attitude, Item 1).

Variable: In general, nurses perceive themselves to be less powerful than physicians (Matheson & Bobay, 2007). (Attitude, Item 2).

Variable: Nurses have been identified as an oppressed group (Roberts, 1996). (Knowledge, Item 3).

Variable: I act like a physician to receive recognition and prestige. (Practice, Item 12).

Variable: An oppressed group assimilates the norms and values of the dominant group (Matheson & Bobay, 2007; Friere, 1971). (Knowledge; item 5)

Variable: I teach my students that nurses are subordinate to physicians. (Practice, Item 6).

Construct Number Two – Marginalization

Construct definition: Marginalization occurs when members of a group feel unimportant or like their opinion does not matter (Roberts, 1983).

Variable: Students should please the nurses on the unit (Randle, 2003). (Attitude, Item 4).

Variable: Students nurses should not disagree with expert nurses on the unit (Randle, 2003). (Attitude, Item 7).

Variable: Marginalization occurs when group members feel unimportant (Roberts, 1983). (Knowledge, Item 9).

Variable: Student nurses should be encouraged to emulate physicians in appearance (Roberts, 1996). (Attitude, Item 4).

Variable: Marginalized leaders are inflexible (Matheson & Bobay, 2007; Roberts, 1983). (Knowledge, Item 11).

Variable: I teach students to show respect to elite staff (Matheson & Bobay, 2007; Roberts, 1983). (Practice, Item 13).

Construct Number Three – Low Self Esteem

Construct definition: Low self esteem occurs when individuals feel devalued (Roberts, 1983).

Variable: Nursing students are dependent upon those superior to them in the hierarchy of healthcare delivery (Sofield & Salmond, 2003). (Attitude, Item 14).

Variable: Students must understand that the hierarchy in healthcare makes nurses less powerful (Sofield & Salmond, 2003; Roberts, 1983). (Attitude, Item 16).

Variable: There is a hierarchy in healthcare and nurses are subordinates within that system (Sofield & Salmond, 2003; Roberts, 1983). (Attitude, Item 15).

Variable: Self-esteem is eroded when students are criticized (Hughes, 2003; Jackson, et al, 2002; Vessey, et al, 2009). (Knowledge, Item 17).

Variable: Students must demonstrate their value to the healthcare team. . (Hughes, 2003; Jackson, et al, 2002; Vessey, et al, 2009). (Practice ; Item 18).

Variable: Students are taught that they must adapt to the hierarchy in healthcare. (Practice, item 19).

Variable: Criticism threatens a student's sense of self-mastery (Hughes, 2003; Jackson, et al, 2002; Vessey, et al, 2009). (Knowledge Item 20).

Construct Number Four – Submissive-Aggressive Syndrome

Construct definition: Submissive-aggressive syndrome results in individuals feeling unable to speak up and confront issues which concern them (submissive); however, if they do speak out to confront an issue they do it in an ineffective confrontational manner (aggressive).

Variable: It is acceptable for student nurses to speak directly to the primary nurse when they have concerns in clinical (Randle, 2003). (Attitudes, Item 21).

Variable: Nursing students should not approach a physician directly with questions without receiving permission from their instructor (Randle, 2003). (Practice, Item 22).

Variable: Nursing students must follow all orders given by their primary nurse (Roberts, 1983). (Attitudes, Item 23).

Variable: Nursing students should follow every order given by a physician (Roberts, 1983). (Attitudes, Item 24).

Variable: Nurses seldom confront physicians directly when they have complaints (Roberts, 1983). (Knowledge, Item 25).

Variable: Oppression results in passive-aggressive behavior (Roberts, 1983). (Knowledge, Item 26).

Variable: I teach students not to approach a physician directly without permission (Randle, 2003). (Practice, Item 27).

Construct Number Five – Horizontal violence

Construct definition: HV is defined as subtle or overt acts of aggression between group members. An example of a subtle act of HV is ignoring the concerns of another

or withholding information. Examples of overt acts of HV are of extreme criticism or ridicule**.**

Variable: Sometimes students concerns about a patient are unimportant. (Attitude, Item 28).

Variable: Criticizing students makes them resilient. (Attitude, Item 29).

Variable: It is acceptable for the primary nurse to criticize students. (Attitude, Item 30).

Variable: Sometimes it is appropriate for the primary nurse to withhold patient information from a student who is assigned to that patient (Attitude, Item 31).

Variable: It is acceptable for primary nurses to be abrupt when students ask questions. (Attitude, Item 32).

Variable: I have reported nurses who have withheld patient information from my students. (Practice, Item 33).

Variable: I teach my students about horizontal violence. (Practice, Item 34).

Variable: I teach conflict resolution skills. (Practice, Item 35).

Variable: It is not okay to criticize students in front of patients. (Attitude, Item 36).

Variable: It is okay to criticize students in front of nursing staff. (Attitude, Item 37).

Variable: There would be negative consequences if a student reported horizontal violence to the administration of a clinical agency (Longo, 2007). Attitude, Practice, Item 38).

Variable: Horizontal violence against nursing students should be reported. (Knowledge, Practice, Item 39).

Variable: I have reported nurses who have engaged in horizontal violence against my students. (Practice, Item 40).

Variable: An overt act of aggression between group members is horizontal violence. (Knowledge, Item 41).

Variable: Ignoring the concerns of another is horizontal violence. (Knowledge, Item 42).

Variable: Withholding information is an act of horizontal violence. (Knowledge, Item 43).

Variable: Extreme criticism is an act of horizontal violence. (Knowledge, Item 44).

Variable: Acts of horizontal violence may be subtle. (Knowledge, Item 45).

Variable: There are times when it is acceptable to ignore a student. (Practice, Item 46).

Delphi Panel Review

The content validity of this 46-item scale was performed by five internationally known nurse experts in the field of oppression in nursing and horizontal violence to assess the instrument for relevancy, clarity and comprehensiveness through Delphi technique (DeVellis, 2012). The survey items are based on what has been tested in past studies on HV to enhance validity (Agarwal, 2010). Definitions of constructs in this model are based on the literature. When items are self-developed, verifying survey items is very important (Agarwal, 2010). This self-administered survey instrument is designed to measure the attitudes, knowledge and practices of nurse educators, with constructs related to the dimensions of oppression based on Friere's pedagogy (1971).

Items were written to be short and brief while conveying meaning; and were developed to be as simple and clear as possible.

Delphi technique was utilized for construct validity. Delphi panel expert panel review is a series of sequential questionnaires or "rounds" interspersed by controlled feedback, that seek to gain the most reliable consensus of opinion of an expert panel. The technique has been used widely in business, industry and health care research. RAND Corporation developed the Delphi method in the 1950s, originally to forecast the impact of technology on warfare (Sackman, 1974). The method involves a group of experts who evaluate questionnaires and give feedback on items providing statistical representation of the group response. The instrument is revised based upon feedback and the process repeats itself. The goal is to decrease the range of responses and arrive expert consensus. Revisions are made to the instrument based upon the recommendations of the expert panel of reviewers. Consensus of the panel is sought with majority panel member recommendations followed.

The expert panel is asked to identify variables which are ambiguous or unclear and also identify any which may be double-barreled. Unclear items are revised to improve clarity. The panel is asked to identify elements which may lead to a response that is socially desirable. Deviation from socially prescribed behaviors leads respondents to report what is socially acceptable rather than their true answers (Alreck & Settle, 2004). These elements will be revised to elicit a true answer, as opposed to a socially desirable response. The expert panel is asked to review the order of questions

to reduce order bias (Alreck & Settle, 2004). The expert panel is also asked to review the demographic questions for appropriateness.

In this study, the Delphi Panel was composed of five nurse researchers with terminal PhD degree in nursing. One of 5 is the seminal researcher domestically on oppression in nursing. This panel includes five nurse scholars with research expertise in the area of oppression in nursing, horizontal violence in nursing, as well as expertise in instrument development. Three of the Delphi Panel of 5 members are experts in research the area of horizontal violence in nursing. All members of the Delphi Panel are tenured professors in nursing.

The expert panel reviewed the instrument for clarity, focus and brevity, as well as content validity; i.e., does the variable measure the concept. Delphi establishes face and content validity of the tool for face and content validity. To establish face validity, the expert panel reviewed items on the instrument to validate that the items measure what they are intended to measure. Content validity is most often measured by relying on the knowledge of people who are familiar with the construct being measured. These subject-matter experts were provided access to the measurement tool and asked to provide feedback on how well each question measure the construct in question. Their feedback was then analyzed and informed decisions were made about the effectiveness of each item. Majority consensus was represented by 3/5 members of the panel.

The instrument underwent three rounds of Delphi Panel Review. The first round 46 items were reviewed and the expert panel majority consensus recommended

19 items for revision and the experts provided comments and recommendations for those revisions. During Round 2, the 19 items were revised based upon expert recommendations and returned to the panel for round 2 review. This resulted in a third and final Round 3 with 5 items recommended for revision.

Consensus on final revision of 5 items was received demonstrating face and construct validity of the instrument through Delphi Expert Panel Review. The NEKAP-HV© instrument is a 46 Item Questionnaire using a Likert Scale intended to measure 3 constructs of nurse educator knowledge, nurse educator attitude, and nurse educator Practice; across 5 the five dimensions of assimilation, marginalization, low self-esteem, submissive-aggressive behavior and horizontal violence. An ordinal scale such as a Likert scale asks survey participants to respond to a series of statements about a topic to see agreement or disagreement. It measures cognitive and affective components of attitudes. Affective domains consider general feelings about a topic. Cognitive measures awareness and knowledge and behavioral is related to an intention or expectation for a particular action.

Inclusion/Exclusion Criteria of Sample

The following inclusion/exclusion criteria were established:

Inclusion Criteria

1. Nurse educator in the U.S. with a minimum of a master's degree.
2. Employed at a school of nursing accredited by the Collegiate Center for Nurse Education (CCNE).
3. 18 years or older.

Exclusion Criteria

1. Is not a Nurse Educator in the U.S. and does not have a master's degree.
2. Is not employed at a school of nursing accredited by the CCNE.
3. Under age of 18.

Participant Recruitment

A convenience sample of nurse educator participants who met inclusion criteria were recruited via email. Email addresses of nurse educators were gathered from public domain online databases to include schools and colleges of nursing in the United States accredited by the Colleges of Nursing Commission on Collegiate Nursing Education (CCNE). These schools were identified via college websites. Email addresses were gathered by a research assistant via university website and entered into an Excel data base. To reduce selection bias and increase likelihood of a database that was representative of the nation, the research assistant utilized the 10 Regions established by the Center for Medicare & Medicaid Services and gathered 150 email addresses from a random sample of schools in each of the ten CMS regions. Random sampling included selection of schools from both urban and suburban populations in each region. This yielded a data base of 1500 email addresses for the sample.

Data Coding and Analysis

Data were exported from SurveyMonkey® and uploaded into Microsoft Excel® and then uploaded into IBM Statistics SPSS Version 24.0 and stored on a memory key. The principal investigator (PI) maintains a memory key in a locked

filing cabinet in her home office. Prior to uploading to SPSS, data were recoded from string to numeric in Excel and reviewed for missing data values. There were a total of 255 respondents of which 254 completed 100% of the survey. One survey was incomplete and discarded.

Demographic characteristics are presented in tabular form using descriptive statistics and non-parametric statistics. Non-parametric statistics are appropriate when the level of the data is nominal or ordinal (Portney & Watkins, 2008). Descriptive statistics reported and analyzed for responses on the self-report survey instrument are measures of central tendency; i.e., the mean. The mean can be subjected to arithmetic manipulations making it the most reasonable estimate of population characteristics.

Spearman Rho correlation coefficient shows the linear relationship between two sets of data. For example, is there a relationship between nurse educator knowledge of horizontal violence and attitude of horizontal violence; is there a relationship between nurse educator knowledge of horizontal violence and practice; is there a relationship between nurse educator nurse educator attitude of horizontal violence and practice? Spearman Rho correlation coefficient is a measure of the linear correlation between two variables X and Y, giving a value between +1 and −1 inclusive, where 1 is total positive correlation, 0 is no correlation, and −1 is total negative correlation (Portney & Watkins, 2009).

A Priori G*Power© Analysis

A Priori Power Analysis was conducted to determine sample size using G*power© 3.0 software. The effect size of 0.30 is a medium effect size.

The alpha is 0.05 which is the level of significance or the probability of detecting a type 1 error (false positive). The Power (1-beta) is 0.95 which is the probability of detecting a true relationship or group differences. The total minimum sample size calculated is 138. Data collection will continue beyond this point because the larger the sample, the more representative it is of the population and the smaller the sampling error is. According to Portney and Watkins (2009) and Polit and Beck (2008), the issue of sample size is essential as it directly affects the statistical power of the study or the probability of detecting a true relationship or group difference. A power analysis can reduce the risk for Type II errors which is a false negative by estimating in advance how big a sample is needed.

Correlational Analysis: A Priori: Compute Required Sample Size

Input:	Effect size f	=	0.30
	α err prob	=	0.05
	Power (1-β err prob)		0.95
Output:	Lower Critical *p*		0.167188
	Upper Critical *p*		0.167188
	Total sample size		138
	Actual power		0.9540

Figure 4: A Priori Compute Sample Size for Correlational Analysis (G*Power 3.0.10)

F tests – ANOVA: A Priori: Compute Required Sample Size

Input:	Effect size f	=	0.25
	α err prob	=	0.05
	Power (1-β err prob)	=	0.95
	Number of groups	=	5
	Corr among rep measures	=	0.5
Output:	Noncentrality parameter λ	=	19.500000
	Critical F	=	2.419187
	Numerator df	=	4.000000
	Denominator df	=	190
Total sample size		=	195

Figure 5. A Priori Compute Sample size for ANOVA (G*Power 3.0.10).

Chapter IV

RESULTS & DISCUSSION

Introduction

This dissertation study utilized a newly created validated survey instrument administered to a national sample of nurse educators at CCNE accredited colleges. A total of 255 surveys were returned. One survey was incomplete and discarded leaving a total sample of 254 (*n*=254). One hundred percent of final sample of 254 participants who began the survey completed the survey.

Characteristics of the Sample

U.S. Geographical Locations of Respondents

Responses were received from 45 states. States with no response were Alaska, North Dakota, Rhode Island, Alabama and South Carolina.

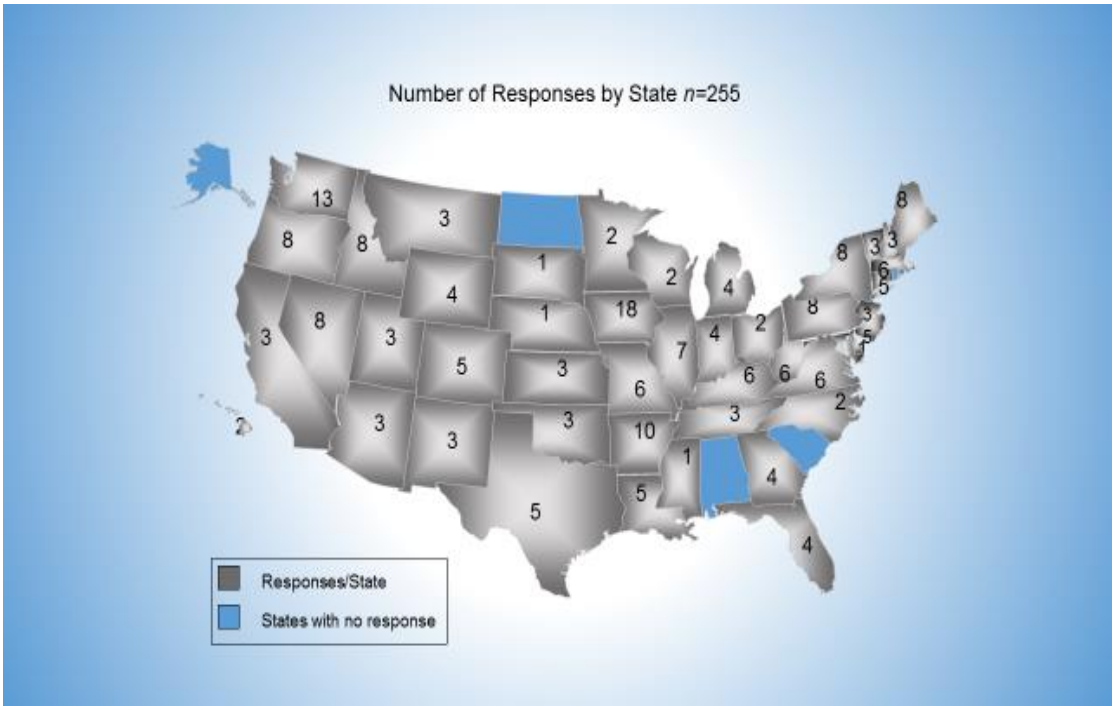

Figure 6: Responses by State to NEKAP-HV

https://www.morrisongrants.com/services/free_resources/templates

Geographic Region of Responses

The majority (44.9% *n*=114) of respondents identify that they teach in an urban area. This is followed by suburban (35.4% *n*=90) and least represented are educators in rural areas (19.3% *n*=49).

Table 2 Geographic Region of Respondents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	.4	.4	.4
	Rural	49	19.3	19.3	19.7
	Suburban	90	35.4	35.4	55.1
	Urban	114	44.9	44.9	100.0
	Total	254	100.0	100.0	

Table 2: Geographic Region of Respondents

Gender of Respondents

The nursing profession is predominately female, and this is also reflective of nurse educators in this sample which are 95% female and 5% male. This sample is consistent with the National Survey of Nurse Faculty which finds that 94.7% of faculty are female and 5.3% are male (http://www.evaluatinginnovationsinnursing.org/nufaqs-nurse-faculty-data-query/)**.**

Teaching specialty

The highest percentage of nurse educators practice across specialty settings (61% n=254) including wound care, family health, and college health. This is followed by medical/surgical/adult nursing (40% n=254), critical care (34% n=254),

community health (29% n=254), pediatrics (22% n=254) and psychiatric nursing (17% n=254).

Table 3 Respondent Teaching Specialty					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Administration	7	2.8	2.8	2.8
	Community Health	29	11.4	11.4	14.2
	Critical care	34	13.4	13.4	27.6
	Informatics	1	.4	.4	28.0
	Leadership	20	7.9	7.9	35.8
	Medical/Surgical - Adult	40	15.7	15.7	51.6
	Mother/Baby	15	5.9	5.9	57.5
	Pediatrics	22	8.7	8.7	66.1
	Practice across specialties: Wound Care; Family Health, College Health	61	24.0	24.0	90.2
	Psychiatric	17	6.7	6.7	96.9
	Research	8	3.1	3.1	100.0
	Total	254	100.0	100.0	

Table 3: Respondent teaching specialty

Focus area of teaching

The focus area of teaching of respondents demonstrates that 7.9% (n=254) teach predominately in the clinical setting; 54.3% (n=254) teach mostly didactic and 37.8% (n=254) teach equally between clinical and didactic.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Clinical	20	7.9	7.9	7.9
	Didactic	138	54.3	54.3	62.2
	Equal between didactic and clinical	96	37.8	37.8	100.0
	Total	254	100.0	100.0	

Table 4: Focus Area of Teaching

Highest level of education

Twice as many respondents are educated at the doctoral level with less than half indicating highest level of degree at the master degree level. This difference exceeds the national distribution of Nurse Faculty in the US as reported by the National Survey of Nurse Faculty indicating 63.8% of faculty are prepared at master degree and 28.2% at doctorate level. This variance can be explained by the fact that only schools accredited by the CCNE were included in this study and those schools require faculty are prepared at a minimum of masters level for undergraduate programs and doctorate is required for schools with graduate programs.

Highest level of education					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	.4	.4	.4
	Doctoral degree	181	71.3	71.3	71.7
	Master's degree	72	28.3	28.3	100.0
	Total	254	100.0	100.0	

Table 5: Highest level of education

Years of experience as registered nurse

This demographic may not represent national trends as no national data that evaluates years of practice by nurses was identified by the PI. Interestingly, based upon PI review, the nurse workforce data includes age, gender, highest degree and practice setting but does not include years of practice.

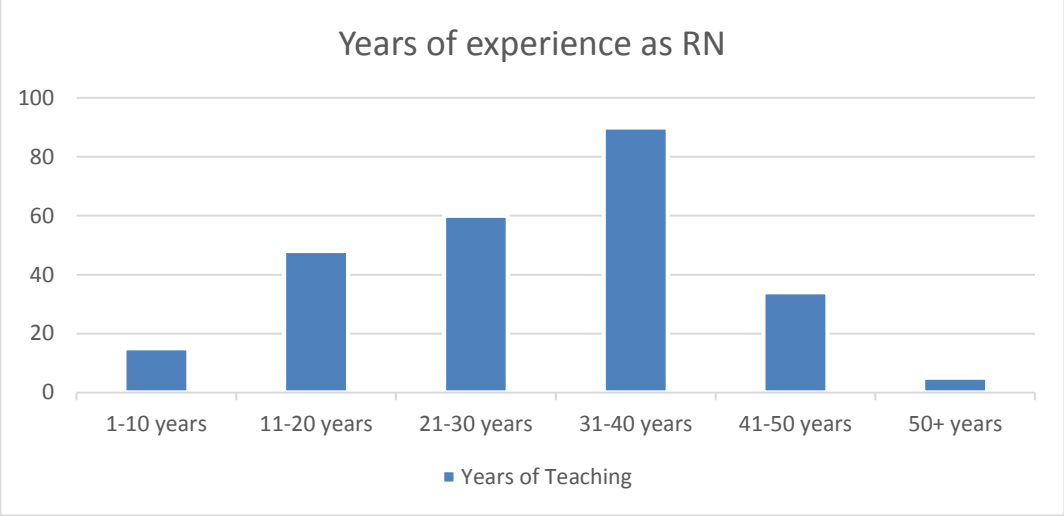

Table 6: Years of nursing experience

Years of experience as nurse educator

Comparative demographic data of average years of practice of nurse educators was not identified. The largest percentage of respondents have 1-10 years of experience with the next category 11-20 years at 25.59% with lower percentages of nurse educators with more than 20 years of experience. This has the potential to introduce respondent bias although the demographics for this nationally are unclear.

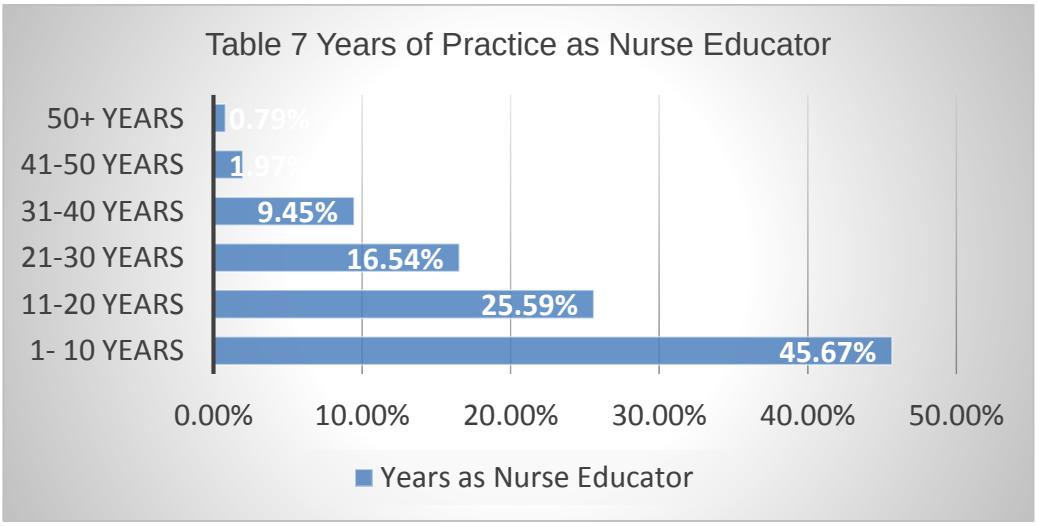

Table 7: Years of practice as a nurse educator

Reliability Testing Of Instrument: Cronbach's Alpha

Confusion surrounding the cause of high and low Cronbach's alpha scores can cause scales to be incorrectly discarded or wrongly labeled as untrustworthy (Goforth, 2015). The resulting coefficient of reliability ranges from 0.0 to 1.0 providing an overall assessment of a measures' reliability. The higher the alpha coefficient, the more the items have shared covariance and probably measure the same underlying concept. Standards for what makes a "good" coefficient are entirely arbitrary and depend on theoretical knowledge of the scale in question.

Many methodologists recommend a minimum a coefficient between 0.65 and 0.8 or higher with a maximum of 0.90 (Goforth, 2015). Coefficients below 0.5 are usually unacceptable. In interpreting a coefficient it is important to remember that a high alpha is both a function of the covariance among items and the number of items in the analysis. Therefore, a high coefficient is not in and of itself the mark of a good or reliable set of items and you can often increase the coefficient by increasing the number of items in the analysis. In fact because highly correlated items will also produce a high a coefficient, if it is very high; i.e., >0.95, scale items may be redundant. Important to consider researchers expertise as well as the method for development of the instrument when utilizing Cronbach's alpha. The NEKAP-HV scale demonstrated internal consistency as measured by Cronbach's Alpha in the acceptable range (a=.722) for a newly developed instrument (Goforth, 2015).

Research Questions 1 a. – 1 e.

Research questions 1 a-e through 3 a-3 measure the domains of educator knowledge, attitudes and practice through the dimensions of assimilation, low self-esteem, submissive-aggressive syndrome and horizontal violence. Selected variables are detailed.

RQ 1a: What is Nurse Educator (NE) Knowledge (K) of HV as measured on dimension of assimilation?

Item variable measuring knowledge of HV on the dimension of assimilation shows that 40.6% of nurse educators who responded to this survey demonstrated a low level of knowledge of the dimension of assimilation when responding to item "oppressed groups assimilate the norms of the dominate group." Anecdotal comments offered by respondents to this item reveal their opinions and demonstrate that nurse educators in this sample had polarizing views on this variable.

One respondent commented "Nurses perceive themselves and respond as an oppressed group" while another demonstrated knowledge that nurses have self-identified as an oppressed group; i.e., "They have been identified by themselves but not by any outside group." Another respondent stated that "as a baby boomer we were oppressed and had to stand up when MD walked into the room." The respondents believe that this has been the case "historically but has changed in present culture." One respondent states that "nurses perpetuate this" while another states that "nurses are still fighting for APRN rights". A respondent offers the compelling question "Why should medicine control nursing?" With a quarter of respondents neither agreeing or disagreeing on this variable with more than one quarter in the range of

slightly disagree to strongly disagree the chart on provides a visual representation of the knowledge gap that is suggested by this study by nurse educators regarding assimilation and oppressed group behaviors which result in horizontal violence. Fifty-nine percent of respondents demonstrated knowledge of assimilation and 21 percent do not. An additional 20% are neutral indicating they are not sure.

Figure 6 Research Q1a

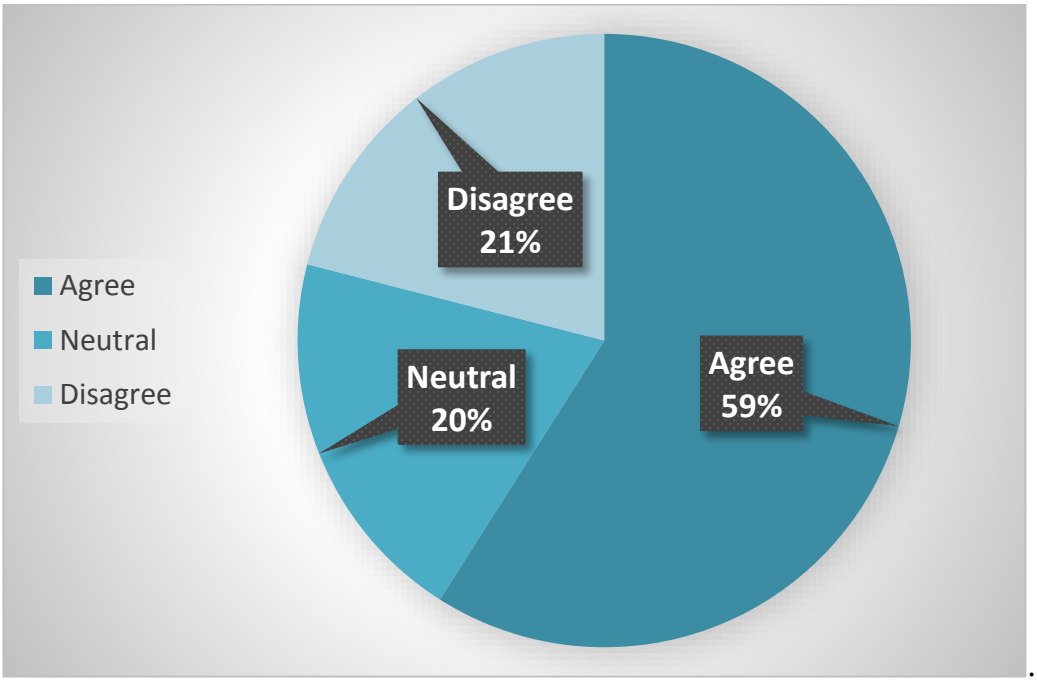

Figure 6 RQ 1a: What is Nurse Educator (NE) Knowledge (K) of HV as measured on dimension of assimilation? Variable: An oppressed group assimilates the norms of the dominant group.

Research Question 1 b.

RQ 1b: What is NE K of HV as measured on dimension of marginalization?

When aggregating the data on the agree side of the scale measuring nurse educator (NE) knowledge on the dimension of marginalization 93% of NEs agree with

this variable indicating strong knowledge in this sample. The respondents offered anecdotal comments on this variable stating "marginalization occurs when nurses are mean, demeaning and rude to new graduate." One respondent states "I think there are many factors" and another comments "unfortunately this occurs in healthcare." Noteworthy comments include "marginalization is perpetuated on the powerless by the powerful" and the "lack of unified vision for nurses contributes." An underlying attribute suggested by one respondent is that marginalization occurs "because of pressures of the healthcare system."

Figure 7 Research Q1b

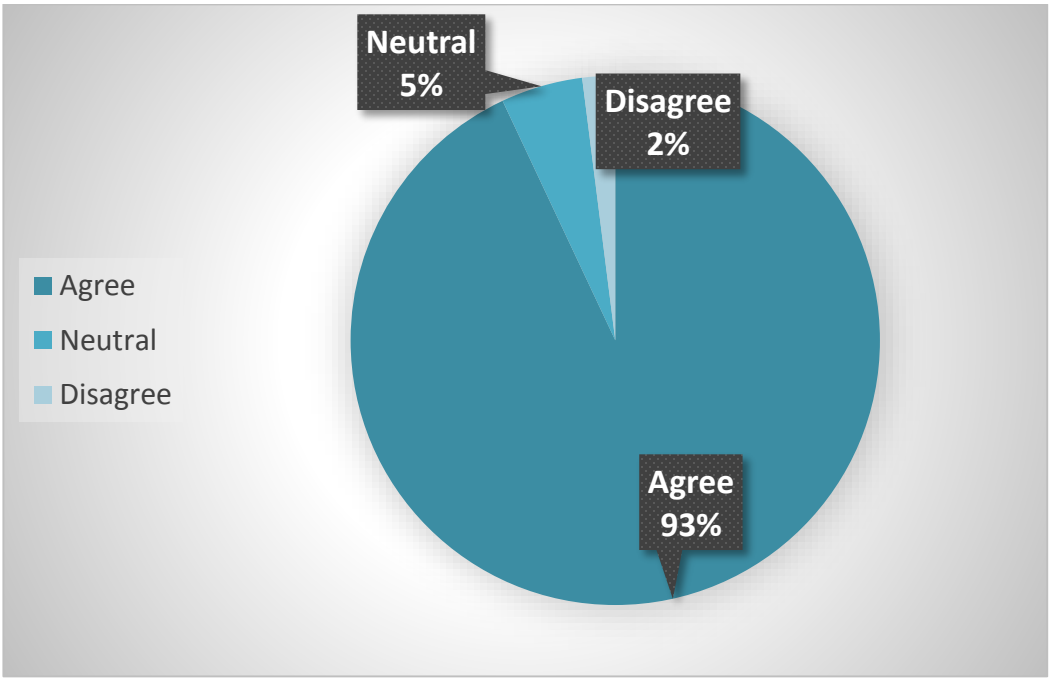

Figure 7: RQ 1b: What is NE K of HV as measured on dimension of marginalization?
Variable: Marginalization occurs when group members feel unimportant.

RQ 1c: What is NE K of HV as measured on dimension of low self-esteem?

On the dimension of low self-esteem, 33.8% of NEs demonstrated a low level of knowledge compared to 66.2% in the slightly agree to strongly agree range suggesting knowledge of the impact of criticism on students' self-esteem. There was a range of anecdotal comments (*n*=54) offered by respondents including "constructive criticism is good" and "critique is powerful". However, their comments also indicate there are caveats to criticism and that "it depends on the faculty" and "self-esteem is eroded when harshly criticized" and it can be "belittling" and "bullying" and that "we should teach not criticize" and further to that point, that NEs "need to give more positive feedback versus criticize and "self-esteem is eroded when anyone is criticized."

Figure 8 Research Q1c

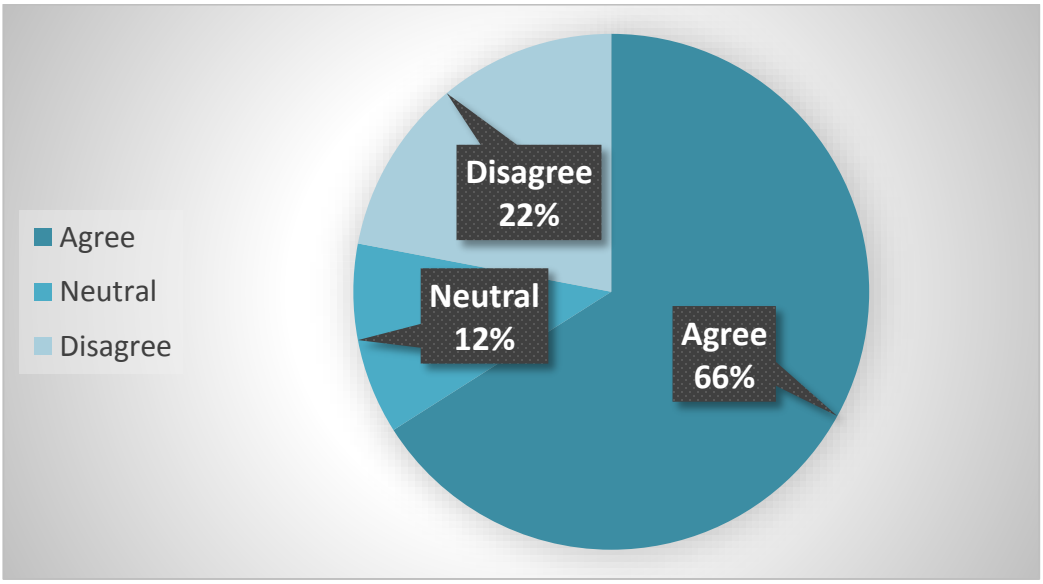

Figure 8: RQ 1c: What is NE K of HV as measured on dimension of low self-esteem? Variable: Self-esteem is eroded when nursing students are criticized.

Research Q 1d: What is NE K of HV as measured on dimension of submissive-aggressive behavior?

The variable to measuring research question 1 d. demonstrates that 80.4% of NEs have knowledge of submissive-aggressive behavior with 19.4% of nurse educators either unsure or in disagreement on the knowledge scale, indicating a low level of knowledge of this dimension for almost one-fifth of this sample. Anecdotal comments offered by respondents reveal that some NEs believe that "It can but it is not a causal relationship" and that "oppression results in overt behavior" and that "those who feel powerless generally exert their power on those they feel superior to". Although one respondent thinks that "it is not all the time but often" and another states it "can be unconsciously driven." Noteworthy respondent comment is that "oppression is the result" and that it results in "subservience."

Figure 9 Research Q1d

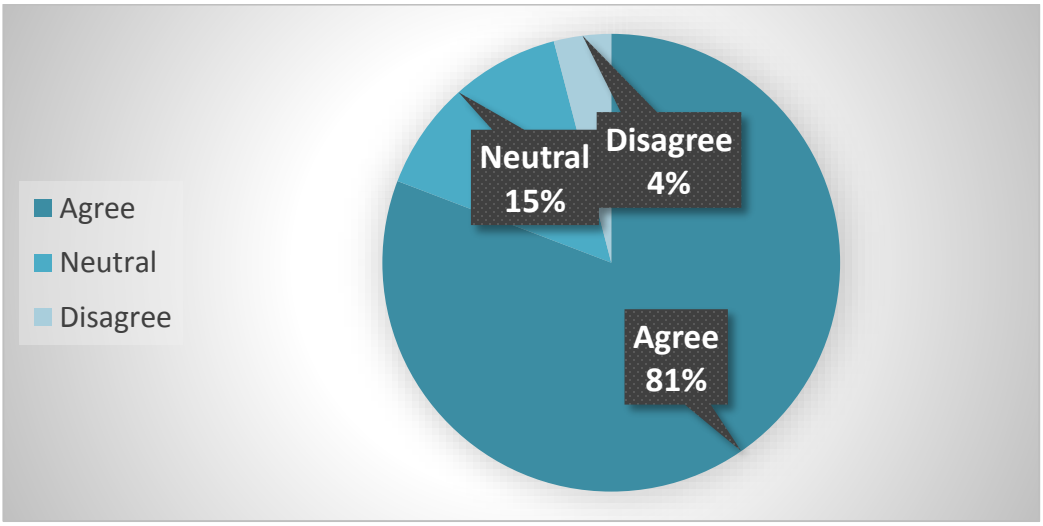

Figure 9: Research Q 1d: What is NE K of HV as measured on dimension of submissive-aggressive behavior? Variable: Oppression results in passive-aggressive behavior**.**

RQ 1e: What is NE K of HV as measured on

Just above three quarters of NEs who responded believe that ignoring the concerns of another is HV while 13.8 % were not sure as indicated by responding neither agree nor disagree. Notable is that within this sample, 9.8% of respondents who disagree that ignoring others is defined as HV thereby demonstrate low knowledge on this dimension. Respondents commented that ignoring concerns "can be HV especially when a student reports a patient concern and it is ignored because they are a student." However the respondents also indicated that this is "situationally dependent" another further stating that it "depends on the situation – everything under the sun can't be addressed" and that "there are people who complain incessantly and after a while otherwise considerate individuals might ignore them" yet "it is definitely a lack of respect, especially when done by a superior" however, one states that "Intentionality of harm is not a given." These responses from a small number of participants in this study suggest a lack of sensitivity on the part of some NEs in this sample of the impact on the student when their concerns are ignored.

Figure 10 Research Q1e

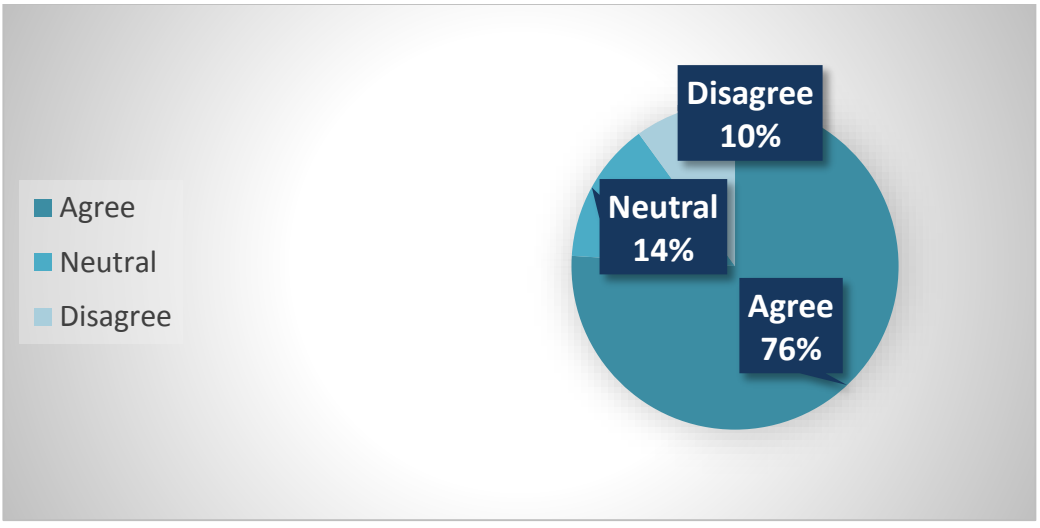

Figure 10: RQ 1e: What is NE knowledge of HV as measured on dimension of horizontal violence. Variable: Ignoring the concerns of another is HV.

Research Questions 2 a. – 2 e.

RQ 2a: What is NE Attitude (A) of HV as measured on dimension of assimilation?

When measuring NE attitude of HV on dimension of assimilation, 84.3% of NE in this study slightly agree, agree, or strongly agree that nurses perceive themselves less powerful than physicians. Respondents commented that "nurses are treated as such in the majority of healthcare organizations by nurses" but that it "depends on culture of their workplace." Respondents further offer that this is a common perception with "RNs but APRNs not as strongly." These nurse educators state that "we need to train our nurses to be leaders" and that "nurses are rarely at the table when vital organizational decisions are made." Noteworthy comments regarding perceptions of power by nurses is that "nurses still giving up their chairs to physicians" and the "power is primarily in the hands of physicians." Commenters also state that nurses have been "traditionally less powerful – (but that it) may be a gender issue."

Figure 11 Research Q2a

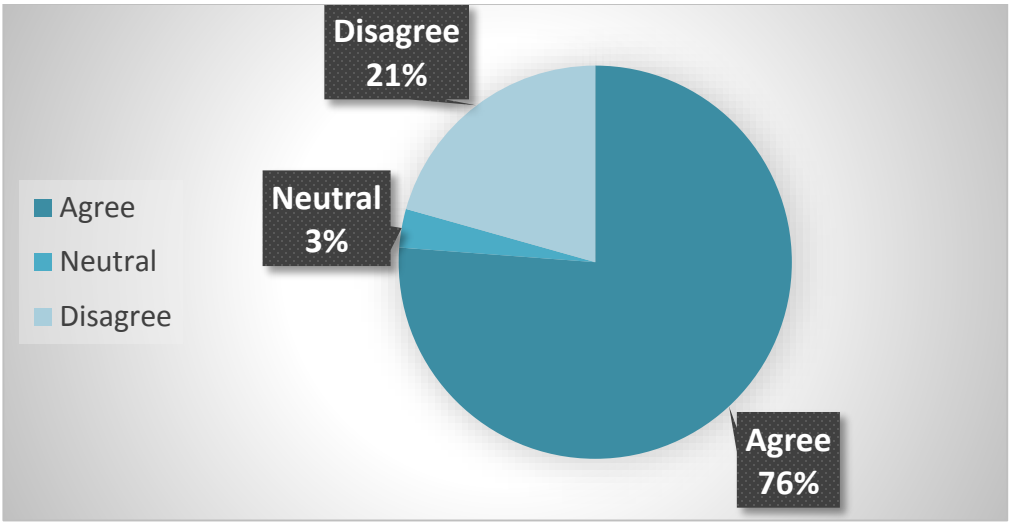

Figure 11: RQ 2a: What is NE Attitude (A) toward HV as measured on dimension of assimilation? Variable: In general nurses perceive themselves less powerful than physicians**.**

RQ 2b: What is NE attitude toward HV as measured on dimension of marginalization?

A majority of respondents (67.3%) believe that nurses are dependent upon them above them in the healthcare hierarchy while 11.8% neither agree nor disagree and 20.8% are in the slightly disagree to strongly disagree range indicating that they do not see nurses as dependent. Comments included thoughts that "students are dependent upon ALL in the healthcare system" and "this is sad to say" and ""I agree but desperately want it not to be true;" yet these respondents also indicate that it "depends on preceptors and educators" because "they are nursing students." However, this is contrasted with views that students are "part of the team and that "by the end of nursing school more independent" and that "we are interdependent. Silos should be gone, hierarchy flattened and the patient in the center of the circle."

Figure 12 Research Q2b

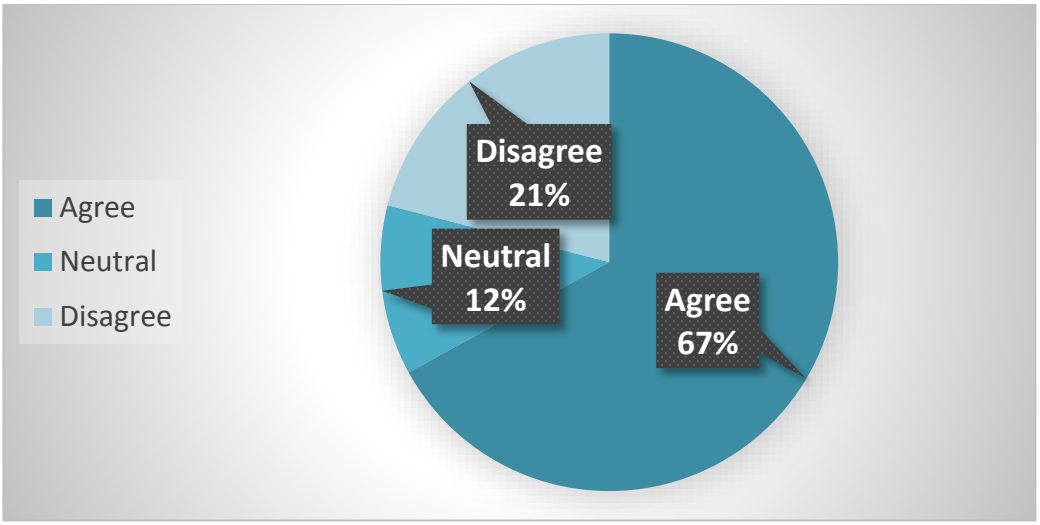

Figure 12: RQ 2b: What is NE A of HV as measured on dimension of marginalization?
Variable: Nursing students are dependent upon those above them in the healthcare hierarchy.

RQ2c: What is NE attitude toward HV as measured on dimension of low self-esteem?

Just over a quarter of NE slightly agree to strongly agree that the hierarchy in healthcare makes nurses less powerful while 31.1% strongly disagree, 26.8% disagree and 10.2% slightly disagree. 6.3% neither agree nor disagree. Respondents comment that "they should be taught to be powerful and break down stereotypes;" and "teach them to change the dynamic" because "they can change it" but that "students must be aware in order to change it and "they need the skills to change it." NEs further state that students "need to be taught ways to lead away from traditional hierarchy through leadership" and that we need to "teach them to find their power." Their comments identify that "nurses are less powerful because they do not speak up" and that "apathy makes nurses less powerful" and "we need to give them the skills to eliminate the hierarchy."

Figure 13 Research Q2c

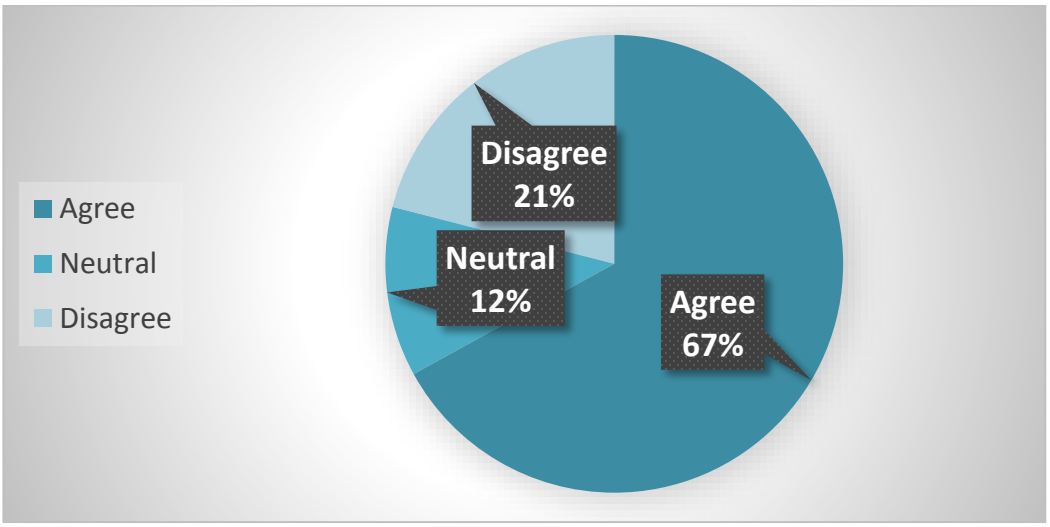

Figure 13: RQ2c: What is NE Attitude of HV as measured on dimension of low self-esteem? Variable: Students must understand that the hierarchy in healthcare makes nurses less powerful.

RQ 2d: What is NE A of HV as measured on dimension of submissive-aggressive behavior?

Just over three quarters (75.2%) of NEs disagree that nursing students must follow every order given by their primary nurse while 17.4% believe that they should and 7% not sure as indicated by a neutral response on this variable. Respondents that instead of following every order, "they should be taught to speak up" because "asking questions equates to quality care" and "unsafe orders should always be questioned." One respondent believes it is situationally dependent offering a comment that "this depends on the order and the rationale" while another states that "If they disagree with the primary nurse they should report it to the instructor" and "they have the right to question orders" and that "they are taught to question what doesn't make sense.

Figure 14 Research Q2d

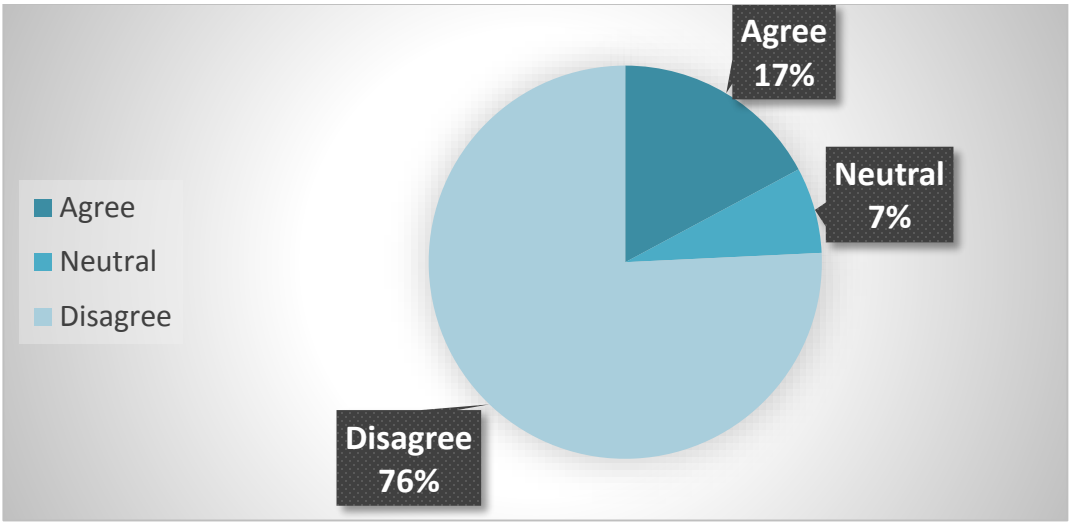

Figure 14: RQ 2d: What is NE A of HV as measured on dimension of submissive-aggressive behavior? Variable: Nursing students must follow all orders given by their primary nurse.

RQ 2e: What is NE attitude of HV as measured on dimension of horizontal violence?

In this study of NEs 19.8% (n=254) neither agree nor disagree or slightly agree, agree or strongly agree that there are times when it is acceptable to ignore a student. 30.7% strongly disagree, 39.8% disagree and 9.8% slightly disagree. "A significant minority of students are self-absorbed and thin-skinned when performance is poor they defend and deflect" while another states that "I try to never ignore but sometimes it is hard to discern the true issue they are asking." One respondent commented that "student's concerns should always be addressed however I would not do it at that exact moment the concern was brought up if it was not appropriate" and other states that "there should always be a reasoning for why the student voices a concern." A counter to these voices is the respondent who stated" "if we ignore their concerns we silence their voice."

Figure 15 Research Q2e

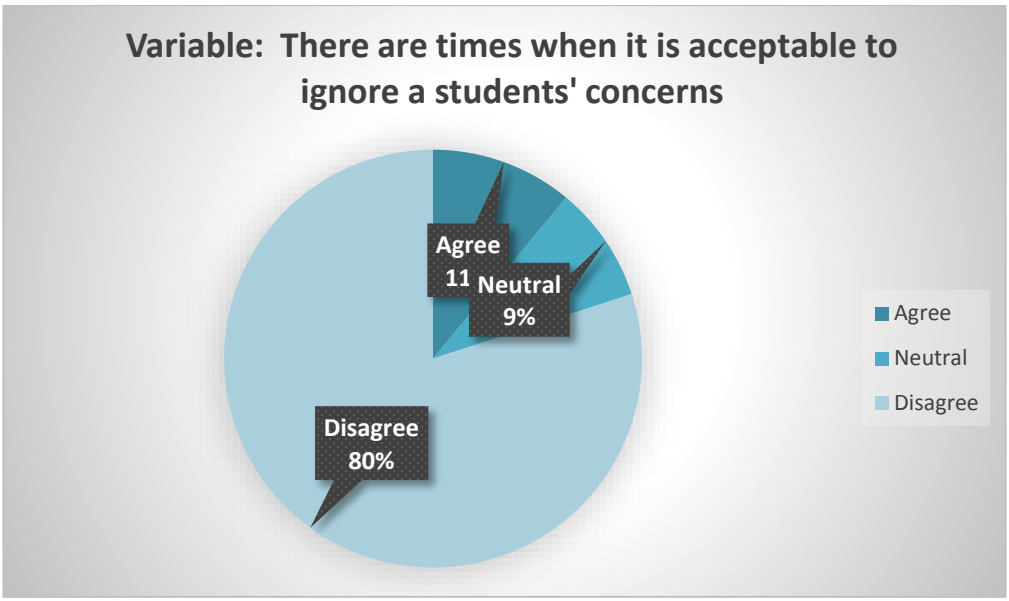

Figure 15: RQ 2e: What is NE A of HV as measured on dimension of horizontal violence? Variable: There are times when it is acceptable to ignore a students' concerns.

Descriptive Research Questions 3 a. – 3 e.

RQ 3a: What is NE Practice of HV as measured on dimension of assimilation?

Variable: I teach my students that nurses are subordinate to physicians.

The majority (97%) of respondents disagreed that they teach their students that they are subordinate to physicians with one stating that "I teach we have different but just as important role;" and "Seriously? Never. Nurses are not subordinate" and another wrote "never, in fact I have gone a bit overboard in criticizing physicians for their arrogance and lack of consideration for nurses" "Never! I tell them physicians are experts in medicine and nurses are experts in nursing." As seen in other comments related to the healthcare team, commenters stated "we are part of a team," and "we all

bring something to the table". In direct disagreement to the variable one participant stated "I teach the opposite, nurses are equal to physicians"

Figure 16 Research Q3a

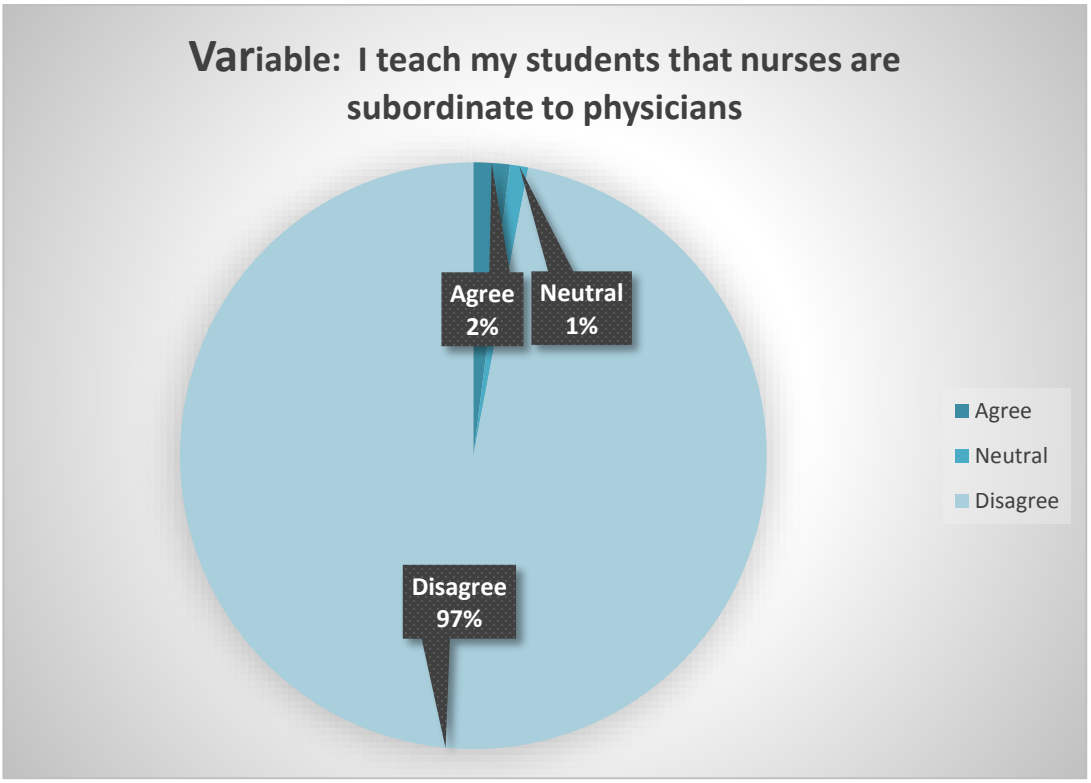

Figure 16: RQ 3a: What is NE Practice of HV as measured on dimension of assimilation? Variable: I teach my students that nurses are subordinate to physicians.

RQ 3b: What is NE P of HV as measured on dimension of marginalization?

Eighty-nine percent of NEs disagree with the variable "I act like a physician to receive power and prestige," providing comments in response including "Never, why would I want to act like a physician?" and "I act like a nurse leader" as well as another who states "I act like a well-educated person." On the other hand, there are comments indicating sometimes nurses do "act like a physician" as indicated by the commenters

who stated ““I am a PhD in nursing – I have referred to myself as Dr.___when calling to set a medical appointment because I am always seen much quicker than when I do not use the title of doctor (they assume I am an MD instead of a PhD and I let them assume it.” One nurse educator commented that “I am an APN, so yes I do act like a physician when I am in clinic.” Another offered “In some situations I make my status as “Doctor” known so I’ll receive recognition” and “because I am an NP people always assume I am a physician”

Figure 17 Research Q3b

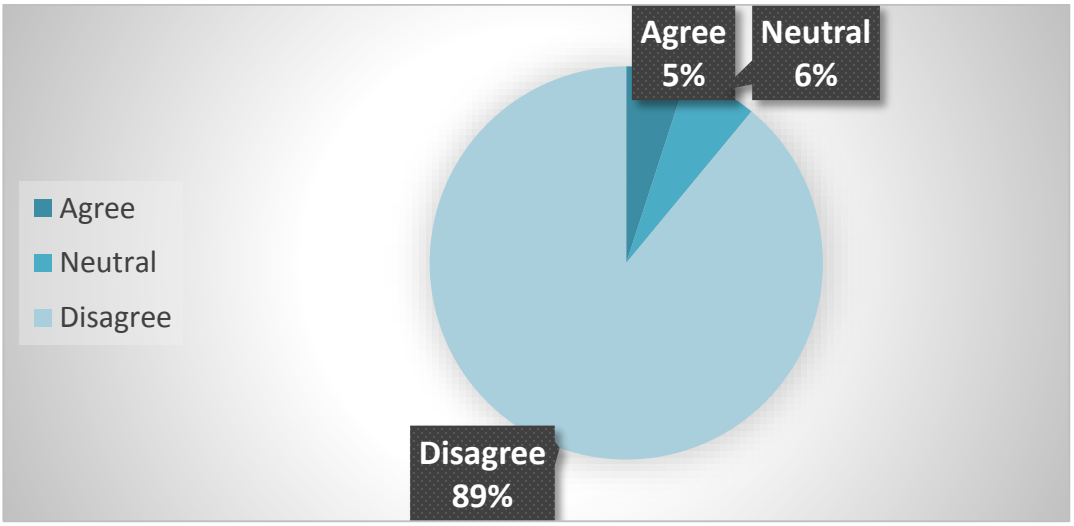

Figure 17: RQ 3b: What is NE P of HV as measured on dimension of marginalization? Variable: I act like a physician to receive recognition and prestige

RQ 3c: What is NE P of HV as measured on dimension of low self-esteem?

Seventy-eight percent of respondents (n=254) agreed that students must demonstrate their value to the healthcare team, while almost 20% either were unsure as indicated by a neutral response or disagreed that a student must demonstrate their value. Respondents offer comments to support their responses stating that “they are

unofficial members, their value is reflective of their preceptors" and that "students do "this over time with learning how to ask questions and transmit knowledge." While two respondent state that "students do not need to prove their worth to anyone," and "the team should accept them." An opposing viewpoint is that "today, yes everyone must prove their value to the team" and another states "don't like it but it seems to be the norm" and "unfortunately we all seem to need to prove our worth."

Figure 18 Research Q3c

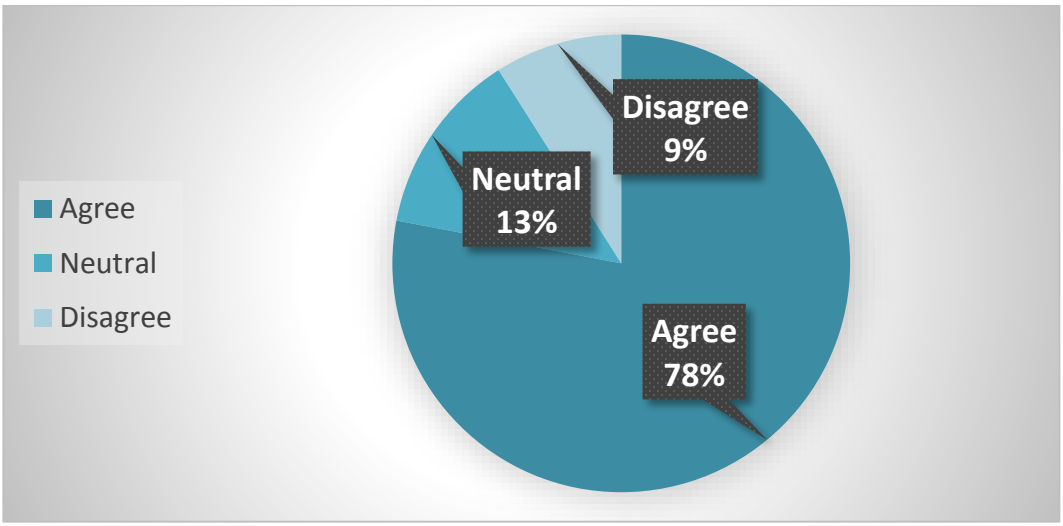

Figure18: RQ 3c: What is NE P of HV as measured on dimension of low self-esteem? Variable: Students must demonstrate their value to the healthcare team.

RQ 3d: What is NE P of HV as measured on dimension of submissive-aggressive behavior?

Seven percent of respondents agree that criticizing students makes them resilient while 16% are neutral indicating they are not sure how they feel about this. Respondents state that criticism is acceptable "as long it is constructive" but that it "depends on the student and the approach of the faculty." One respondent offers

"when I criticize my students it is in the context of assisting them to learn, not to make them resilient" and another states that "students need to be able to accept constructive feedback. They need to know they are not always right." Additional comments explain that "this is a way of life – feedback, peer review" yet, "critiquing is different from criticizing" and another states "it is unfair to the student to send them out into the world unprepared for negative people in the workplace."

Figure 19 Research Q3d

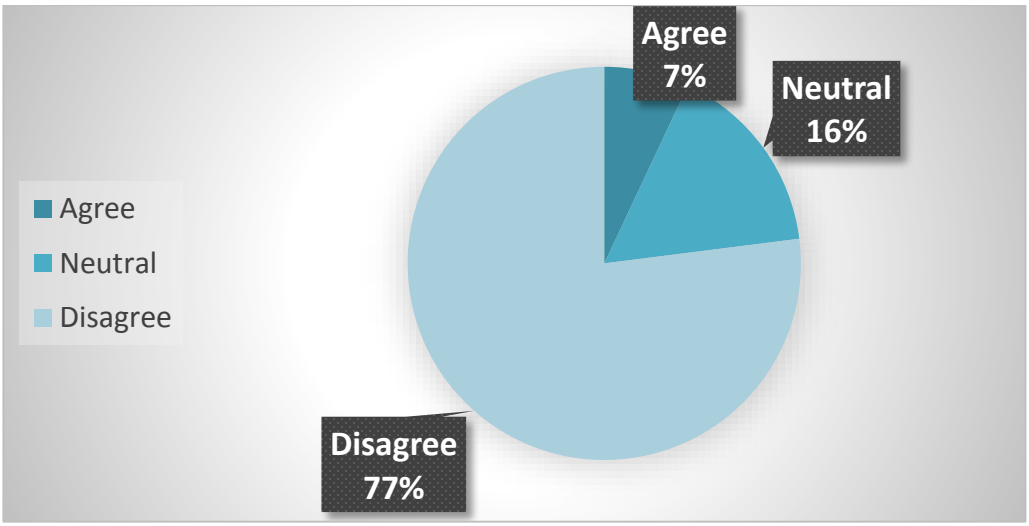

Figure 19: RQ 3d: What is NE P of HV as measured on dimension of submissive-aggressive behavior? Variable: Criticizing students makes them resilient.

RQ 3e: What is NE practice of HV as measured on dimension of HV?

The majority (90% n=254) of respondents indicate that they teach conflict resolution skills demonstrating they a best practice related to providing students with education related to addressing interpersonal conflict which is a core attribute of HV. However, respondents also indicated that "We need more education for students" and one respondent states that "formal teaching is done in another course." One

respondent states that “I make suggestions about how students can handle these situations but mostly I try to work around them because I’m more interested in helping students get their clinical experience with patients” while another indicates that “I teach conflict engagement.”

Figure 20 Research Q3e

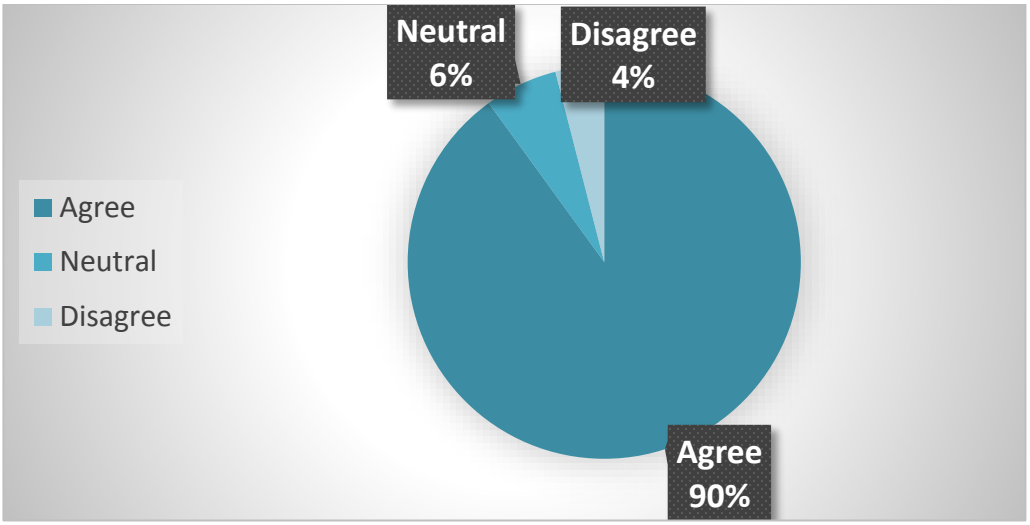

Figure 20: RQ 3e: What is NE practice of HV as measured on dimension of HV?

Variable: I teach conflict resolution skills**.**

Descriptive Statistics – Mean Scores

The mean score represents the average response on each variable indicating the level of agreement or disagreement. Scores range from 1 to 7 and the closer the mean score is to 7 the more likely the respondent is agree and therefore demonstrate knowledge of oppression, practices that demonstrate awareness of horizontal violence as well as attitudes reflecting awareness of oppression. Scores less than 4 reflect disagreement on the variable indicating less knowledge of the dimensions of

oppression, poorer attitudes and practices that demonstrate low level of awareness of horizontal violence and the impact it has on student nurses.

Descriptive Statistics of Variables	N	Mean	Std. Deviation
It is natural within healthcare systems for physicians to hold all the power	254	4.50	2.345
In general nurses perceive themselves to be less powerful than physicians	254	3.01	2.065
Nurses have been identified as an oppressed group	254	3.29	1.873
Student nurses should emulate physicians in appearance	254	4.00	2.225
An oppressed group assimilates the norms of the dominant group	254	2.76	1.540
I teach my students that nurses are subordinate to physicians	254	6.19	1.800
Students should not question the standards on the unit	254	4.76	1.802
Marginalization occurs when group members feel unimportant	254	2.66	1.832
Marginalized leaders are inflexible	254	2.95	1.648
I act like a physician to receive recognition and prestige	254	4.93	2.379
I teach my students that they must show respect to elite staff	254	3.36	1.711
Nursing students are dependent upon those above them in the healthcare hierarchy	254	3.06	1.834
Nurses are subordinates within the healthcare hierarchy	254	3.80	2.251
Students must understand that the hierarchy in healthcare makes nurses less powerful	254	4.26	2.243
Self-esteem is eroded when nursing students are criticized	254	3.29	1.948
Students must demonstrate their value to the healthcare team	254	2.87	1.901
Nursing students must receive permission from instructor before approaching a physician	254	3.88	2.200
Nursing students must follow all orders given by their primary nurse	254	3.94	2.163
Nursing students must follow every order given by the physician	254	4.22	2.210
Nurses seldom confront physicians when they have concerns	254	3.40	1.971
Oppression results in passive-aggressive behavior	254	3.08	1.977
Criticizing students makes them resilient	254	3.74	1.759
It is acceptable for the expert nurse to criticize the student nurse	254	4.03	2.247
Sometimes it is appropriate for the primary nurse to withhold patient information from the student assigned to that patient	254	4.21	2.329
I have reported nurses who have withheld information from my students	254	3.16	1.409
I teach my students about horizontal violence between nurses	254	3.28	2.135
I teach conflict resolution skills	254	3.18	2.261

It is not okay to criticize students in front of patients	254	4.74	2.245
It is okay to criticize students in front of nursing staff	254	5.18	2.319
There would be negative consequences if a student reported horizontal violence to an administrator of a clinical agency	254	3.67	1.964
Horizontal violence should be reported	254	3.64	1.859
I have reported nurses who have engaged in horizontal violence against my students	254	3.22	1.880
An overt act of aggression between group members is horizontal violence	254	2.95	1.873
Ignoring the concerns of another is horizontal violence	254	3.16	1.983
Withholding patient information from a student nurse assigned to that patient is not an act of horizontal violence	254	3.31	1.840
Extreme criticism if not an act of horizontal violence	254	4.74	2.413
Acts of horizontal violence may be subtle	254	3.13	1.959
There are times when it is acceptable to ignore a students' concerns	254	4.07	2.197
I believe that nurses are more powerful than physicians	254	3.26	1.624
Sometimes I criticize my students	254	3.35	2.019
Valid N (listwise)	254		

Table 8: Descriptive Statistics on Variables 1-43 NEKAP-HV

Discussion of Descriptive Results

Dimensions of Oppression - Assimilation

Assimilation to a group is successful when the traits of the old group are replaced with the traits of the new group identity (Roberts, 1983). Simons & Mawn (2010) found that respondents in their study had difficulty "fitting in" when they felt different as they joined the profession of nursing. NEs in this study agreed (59.3% n=254) that an oppressed group assimilates the norms of the dominant group indicating strong knowledge on this dimension; however, 20.1% were neutral and 20.5% disagreed indicating that almost half of the respondents have poor knowledge on the dimension of assimilation. Roberts, DeMarco & Griffin (2009) suggest that understanding the dimensions of oppression are necessary to allow the system to

empower individual nurses and focus on strategies to break the cycle of oppression. These researchers go on to discuss the resistance by nurses and administrators to acknowledge the existence is what creates the barriers to changing the negative behaviors. Behavior change by empowering the oppressed comes from understanding the cycle and this study provides a deeper understanding of the knowledge this sample of nurse educators possess on the dimension of marginalization of nurses.

This low level of knowledge on the dimension of assimilation is contrasted by an attitude toward assimilation that can occur when a nurse educator believes that students should not question the standards on the medical unit, a variable in this study. On this variable of attitude toward behaviors that students allow students to assimilate safely and professionally onto a medical unit, 98% (n=254) of nurse educators in this study disagree that students should not question standards on the medical unit and instead state that "everyone should question standards" and that "we should teach them to question in an professional, appropriate manner" suggesting that this sample of nurse educators are aware of the need to provide the student nurse with skills to engage in crucial conversations as they assimilate into the culture of healthcare delivery on in-patient medical units.

Dimensions of Oppression - Marginalization

On the dimension of marginalization as it relates to oppression, Roberts, DeMarco & Griffin (2009) describe the theory of Friere (1971) that reveals that dominated people feel devalued when the powerful promote their own attributes as the ones to value and that they become marginal when they cannot become members of

the dominant group. When measuring NE knowledge of marginalization, the majority (92.88% n=254) of NEs agree that marginalization occurs when group members feel unimportant while a lesser percentage (47.4% n=254) agree that marginalized leaders are inflexible (an attribute identified in the literature by Roberts, 1983). When asked if they agreed that students must follow every order given by their primary nurse, 17.3% (n=254) agree that students must follow every order with three quarters (75.2%) disagreeing and that students must question orders when they have concerns. These findings suggest that while the majority of nurse educators in this study have strong knowledge of marginalization as a dimension of oppression, 17% of the participants in this study may be engaging in behaviors that have the potential to marginalize their students when agreeing that students must follow all orders given by their primary nurse. These findings further suggest the need to provide resources and education to nurse educators to ensure that all student nurses are receiving education that empowers them to question orders as appropriate.

Dimensions of Oppression – Low Self-Esteem

Randle (2003) conducted a three year study exploring student nurse self-esteem and found common negative bullying behaviors in the socialization of nurses were internalized leading to erosion of students' self-esteem. Randle talked about self-esteem as a major predictor of human behavior and that the professional socialization process impacts professional self-esteem through the assimilation of professional norm and that the health of a nurse's self-esteem include the use of authentic-self and being empathetic which results in strong relationship development

while nurse theorists suggest that healthy self-esteem affects care in a positive direction (Olsen, 1995, Carson et al. 1997, Arthur & Thorne 1998, Freshwater 1998, Reeve 2000, Randle 2001b).

In this study, on the dimension of low self-esteem, 19.84% (n=254) of respondents believe there are times when it is acceptable to ignore a students' concerns. Although this applies only to the sample in this study, this finding is suggestive of the endemic problem in nursing when educators believe that there are times when it is okay to ignore a student; when in fact, that very behavior has a significant negative impact on nursing by perpetuating the cycle of behaviors that then continue to be embedded in the practice. As Randle (2003) found, students assimilate professional roles through enculturation and students who initially perceived themselves as caring, kind, empathetic and supportive disintegrated when they shaped their own attitudes, behaviors and beliefs by watching others. The result was that patients were no longer central to the nurse. The need to educate competent, confident, caring nurses has never been more critical in our fragmented healthcare system where vulnerable patients are served.

Nurse educators in this study also agree (39.36% n=254) that "sometimes I criticize my students." Respondents commented that they needed a definition of "criticize" which was a surprise to the PI. Webster defines it as identifying faults in a disapproving way. When almost half of the respondents agree that they criticize their students, this is an indicator that there is a need to ensure that educators are provided with the resources to provide critique of students; as opposed to criticism.

Respondent comments indicate a very strong inclination toward attitudes that criticism is critical to the process, but that it must be done constructively through appropriate feedback and these respondents see it as essential to the role of the nurse educator. What is not completely known from this measurement is whether or not the educators in this sample are aware of the impact this may have on the dimension of low self-esteem in students. However, on the variable to measure knowledge of low self-esteem; i.e., "student nurses who feel devalued develop low self-esteem, 83.34% (n=254) agreed and 14.68% were neutral and 1.98% disagreed indicating a minority of respondents in this study on this variable had low knowledge. With self-esteem referring to an individual's perception of themselves, and that self-esteem is believed to be constructed through interaction with and feedback from others of significance (Randle, 2003, Terry et al. 1999), ensuring the nurse education community is equipped with appropriate tools to critique students in a way that empowers them is critical to stopping the cycle of HV through empowering students by building their self-esteem, as opposed to eroding it.

Dimensions of Oppression – Submissive-Aggressive Behavior

Sofield & Salmond (2003) found that verbal abuse is a nearly universal experience (n=461) with findings that the majority of nurses lack the skills to respond to and cope with verbal abuse. This was compounded by organizations that take no action with verbal abuse occurs. These researchers found this to be characteristic of oppressed group behaviors and that organizational cultures support a power differential between physician and nurse that leads to a passive response from nurses.

They further identify an attitude that "nothing ever changes" as also reported by Rosenstein (2002). Nurses are then described as accepting the status quo by giving up and letting go which results in a lack of action to change the situation.

Submissive-aggressive behavior occurs when individuals are afraid to speak up (passive) and then when they cannot cope with a situation, they speak out in anger (aggressive). This leads to a breakdown in communication and deepens the inter-personal conflict. In this study, on the measure of submissive-aggressive behavior, 80.03 % (n=254) agree that oppression results in passive aggressive behavior; however, 15.38% are neutral and 4.33% disagree indicating a low level of knowledge on this dimension. Contrasting this finding with 18.59% of respondents who agree that nursing students must follow every order given by the physician, suggests that some educators lack the knowledge, attitude and behaviors necessary to ensure that nurses entering the profession are able to speak up and question a physician's order when it is appropriate. Preventable patient injury is the third leading cause of death in this country and the majority of these deaths are medication error related (IOM, 1999, John, 2013).

Dimensions of Oppression – Horizontal Violence

Horizontal violence as a dimension was measured throughout this study as it considered nurse educators' knowledge, attitudes and practice of horizontal violence through oppression dimensions. Horizontal violence has been well-studied as a unique dimension and been found to be highly prevalent and is identified as a global problem in the nursing literature. While the majority of respondents agreed that HV

should be reported (95.22% n=254), only 57.72% of respondents (n=254) indicated that they have in fact reported acts of HV against their students. While many commented that they have not had this experience, the literature of incidence and prevalence of HV in healthcare settings suggests that they may lack the ability to identify HV. While 90.43% (n=254) agree that an overt act of aggression between group members is HV, not every respondent in this study agreed which suggests that there is a small percentage of nurse educators who have a low level of knowledge related to HV. Further to this point, 76% (n=254) agree that ignoring the concerns of another is HV which again suggests that a minority of nurse educators lack knowledge related to the characteristic behaviors of horizontal violence. In fact, withholding information from the novice nurse is a characteristic behavior of horizontal violence and 20.95% (n=254) of respondents agreed that withholding information from a student is not horizontal violence, when in fact it is a classic negative act (Griffin, 2004).

Nurse Educator Knowledge, Attitudes & Practice

Decades of social research demonstrate that there is poor correlation between knowledge, attitudes and behaviors and that contrary to what would be expected, knowledge does not predict behavior. Indeed, this study further supports that premise. Although there were statistically significant correlations between knowledge and attitude, attitude and practice and practice and knowledge, these correlations were negative suggesting that despite nurse educators having knowledge of HV and

oppression, their attitudes and practice were negatively correlated as opposed to positively correlated.

However, when looking at correlations between groups based on years of experience as an educator, the findings of this study suggest that the longer a nurse educator is practicing as faculty, the more likely they are to have knowledge of horizontal violence and positive attitudes and practices that recognize the impact of negative acts of HV on student nurses.

Correlational Research Question 4 a. – 4 c.

RQ 4 a. What is the relationship between NE knowledge and attitude?

Spearman's rank correlation coefficient rho (Charles Spearman) is a non-parametric measure of rank correlation – i.e., the statistical dependence between the rankings of 2 variables. Spearman's Rho measures the strength and direction of association between two ranked variables and as the value of one variable increases, so does the value of the other or as the value of one variable increases, the value of the other variable decreases. With alpha set at .05 there is a less than 5% chance that the strength of the relationship (p coefficient) happened by chance if the null hypothesis is true.

There is a statistically significant relationship between nurse educator knowledge of HV and attitude on the dimension of marginalization. However, these results show a negative and very weak correlation (r = -.143, $p<.05$) between nurse educator knowledge of HV and their attitude. Although this may seem counterintuitive; in fact it decades of research in the social sciences have demonstrated

that knowledge does not always change behavior in a positive direction (Kruglanski, Jasko, Chernikova, Milyavsky, Babush, Balder & Pierro, 2015). Research in the field of behavioral sciences demonstrates a positive correlation between attitude and behavior when motivated by a goal that may be relevant to this study. These results indicates that increased knowledge on the dimension of horizontal violence is negatively associated with nurse educator attitude indicating that even though NE have knowledge on the dimension of marginalization, they may be treating their students as if their concerns are not important. This may result in their students feeling marginalized. With research that discusses positive attitudes toward knowledge when associated with a goal, this suggests that goal setting related to integration of teaching around horizontal violence for nurse educators may be appropriate.

Table 9*:* Spearman Rho Correlation Coefficient NE Knowledge and Attitude			Marginalization occurs when group members feel unimportant	Students should not question the standards on the medical unit
Spearman's rho	Marginalization occurs when group members feel unimportant	Correlation Coefficient	1.000	-.143*
		Sig. (1-tailed)	.	.011
		N	254	254
	Students should not question the standards on the medical unit	Correlation Coefficient	-.143*	1.000
		Sig. (1-tailed)	.011	.
		N	254	254
*. Correlation is significant at the 0.05 level (1-tailed).				

Table 9: Spearman Rho Correlation Coefficient NE Knowledge and Attitude

H 4 a. There is a relationship between NE K and A

Statistically significant relationships are found between nurse educator knowledge and attitude and therefore the hypothesis is accepted. There is a statistically significant relationship between NE attitude and practice ($r=.405$, $p<.05$). The closer to 1.0 the stronger the linear relationship between two variables. In this case the relationship shows a moderate effect and suggests that nurse educators who have beliefs and attitudes that reflect understanding of oppression and horizontal violence are more likely to practice in a manner that reflects that belief and suggests that they have an awareness of the impact of their attitude about oppressed group behaviors and their practice as nurse educators.

RQ 4 b. What is the relationship between NE attitude and practice?

There is a moderate significant relationship between nurse educator attitude and practice suggesting that the affective domain of attitude has an impact on the practice of nurse educators related to horizontal violence. Bloom's taxonomy (1956) identifies the affective domain as the human emotional response to learning that shapes the learner, suggesting that nurse educator attitude toward horizontal violence has an impact on their practice of horizontal violence.

Table 10*:* Spearman Rho Correlation Coefficient NE Attitude and Practice	I teach my students that nurses are subordinate to physicians	Students should not question the standards on the medical unit

Spearman's rho	I teach my students that nurses are subordinate to physicians	Correlation Coefficient	1.000	.405**
		Sig. (1-tailed)	.	.000
		N	254	254
	Students should not question the standards on the medical unit	Correlation Coefficient	.405**	1.000
		Sig. (1-tailed)	.000	.
		N	254	254
**. Correlation is significant at the 0.01 level (1-tailed).				

Table 10: Spearman Rho for Correlation between NE Attitude and Practice.

H 4 b. There is a relationship between NE A and P

There is a moderate but significant relationship between nurse educator attitude and practice so the hypothesis is accepted that there is a relationship and the null is rejected that there is no relationship.

RQ 4 c. What is the relationship between NE knowledge and Practice?

There is a positive but weak correlation between nurse educator knowledge and practice, which again may seem counterintuitive, but decades of research in the social sciences demonstrate that knowledge does not predict behavior. These findings are significant as the problem of oppression and horizontal violence in nursing will not change unless researchers, policy makers and administrators find better ways to eliminate the problem from the profession. Because nurse educators are the members of the team who first socialize future nurses, the impact of low knowledge and poor attitudes toward negative behaviors toward nurses in the form of HV is important to discuss to advance quality improvement efforts and improve curriculum. In fact, it is

only recently that horizontal violence has begun to make its way into nursing textbooks which demonstrates this is a new area of curriculum for nurse educators.

Table 11: Spearman Rho Correlation Coefficient NE Knowledge and Practice			Oppression results in passive-aggressive behavior	I teach my students about horizontal violence between nurses
Spearman's rho	Oppression results in passive-aggressive behavior	Correlation Coefficient	1.000	.258**
		Sig. (1-tailed)	.	.000
		N	254	254
	I teach my students about horizontal violence between nurses	Correlation Coefficient	.258**	1.000
		Sig. (1-tailed)	.000	.
		N	254	254
**. Correlation is significant at the 0.01 level (1-tailed).				

Table 11: Spearman Rho for Correlation between NE Knowledge and Practice.

H 4 c. There is a relationship between NE knowledge and practice

There is a weak but statistically significant relationship between nurse educator knowledge and practice so the hypothesis is accepted and the null hypothesis that there is no relationship is rejected.

Analysis of Variance between groups (ANOVA)

Years of experience were considered through ANOVA. An ANOVA comparison between groups and within groups found four variables with statistically significant differences between groups when measuring responses on variables as responses on the NEKAP-HV and level of education. Level of education was selected

from the demographic data to provide an ability to look at differences between groups as it was considered to be the most likely variable to influence knowledge, attitudes and practice when compared with the other demographic variables such as geographic region or gender.

While this demographic data did not meet the assumptions of normalcy required by ANOVA of equality of group to determine differences, ANOVA is considered robust enough to allow for violations of normalcy (Polit & Beck, 2015). These findings suggests that the higher the level of education of the nurse educator the more likely they are to have knowledge of horizontal violence; attitudes that demonstrate awareness of the phenomenon and practice that educates the student about HV based upon some variables.

To end the cycle of HV, it is necessary to find a way to break the cycle. While nurse educators are gaining experience to enable them to better prepare nurses for the workforce, they may also be launching students into that workplace, potentially, without the necessary skills to resolve inter-personal and inter-professional conflict. Hence, the continued exodus of nurses out of the profession, when they find the negative behaviors in the workplace intolerable and they lack the communication skills to confront it.

These findings have significance for nurse educators nationally, as HV and oppressed group behaviors are endemic to the profession. This study was small, but the results bridged a gap in the literature and now we have a better understanding of

what nurse educators believe, know and practice related to horizontal violence and oppression in nursing.

Post-Hoc G*Power Analysis

Power analysis is a process to calculate needed sample size given effect size, alpha and power and was conducted both A Priori and Post-Hoc. Alpha provides probability of Type 1 Error (rejecting a true null hypothesis) as well as a Type 2 error that is incorrectly retaining a false null. Commonly set by researchers at .05 (Portney & Watkins, 2009).

Power (beta) is the probability of finding true significance and is usually set at .80. With alpha set at .05 and power (beta) set at .80, a post hoc analysis was conducted using G*Power 3.10.0 software at the completion of the study to determine the adequacy of sample size; as well as to determine the effect size. The Post hoc power analysis with an n=254 demonstrates medium effect size of 0.3 which is recommended. Beta of 0.99 is excellent indicating adequate sample size.

Table 12 & 13: **Post Hoc Analysis using G*Power 3.10.0**

Exact - Correlations: Difference from constant (one sample case)		
Options:	exact distribution	
Analysis:	Post hoc: Compute achieved power	
Input:	Tail(s)	= One
	Effect size r	= 0.3
	α err prob	= 0.05
	Total sample size	= 254
	Population correlation ρ	= 0
Output:	Lower critical ρ	= 0.103440
	Upper critical ρ	= 0.103440
	Power (1-β err prob)	= 0.999444

Table 12: Post Hoc Analysis using G*Power 3.10.0

F tests - ANOVA: Repeated measures, between factors			
Analysis:	Post hoc: Compute achieved power		
Input:	Effect size f	=	0.25
	α err prob	=	0.05
	Total sample size	=	254
	Number of groups	=	2
	Repetitions	=	3
	Corr among rep measures	=	0.5
Output:	Noncentrality parameter λ	=	23.812500
	Critical F	=	3.878624
	Numerator df	=	1.000000
	Denominator df	=	252
	Power (1-β err prob)	=	0.998141

Table 13: Post Hoc Analysis using G*Power 3.10.0

Summary of key findings

a. The NEKAP-HV instrument demonstrates internal consistency as measured by Cronbach's Alpha (.722).

b. There are moderate statistically significant positive correlations between nurse educators' attitudes toward behaviors of horizontal violence and practice (*r*=.405, *p*.05).

c. There are weak but statistically significant negative correlations between nurse educator practice and knowledge (*r*=.258, *p*.05).

d. There are weak but statistically significant negative correlations between nurse educator knowledge and attitude (*r*=-.143, *p*.05).

e. The higher the level of education (doctorate versus masters' degree) the more likely they are to have knowledge of the phenomenon of horizontal violence, more positive attitudes reflecting better awareness of the problem, and practice that reflects sensitivity to the impact of HV on nursing students.

f. Nurse educators in this study agree that there has been a long-held tradition of a power-imbalance in healthcare settings resulting in oppression of nurses that is slowly changing.

g. Nurse educators in this study believe that nursing students need to be given the skills to empower future nurses to help continue to change the system that allows oppression to exist.

Review of hypothesis (accept or reject)

In correlational design we do not manipulate and independent variable and there is no effort to control for other possible factors that may vary. For this reason, a significant correlation does not show that one factor causes changes in another (i.e., causality). A significant correlation shows that two factors are related but it does not provide an explanation for how or why they are related.

RQ 4a: Accept the hypothesis: There is a relationship between nurse educator knowledge and attitude.

RQ 4b: Accept the hypothesis: There is a relationship between nurse educator attitude and practice.

RQ 4c: Accept the hypothesis: There is a relationship between nurse educator knowledge and practice.

Chapter V

SUMMARY & CONCLUSIONS

Oppression as a Theoretical Frame

Roberts (1983) seminal discussion on nursing as an oppressed group states nurses are "forced to be dependent and submissive in order to deal with the domination of a powerful group" (p. 28). The majority of respondents (97%) in this study do not teach their students that nurses are subordinate to physicians and that students are instead "part of the team," however, 67.2% also believe that nursing students are "dependent upon those above them in the healthcare hierarchy," and 38.6% agree that nurses are subordinates within the healthcare hierarchy. Respondents commented that oppression in the workplace environment is slowly changing over the years and that "this should not be the case, but it often is" and suggest that this is because "nurses don't speak up."

The difficulty with nurses "speaking up" is validated (n=1700) by *Silence Kills: The Seven Crucial Conversations for Healthcare* (Maxfield, Grenny, McMillan, Patterson & Switzler, 2005). In this study they found that when the concern is physician competence 72% of nurses say it is difficult to impossible to confront the physician. When the concern is poor teamwork 78% find it difficult to impossible to confront a physician and when the concern is verbal abuse or disrespect, 59% of nurses find it difficult to impossible to speak up.

This current study demonstrates the need to provide nursing students with skills to become empowered to speak up and confront concerns when they arise

because in the healthcare industry, indeed "silence kills." In this current study, 14.97% (n=254) of NEs agree that nursing students must receive permission from their instructor before approaching a physician and 7.1% are neutral. This finding suggests that while over three quarters (77.96% n=254) of NEs in this study empower their students to approach physicians directly, almost 15% require that they seek permission first, indicating a dis-empowering approach to providing students with the skills for appropriate communication with physicians. Nurse educators offer comments that student nurses approaching a physician is "dependent on the situation" and that instructors want "to review their thought process" contrasted with an educator who stated that they "would not want a student to be placed in a position of questioning a physicians' order." However, students may indeed be in this position and nurse educators in this study recognize the need to prepare them to be effective communicators in the healthcare setting. Yet, some of the nurse educators in this sample may be disempowering future nurses by not preparing them effectively with the necessary skills to confront a physician (or another nurse) when they have a concern. This may be because these nurse educators lack the skills themselves, or simply because they prefer to avoid confrontation.

Roberts, DeMarco & Griffin (2009) discuss the traditional role of the "good nurse" as described by Glass (1998) that the good nurse would "not challenge the system" and that once nurses felt "safe to speak up" they felt empowered. Friere (1971) identifies the first step in altering a silent voice is to begin to understand the cycle that allows it to continue (Freshwater, 2000; Roberts, 2000). This study may

provide some understanding of this cycle. This research demonstrates an awareness on the part of nurse educators of the need to teach nursing students to speak up and become agents of change; however, it also demonstrates that not all nurse educators in this study believe that nurses have the skills to do so and that this continues to be a problem within the nurse education environment and then ultimately within the healthcare system.

General Discussion of study findings

Roberts (1983) seminal work on the influence of oppressed group behaviors in nursing underpins this discussion. The theoretical framework of oppression in nursing has been further validated by this study. Nurse educators in this study provided applied relevance of this theoretical frame through their responses. The message from the nurse educators who participated in this study is that the hierarchy in healthcare makes nurses less empowered but they also state that the longstanding traditions are slowly changing where physicians have been traditionally known to "hold all the power."

These respondents also see nurses as part of the problem and identify the need to empower student nurses with the leadership skills to become change agents and end the cycle of horizontal violence in nursing. This study demonstrates that student nurses need the necessary skills to tear down the silos that exist in healthcare, level the hierarchy that makes nurses less empowered, with a focus on inter-professionalism, collaboration and mutual respect between all members. The respondents report that there must be respect between all members of the healthcare team, from the Chief

Executive Officer/Chief Nurse Administrator to the housekeeping aide, in order to create the safest environment for patients and providers. Nurses need to find their voice to overcome the negative behaviors that exist in oppressed environments.

Roberts (1983) discussed characteristic passive-aggressive behavior in nursing when nurses complain about physicians but rarely complain explicitly to the physician and identifies this as passive-aggressive behavior. In this study, 33.6% of respondents (n=254) agree that nurses seldom confront physicians when they have concerns and 6 percent were neutral indicating they are not sure. Respondents offered comments that confronting physicians "can have consequences so by learned behavior, nurses are reinforced to be passive." This respondent also stated that "this is changing, but it needs to stop." Other respondents stated that this depends on the hospital and specialty field of the physician which implies that nurses are less likely to speak up in these settings. Two educators with decades of experience stated that nurses do not confront physicians while students are intimidated or "afraid of bothering the doctor." One respondent states "in my experience nurses avoid confronting physicians."

When considering the impact of this avoidance on the potential for patient injury, the results of this study further validate the need to improve communication between physicians and nurses. The Joint Commission Seminal Event Alert No. 40 (2008) directly connects patient safety with breakdown in communication and the findings of this study demonstrate that although things are improving, there are nurses who are afraid to confront physicians when they have a concern and that students are often intimidated and this behavior is directly connected to oppression.

Practical Implications

The findings from this study suggest that nurse educators with greater years of experience are better prepared to have positive practice behaviors that include a strong knowledge of horizontal violence, as well as knowledge related to oppression in nursing. However, the problem with HV in healthcare is significant as discussed throughout this study. Nurses are entering a fragmented, unsafe, complex healthcare system potentially unprepared for the realities of the oppression which continues to exist in many organizations. These nurse educators in this study report that this has long been a problem, but that it is slowly changing. The problem is, we do not have time to wait for the "slow change." Nurse educators in this study indicate that students need the skills to become change agents but the question remains regarding how skilled nurse educators are as a population to empower future nurses through specific education to promote this change. Traditional systems can take decades to change and we know from the early work of Roberts (1983) that identified nurses as an oppressed group as well as this current study, that change is still needed.

Limitations

Descriptive studies are important when researching a new area, so the design of this study was appropriate to answer the research questions to explore the phenomenon of horizontal violence using an oppression lens in a new population; i.e., nurse educators. An important attribute of descriptive design is the ability to provide trend analysis. However, self-report is always a limitation of any survey instrument

and whether the results of the sample can be generalized to the population. A second limitation of this study is that there was only one sample with no control group.

Social-desirability bias; i.e., respondents choosing answers that put them in the best light. This is a significant concern in a study considering a sensitive topic such as oppression in nursing and despite confidentiality being assured, respondents may have been affected by social desirability bias.

Although the study had an adequate sample size based on A Priori and post hoc analysis, sample size is a limitation of this study (n=254). The survey was sent to a national sample of 1500 nurse educators with a 17% response rate which is considered acceptable for social science research using survey design. However, the size of the sample limits the ability to conclude that this study is generalizable to the national population of all nurse educators.

Future Directions

Nurse educators need resources to teach about HV, particularly related to conflict resolution and effective communication techniques for expressing concerns when they arise. This study suggests that a small percentage of nurse educators may have low levels of knowledge of horizontal violence. This provides evidence to support development of additional education for nurse educators on the topic of oppression in nursing and horizontal violence.

The respondents offered many comments that suggest the need to develop empowerment structures for nursing students to better prepare them “be the change” and support reduction of silos in healthcare delivery with a focus on inter-professional

collaboration where every member of the team is valued, and every member of the team is empowered to speak up and express concerns in a safe environment.

Some respondents commented that the wanted a definition for terms such as "marginalization" and "criticize". It is recommended that revisions be made to the NEKAP-HV to include operational definitions of terms. To increase the generalizability of the findings to the population of nurse educators nationally, it is recommended that the NEKAP-HV be administered to a larger sample of nurse educators. To increase response rate, the survey could be mailed with self-addressed stamped envelopes.

No research has been identified in peer-reviewed published nursing literature about why those who engage in negative acts do so; i.e., what makes the nurse bully a bully from the bully's perspective? Research in this area is recommended.

Finally, from a policy perspective nurse leaders need to actively support national adoption of Healthy Workplace legislation (Healthy Workplace Bill). The Healthy Workplace Bill (HWB) is a National Campaign directed by Dr. Gary Namie to enact anti-bullying laws state-by-state. The HWB has been introduced in 30 states in over 60 versions and national discussions are ongoing. Nurse leaders need to be an active part of this discussion.

REFERENCES

Agarwal, N. (2010). Verifying survey items for construct validity: a two-stage sorting procedure for questionnaire design in information behavior research. (*Journal of the American Society for Information Science and Technology.* (9) 13.

Alreck, P. & Settle, R. (2004). *The survey research handbook.* McGraw Hill: Boston, MA.

Becker, J. & Visovsky, C. (2012). Horizontal Violence in Nursing. MEDSURG Nursing 21(4), 210-213.

Bloom, B.S. (Ed.). (1956). Taxonomy of education objectives. Book 1, cognitive domain. New York: Longman.

Cohen, J. (1988). *Statistical power analysis for behavioral sciences* (2nd Ed.). Hillside, NJ: Lawrence Earlbaum Associates.

Conti-O'Hare, M. & O'Hare, J. (2006) *Nursing Spectrum Online*. Don't perpetuate horizontal violence. http://nsweb.nursingspectrum.com/cfforms/Guest Lecture/Horizontal Violence.cfm

Cox, H. (1991a). Verbal abuse nationwide: oppressed group behavior. Part 1. *Nursing Management*, 22 (2), 32-35.

Cox, H. (1991b). Verbal abuse nationwide: impact and modifications. Part 2. *Nursing Management*, 22 (3), 66-69.

DeVellis, R. F. (2012). *Scale development: Theory and applications*. Thousand Oaks, Calif: SAGE.

Diefenbach, M.A., Weinstein, N.D., & O'Reilly, J. (1993). Scales for assessing perceptions of health hazard susceptibility. *Health Education Research.* (8), 191-192.

Duchscher, J.E. (2002).Out in the real world: Newly graduated nurses in acute-care speak out. *Journal of Nursing administration.* 31(9), 426-439.

Duchscher, J., and Myric, F. (2008). The prevailing winds of oppression: Understanding the new graduate experience in acute care. *Nursing Forum.* (43) 4, 191- 206.

Farrell, G. A. (1997). Aggression in clinical settings: nurses' views. *Journal of Advanced Nursing*, 25 (3), 501-508

Finstad, K. (2009). Response interpolation and scale sensitivity: Evidence against 5-point scales. *Journal of Usability Studies.* (5) 3, 104-110.

Freire, P. 1971. *Pedagogy of the oppressed.* New York: Herder and Herder.

Freshwater, D. (2000). Crosscurrents: against cultural narrationin nursing. *Journal of Advanced Nursing* 32 (2), 384-461.

Gerardi, D., Connell, M.K. (2007). The emerging culture of healthcare: From horizontal violence to true collaboration. *Nebraska Nurse.* 2007 Sep-Nov;40(3):16-8

Glass, N. (1998). Becoming de-silenced and reclaiming voice: women nurses speak out. In *Nursing Matters: Critical Sociologica Perspective* (H. Keleher & F. McNerney eds), pp. 121-138. Churchill, Livingstone, Sydney.

Goforth, C. (2015). Using and interpreting Cronbach's Alpha. *University of Virginia Library Research Data Services & Sciences.* www.data.libraryvirgina.edu

Grifffin, M. (2004). Teaching cognitive rehearsal as a shield for lateral violence: in intervention for newly licensed nurses. *Journal of Continuing Education in Nursing.* 35 (6), 257-262.

Hastie, C. (2002). Horizontal violence in the workplace. *Birth International.* http://www.birthinternational.com/articles/hastie02.html.

Hamlin, L., (2000). Horizontal violence in the operating room. *British Journal of Perioperative Nursing.* (10) 34-42.

Hek, G., & Moule, P. (2006). Making sense of research: An Introduction for health and social care practitioners. *Sage Publications.* P.1-155.

LinkedIN. (2016). Retrieved July 22, 2016 from https://www.linkedin.co

Hughes, A. (2003). Being bullied: What an insight. *British Journal of Perioperative Nursing,* 13, 166-168.

Jackson, D., Clare, J., & Mannix, J. (2002). Who would want to be a nurse? Violence in the workplace – a factor in recruitment and retention. *Journal of Nursing Management,* (10), 13-20.

Kruglanski, A. W., Jasko, K., Chernikova, M., Milyavsky, M., Babush, M., Baldner, C., & Pierro, A. (2015). The rocky road from attitudes to behaviors: Charting the goal systemic course of actions. *Psychological Review, 122*(4), 598-620. doi:10.1037/a0039541.

Longo, J. (2007). Horizontal violence among nursing students. *Archives of Psychiatric Nursing*, 21, 177-178.

Longo, O., & Sherman, R. (2007). Leveling horizontal violence. *Nursing Management*. (38)3, 34-37, 50-51.

Maxfield D, Grenny J, McMillan R, Patterson K, Switzler A. Silence Kills: The Seven Crucial Conversations in Healthcare. Aliso Viejo, CA: American Association of Critical-Care Nurses (AACN) and Vital Smarts; 2005. http://www.aacn.org/WD/Practice/Docs/PublicPolicy/SilenceKills.pdf.

Matheson, L.K. & Bobay, K. (2007). Validation of oppressed group behaviors in nursing. *Journal of Professional Nursing. 23*(4), 226-234.

https://www.morrisongrants.com/services/free_resources/templates

Pendry, P. S. (2007). Moral distress: Recognizing it to retain nurses. *Nursing Economics, 25*(4), 217-221.

Portney, L. & Watkins, M. (2009). *Foundations of clinical research: Applications to practice*. Pearson:Prentice Hall Saddle River. NJ.

Randle, J. (2003 a). Bullying in the nursing profession. *Journal of Advanced Nursing, 43*(4), 395-401.

Randle, J., (2003 b). Changes in self-esteem during a 3-year pre-registration diploma in higher education nursing programme. *Journal of Clinical Nursing. (12)* 142-143.

Roberts, S.J. (1983). Oppressed group behavior: Implications for nursing. *Advances in Nursing Science, 5*(4), 21-30.

Roberts, S. J. (1996). Point of view: Breaking the cycle of oppression: Lessons for nurse practitioners? *Journal of the American Academy of Nurse Practitioners.* (8)5, 209-214.

Roberts, S.J., DeMarco, R., & Griffin, M. (2009). The effects of oppressed group behaviors on the culture of the nursing workforce: a review of the evidence and interventions for change. *Journal of Nursing Management*. (17), 288-293.

Rosenstein, A. Russell, H., & Lauve, R. (2002). Disruptive physician behavior contributes to nursing shortage: study links bad behavior by doctors to nurses leaving the profession. *Physician Executive.*

Sackman, H. (1974). *Delphi assessment: Expert opinion, forecasting, and group process* (No. RAND-R-1283-PR). RAND CORP SANTA MONICA CA.

Sofeld, L. & Salmond, S. (2003). Workplace violence: A focus on workplace abuse and intent to leave the organization. *Orthopaedic Nursing. 22*(4).

Stanley, K., Martin, M., Michel, Y., Welton, J., & Nemeth, L. (2007). Examining lateral violence in the nursing workforce. *Issues in Mental Health Nursing. 28*, 1247-1265.

Woelfle, C. Y. & McCaffrey, R. (2007). Nurse on nurse. *Nursing Forum*. 42(3), 123-131

Vessey, J., DeMarco, R., Gaffney, D., & Budin, W. (2009). Bullying of staff registered nurses in the workplace: A preliminary study for developing personal and organizational strategies for the transformation of hostile to healthy workplace environments. *Journal of Professional Nursing.* 25(5), 299-306.

Weber, D. (2004). Poll results: Doctors' disruptive behavior disturbs physician leaders. *The Physician Executive.* (September – October) 6-14.

APPENDIX A

Delphi Panel Letter of Solicitation

&

Background on NEKAP-HV Instrument Development

Sent via email to Delphi Panel

Greetings Expert Panel!

Thank you for your willingness to serve as a modified Delphi Panel expert reviewer of my survey instrument which I developed to measure Nurse Educators' Knowledge, Attitudes and Practice of Horizontal Violence as Measured through Dimensions of Oppression (NEKAP-HV).

Attached is a background statement regarding the development of the instrument as well as a worksheet for your review.

The panel is asked to identify variables which are ambiguous or unclear. Identify items which may be double-barreled. Identify variables which may lead to a response that is socially desirable. Please review the order of questions to reduce order bias. Please also review the demographic items for appropriateness. Please offer comments for any variables that you suggest for revision.

Revisions will be made to the instrument based upon the recommendations of the expert panel of reviewers. Consensus of the panel will be sought. Majority panel member recommendations will be followed with the majority represented by 80% consensus of the panel.

I may be reached at any time via email at brenda.petersen@student.shu.edu.

I again express my gratitude to you for your contribution.

With regards,

Brenda Petersen, MSN, RN, APN-C, CPNP-PC,

PhD Student, Seton Hall University

School of Health and Medical Sciences

:

Development of Oppression in Nursing Instrument for Expert Panel Review

Brenda Petersen

Seton Hall University

September 22, 2014

Introduction and Background

Literature demonstrates that the phenomenon of horizontal violence is an international problem which negatively affects the professional nurse workplace environment. Within the nursing profession, HV is described as aggressive destructive behavior and intergroup conflict which occurs between nurses. These behaviors exist in what are described as toxic work environments (Woefle & McCaffrey, 2007). The definition of HV emerged from Friere's (1970) pedagogy of oppression which consists of five dimensions. HV is the final dimension of oppression.

The five dimensions of oppression are (1) assimilation, (2) marginalization, (3) low self-esteem, (4) submissive-aggressive syndrome; and the final dimension of oppression which is (5) horizontal violence (Roberts, 1983). Roberts describes characteristics of Friere's (1970) model and states that oppressed group behavior stems from the ability of the dominant group to identify the norms and values as the "right" values for the group. Typically within oppressed groups the dominant group looks and acts differently from the subordinate group and the characteristics of the subordinate group are negatively valued. For this study the pedagogy of oppression is operationally defined as groups who are controlled by forces outside of themselves that have greater prestige, power and status (Roberts, 1983; Friere 1970).

Purpose of the Study

HV is an area of emerging research domestically (Vessey, DeMarco, Gaffney, Budin, 2009). Studies demonstrate that HV is an endemic problem which is

widespread and common within the profession of nursing. Matheson & Bobay (2007) discuss the fact that although more than 20 years have passed since Roberts (1983) initial observations of oppressed group behaviors in nursing; oppressed group behaviors have not been studied as a distinct phenomenon. Research has demonstrated the need to continue to study, as well as define, the dimensions of oppression (Matheson & Bobay, 2007; Friere, 1971). Published studies have looked at experience of nurses with HV and demonstrate that the problem is highly prevalent in the nursing profession both domestically and internationally. We know that HV is a widespread problem. We do not understand why the behavior occurs.

In the under-researched area of HV in nursing domestically there are no published peer-reviewed studies identified which have utilized nurse educators as a sample, despite the fact that research demonstrates that nurses first experience HV while in nursing school (Longo, 2007). This study is intended to address a gap in the literature on oppression in nursing specifically, within nurse education. This tool is designed to measure the five dimensions of oppression. Each dimension serves as a construct. Variables are intended to measure nurse educators' knowledge, attitudes and practice behaviors of HV within each domain (Friere, 1971; Roberts, 1983). Specifically, the instrument is intended to explore nurse educators' knowledge, attitudes, and practice behaviors related to HV utilizing the dimensions of oppression (Friere,

1970).

Research Question

The primary research questions to be answered are:

What are nurse educator's attitudes, knowledge and practice (A, K, P) behaviors utilizing oppression pedagogy as a construct?

Conceptual Framework

Nursing is widely argued to be an oppressed group (Roberts, 1983). With tenets in oppressed group behavior, the understanding of HV first emerged through the work of Freire (1970) as he observed native Brazilians who had been taken over and dominated by Europeans (Roberts, 1996). HV emerges within the oppressed group when the dominant powerful group determines what is valued or rewarded. This causes the oppressed group to feel defective or substandard. Oppression results within a social system when dominant groups control, perpetuate and normalize unequal roles and relationships (Duchscher & Myrick, 2008). The five dimensions of oppression are (1) assimilation, (2) marginalization, (3) low self-esteem, (4) submissive-aggressive syndrome; and the final dimension of oppression which is (5) horizontal violence.

The conceptual frame for this study (Figure 1) is followed by the conceptual model (Table 1).

Figure 1. Conceptual Frame: Pedagogy of Oppression (Friere, 1971)

Pedagogy of Oppression □ Nurse Educator K, A, P

Variables

Assimilation
Marginalization
Self-Hatred and Low self-esteem

Submissive aggressive behavior
Horizontal violence

Summary of Methodology

The survey items are based on what has been tested in past studies on HV to enhance validity (Agarwal, 2010). Definitions of constructs in this model are based on the literature. (See Table 1). With no demonstrated reliability or validity, this questionnaire will be reviewed by an expert panel for construct validity. This panel includes five nurse scholars with research expertise in the area of horizontal violence in nursing, as well as expertise in instrument development. Items were developed to possess important survey question attributes of focus, brevity and clarity (Alreck & Settle, 2004). The expert panel will review the instrument for clarity, focus and brevity, as well as content validity; i.e., does the variable measure the concept. When items are self-developed, verifying survey items is very important (Agarwal, 2010).

This instrument uses a comparative Likert scale with all items rated on the same dimension, to provide simplicity, clarity and economy. The choice to utilize a seven point Likert scale is based upon evidence which demonstrates that 7-point item scales have emerged as optimal (Preston & Colman, 2000; Finstad, 2009). A 7-point scale is demonstrated to more likely reflect a respondent's true subjective evaluation, as it is sensitive enough to minimize response interpolations. Response interpolations have occurred with 5-point Likert items when respondents do not conform within the boundaries set by the scale and it is postulated that 5-point scales do not capture the subtle degrees of measure participants want to express (Finstad, 2009; Deifenbach,

Weinstein & O'Reilly (1993). A 7 point item scale is found to excel not only in objective accuracy but also in perceived accuracy and ease of use (Finstad, 2009).

This self-administered survey instrument was designed to measure the attitudes, knowledge and practices of nurse educators, with constructs related to the dimensions of oppression based on Friere's pedagogy (1970). The questions are supported by what is known from the literature in nursing on horizontal violence. Items were written to be short and brief while conveying meaning; and were developed to be as simple and clear as possible.

The expert panel is asked to identify variables which are ambiguous or unclear and also identify any which may be double-barreled. Unclear items will be revised to improve clarity and double-barreled items will be revised into two distinct items. The panel is asked to identify elements which may lead to a response that is socially desirable. Deviation from socially prescribed behaviors leads respondents to report what is socially acceptable rather than their true answers (Alreck & Settle, 2004). These elements will be revised to elicit a true answer, as opposed to a socially desirable response. The expert panel is asked to review the order of questions to reduce order bias (Alreck & Settle, 2004). The expert panel is also asked to review the demographic questions for appropriateness.

Revisions will be made to the instrument based upon the recommendations of the expert panel of reviewers. Consensus of the panel will be sought. Majority panel member recommendations will be followed, with a majority represented by 3/5

members of the panel. The instrument will then be piloted with a sample of nurse educators.

Concepts as items on questionnaire

Variables are based upon descriptions of HV which have emerged from the research on HV in nursing. The five constructs of Friere's (1970) model are measured through the domains of nurse educator's knowledge, attitudes and practice. (See Figure 2).

Construct Variable 1: Assimilation	Survey Item 1 (A)* Survey Item 2 (A) Survey Item 3 (P) Survey Item 12 (K) Survey Item 30 (P) Survey Item 31 (K)	Source (Roberts, 1983) Source (Matheson & Bobay, 2007) Self-developed Source (Roberts, 1983) Self-developed Source (Matheson & Bobay, 2007)
Construct Variable 2: Marginalization	Survey Item 4 (A) Survey Item 5 (A) Survey Item 32 (K) Survey Item 6 (A) Survey Item 33 (K) Survey Item 28 (P) Survey Item 29 (P)	Source (Randle, 2003) Source (Randle, 2003) Source (Roberts, 1983) Source (Roberts, 1983) Source (Matheson & Bobay, 2007; Roberts, 1983) Source (Roberts, 1983) Source (Matheson & Bobay, 2007; Roberts, 1983)

Construct Variable 3 Low Self Esteem	Survey Item 7 (A) Survey Item 8 (A) Survey Item 9 (A) Survey Item 34 (K) Survey Item 35 (P)	Source (Sofield & Salmond, 2003) Source (Sofield & Salmond, 2003; Roberts, 1983) Source (Sofield & Salmond, 2003; Roberts, 1983 Source (Hughes, 2003; Jackson, et al, 2002; Vessey et al, 2009) Source (Hughes, 2003; Jackson, et al, 2002; Vessey et al, 2009)
Construct Variable 4 Submissive-Aggressive Syndrome	Survey Item 36 (P) Survey Item 37 (K) Survey Item 10 (A) Survey Item 11 (P) Survey Item 13 (A) Survey Item 14 (K) Survey Item 38 (K) Survey Item 39 (K)	Self-developed (Hughes, 2003; Jackson, et al, 2002; Vessey et al, 2009) Source (Randle, 2003) Source (Randle, 2003) Source (Roberts, 1983) Source (Roberts, 1983) Source (Roberts, 1983) Source (Roberts, 1983)
	Survey Item 40 (P)	Source (Randle, 2003)

Construct Variable 5 Horizontal Violence	Survey Item 15 (A) Survey Item 16 (A) Survey Item 17 (A) Survey Item 18 (A) Survey Item 19 (A) Survey Item 20 (P) Survey Item 22 (P) Survey Item 23 (P) Survey Item 24 (A) Survey Item 25 (A) Survey Item 26 (A) Survey Item 21 (P) Survey Item 27 (P) Survey Item 41 (K) Survey Item 42 (K) Survey Item 43 (K) Survey Item 44 (K) Survey Item 45 (K) Survey Item 47 (K)	Self developed Self developed Self developed Self developed Self developed Self developed Self developed Self developed Self developed Self developed Source (Longo, 2007) Self developed Self developed Self developed Source (Randle, 2003) Self developed Source (Longo, 2007) Source (Longo, 2007) Self developed

Figure 2. Constructs/variables and their source (Agarwal, 2010). *(A) =Attitudes; (K) = Knowledge; (P) = Practice

Construct - Worksheet

Following are the questions which will be utilized to measure each concept using a Likert-scale:

Construct Number One – Assimilation

Construct definition: Assimilation is defined as group behavior which includes customs and attitudes acquired through communication or observation. Individuals are fully assimilated to a new group when traits from the old group are indistinguishable from the new cultural group (Friere, 1971; Roberts, 1983).

Variable: Powerful nurses act like physicians (Roberts, 1996). (Attitude, Item 1).

Variable: Nurses should act more like physicians (Matheson & Bobay, 2007). (Attitude, Item 2).

Variable: Nurses have been identified as an oppressed group (Roberts, 1996). (Knowledge, Item 12).

Variable: I act like a physician. (Practice, Item 3).

Variable: An oppressed group assimilates the norms and values of the dominant group (Matheson & Bobay, 2007; Friere, 1971). (Knowledge; item 31)

Variable: I teach students to assimilate into physician culture. (Practice, Item 30).

Construct Number Two – Marginalization

Construct definition: Marginalization occurs when members of a group feel unimportant or like their opinion does not matter (Roberts, 1983).

Variable: Students should please the nurses on the unit (Randle, 2003). (Attitude, Item 4).

Variable: Students should not question standards on the unit (Randle, 2003). (Attitude, Item 5).

Variable: Marginalization occurs when group members feel unimportant (Roberts, 1983). (Knowledge, Item 32).

Variable: Nurses need to act like physicians to receive prestige (Roberts, 1996). (Attitude, Item 6).

Variable: Marginalized leaders are inflexible (Matheson & Bobay, 2007; Roberts, 1983). (Knowledge, Item 33).

Variable: I act like a physician to receive recognition and prestige (Roberts, 1996). (Practice, Item 28).

Variable: I teach students to show respect to elite staff (Matheson & Bobay, 2007; Roberts, 1983). (Practice, Item 29).

Construct Number Three – Low Self Esteem

Construct definition: Low self-esteem occurs when individuals feel devalued (Roberts, 1983).

Variable: Nursing students are dependent upon those superior to them in the hierarchy of healthcare delivery (Sofield & Salmond, 2003). (Attitude, Item 7).

Variable: Physicians are superior to nurses (Sofield & Salmond, 2003; Roberts, 1983). (Attitude, Item 8).

Variable: Hospital administrators are superior to nurses (Sofield & Salmond, 2003; Roberts, 1983). (Attitude, Item 9).

Variable: Self-esteem is eroded when students are criticized (Hughes, 2003; Jackson, et al, 2002; Vessey, et al, 2009). (Knowledge, Item 34).

Variable: I teach students to prove their value. (Hughes, 2003; Jackson, et al, 2002; Vessey, et al, 2009). (Practice; Item 35).

Variable: I teach students there is a hierarchy in healthcare delivery. (Practice, item 36).

Variable: Criticism threatens a student's sense of self-mastery (Hughes, 2003; Jackson, et al, 2002; Vessey, et al, 2009). (Knowledge Item 37).

Construct Number Four – Submissive-Aggressive Syndrome

Construct definition: Submissive-aggressive syndrome results in individuals feeling unable to speak up and confront issues which concern them (submissive); however, if they do speak out to confront an issue they do it in an ineffective confrontational manner (aggressive).

Variable: It is acceptable for student nurses to speak directly to the primary nurse when they have complaints (Randle, 2003). (Attitudes, Item 10).

Variable: Nursing students should not approach a physician directly with questions without first receiving permission to do so (Randle, 2003). (Practice, Item 11).

Variable: Nursing students should follow all orders given by their primary nurse (Roberts, 1983). (Attitudes, Item 13).

Variable: Nursing students should follow every order given by a physician (Roberts, 1983). (Attitudes, Item 14).

Variable: Nurses seldom confront physicians directly when they have complaints (Roberts, 1983). (Knowledge, Item 38).

Variable: Oppression results in passive-aggressive behavior (Roberts, 1983). (Knowledge, Item 39).

Variable: I teach students not to approach a physician directly without permission (Randle, 2003). (Practice, Item 40).

Construct Number Five – Horizontal violence

Construct definition: HV is defined as subtle or overt acts of aggression between group members. An example of a subtle act of HV is ignoring the concerns

of another or withholding information. Examples of overt acts of HV are of extreme criticism or ridicule**.**

Variable: It is okay to ignore my students when I am busy. (Attitude, Item 15).

Variable: Criticizing students makes them resilient. (Attitude, Item 16).

Variable: It is acceptable to criticize students. (Attitude, Item 17).

Variable: Sometimes it is appropriate for the primary nurse to withhold information from a student. (Attitude, Item 18).

Variable: It is acceptable for primary nurses to be abrupt when students ask questions. (Attitude, Item 19).

Variable: I have reported nurses who have withheld information from my students. (Practice, Item 20).

Variable: I teach my students about horizontal violence. (Practice, Item 22).

Variable: I teach conflict resolution skills. (Practice, Item 23).

Variable: It is okay to criticize students in front of patients. (Attitude, Item 24).

Variable: It is okay to criticize students in front of nursing staff. (Attitude, Item 25).

Variable: There would be negative repercussions if a student reported horizontal violence to the administration of a clinical agency (Longo, 2007). Attitude, Practice, Item 26).

Variable: Horizontal violence against nursing students should be reported. (Knowledge, Practice, Item 21).

Variable: I have reported nurses who have engaged in horizontal violence against my students. (Practice, Item 27).

Variable: An overt act of aggression between group members is horizontal violence. (Knowledge, Item 41).

Variable: Ignoring the concerns of another is horizontal violence. (Knowledge, Item 42).

Variable: Withholding information is an act of horizontal violence. (Knowledge, Item 43).

Variable: Extreme criticism is an act of horizontal violence. (Knowledge, Item 44).

Variable: Acts of horizontal violence may be subtle. (Knowledge, Item 45).

Variable: I sometimes ignore my students. (Practice, Item 46).

APPENDIX B

NEKAP-HV DELPHI PANEL SURVEY WORKSHEET

NOTE: This survey will be administered to nurse educators electronically.

Expert Panel: Please feel free to provide any additional comments, suggestions or questions (please indicate the exact wording of any questions you suggest and where/what construct the question should be placed with/under) you believe will enhance the overall quality of this survey. Use as much space as needed. If changes are recommended, please indicate your reasoning so that I may understand and be able to speak to this modification when I defend my dissertation work.

To all panelists: where any such modifications may be involved, it is likely I may choose to either eliminate the question entirely or retain it despite the suggestion made and this may be shown in a subsequent round of the Delphi sent to you – if this happens I will be certain to explain why so that the experts may make according decisions toward consensus in the subsequent round.

Item /Variable	**Does it measure concept?**	**Is it clear?**	**Is it double barreled?**	**Is it biased through socially desirable response?**	**Comments**
Construct No. 1 Definition: **Assimilation** is defined as group behavior which includes customs and attitudes acquired through communication or observation. Individuals are fully assimilated to a new group when traits from the old group are indistinguishable from the new cultural group (Friere, 1971; Roberts, 1983).					
1. Powerful nurses act like physicians					
2. Nurses should act like physicians					
12. Nurses have been identified as an oppressed group					
3. I act like a physician					
31. An oppressed group assimilates the norms and values of the dominant group					

30. I teach students to assimilate into physician culture					
Construct No. 2 Definition: Marginalization occurs when members of a group feel unimportant or like their opinion does not matter (Roberts, 1983).					
4. Students should please the nurses on the unit					
5. Students should not question standards on the clinical unit					
32. Marginalization occurs when group members feel unimportant					
6. Nurses need to act like physicians to receive prestige					
33. Marginalized leaders are inflexible					
28. I act like a physician to receive recognition and prestige					
29. I teach students to show respect to elite staff					
Construct No. 3 Definition: **Low self esteem** occurs when individuals feel devalued (Roberts, 1983).					
7. Nursing students are dependent upon those superior to them in the hierarchy of healthcare delivery					

8. Physicians are superior to nurses					
9. Hospital administrators are superior to nurses					
34. Self -esteem is eroded when students are criticized					
35. I teach students to prove their value.					
36. I teach students there is a hierarchy in healthcare delivery					
37. Criticism threatens a student's sense of self-mastery					
Construct No. 4 Definition: **Submissive-aggressive syndrome** results in individuals feeling unable to speak up and confront issues which concern them (submissive); however, if they do speak out to confront an issue they do it in an ineffective confrontational manner (aggressive).					
10. It is acceptable for student nurses to speak directly to the primary nurse when they have concerns in clinical					
11. Nursing students should not approach a physician without first receiving permission					
13. Nursing students must follow all orders given by their primary nurse					

14. Nursing students must follow every order given by a physician					
38. Nurses seldom confront physicians directly when they have complaints					
39. Oppression results in passive-aggressive behavior					
40. I teach students not to approach a physician directly without permission.					
Construct No. 5 Definition: **Horizontal violence** is defined as subtle or overt acts of aggression between group members. An example of a subtle act of HV is ignoring the concerns of another or withholding information. Examples of overt acts of HV are of extreme criticism or ridicule**.**					
15. It is okay to ignore my students when I am busy.					
16. Criticizing students makes them resilient					
17. It is acceptable for the primary nurse to criticize students					
18. Sometimes it is appropriate for the primary nurse to withhold information about their assignment patient from a student					

19. It is acceptable for primary nurses to be abrupt when students ask questions					
20. I have reported nurses who have withheld patient information from my students					
22. I teach my students about horizontal violence					
23. I teach conflict resolution skills.					
24. It is not okay to criticize students in front of patients					
25. It is not okay to criticize students in front of nursing staff					
26. There would be negative repercussions if a student reported horizontal violence to the administrators of a clinical agency					
21. Horizontal violence against nursing students should be reported					
27. I have reported nurses who have engaged in horizontal violence against my students					

41. An overt act of aggression between group members is horizontal violence					
42. Ignoring the concerns of another is horizontal violence.					
43. Withholding patient information is not an act of horizontal violence					
44. Extreme criticism is an act of horizontal violence					
45. Acts of horizontal violence may be subtle					
46. I sometimes ignore my students					

Respondents will also be asked to offer any comments if desired.

Expert Panel: Please CONTINUE ON to the DEMOGRAPHIC QUESTIONNAIRE FOLLOWING for assessment.

Expert Panel: Please review the following demographic questions and make suggestions:

1. What is your highest level of education attained? Please select from the responses provided below:

a) Associate degree in nursing

b) Baccalaureate degree in nursing

c) Baccalaureate degree outside of nursing

d) Masters of Science of nursing

e) Master's degree outside of nursing

f) Doctoral degree (Please indicate type of doctoral degree)

g) Other (Please specify) : _____

2. How many years have you been in practice as registered nurse? Please select from the ranges provided and pick the range that is closest to the total number of years you have been in practice.

a) 1-5_____

b) 6-10_____

c) 11-20_____

d) 21-30_____

e) 31-40_____

f) 41-50_____

g) 51-60_____

h) 61-70_____

i) 70+_____

3. What is your clinical area of practice specialty, whether in clinical practice or as a nurse educator? Please specify: _____

4. What are your total years in practice as a nurse educator?

a) 1-5_____

b) 6-10_____

c) 11-20_____

d) 21-30_____

e) 31-40_____

f) 40+_____

5. What State do you teach in primarily (more than 50% of your total teaching time)?_____

6. Indicate which type of coursework you teach more than 50% of your total teaching time from the selections below.

a) Clinical

b) Didactic

7. Have you ever worked as a nurse supervisor?

a) Yes

b) No

8. Are you currently a nurse supervisor

a) Yes

b) No

9. Which of the following race/ethnicity do you most closely identify with?

a) Hispanic/Latino

b) American Indian/Native Alaskan

c) Asian

d) Black/African American

e) Native Hawaiian/Pacific Islander

f) White

10. Please indicate your age range:

a) 18-30

b) 31-40

c) 41-50

d) 51-60

e) 61-70

f) 70+

11. Please indicate your gender:

a) Male

b) Female

Thank you very much for your participation in this survey. Your time and attention is very much appreciated!

APPENDIX C

Institutional Review Board (IRB) Approval

OFFICE OF INSTITUTIONAL REVIEW BOARD

SETON HALL UNIVERSITY

July 26, 2016

Brenda Petersen

Dear Ms. Petersen,

The Seton Hall University Institutional Review Board has reviewed the information you have submitted addressing the concerns for your proposal entitled "An Exploration of Nurse Educators' Knowledge, Attitudes and Practice of Horizontal Violence as Measured through Dimensions of Oppression." Your research protocol is hereby accepted as revised and is categorized as exempt.

Please note that, where applicable, subjects must sign and must be given a copy of the Seton Hall University current stamped Letter of Solicitation or Consent Form before the subjects' participation. All data, as well as the investigator's copies of the signed Consent Forms, must be retained by the principal investigator for a period of at least three years following the termination of the project.

Should you wish to make changes to the IRB approved procedures, the following materials must be submitted for IRB review and be approved by the IRB prior to being instituted:

- Description of proposed revisions;
- *If applicable*, any new or revised materials, such as recruitment fliers, letters to subjects, or consent documents; and
- *If applicable*, updated letters of approval from cooperating institutions and IRBs.

At the present time, there is no need for further action on your part with the IRB.

In harmony with federal regulations, none of the investigators or research staff involved in the study took part in the final decision.

Sincerely,

Mary F. Ruzicka, Ph.D.

Mary F. Ruzicka, Ph.D.
Professor
Director, Institutional Review Board

cc: Dr. Deborah DeLuca

Presidents Hall • 400 South Orange Avenue • South Orange, New Jersey 07079-2641 • Tel: 973.313.6314 • Fax: 973.275.2361

APPENDIX D

Letter of Solicitation to Survey Participants

STUDY TITLE: An Exploration of Nurse Educators Knowledge, Attitudes and Practice (KAP) Behaviors of Horizontal Violence (HV) measured through dimensions of Oppression

Affiliation: My name is Brenda Petersen, RN, APN-C, CPNP-PC. I am a doctoral student at Seton Hall University School of Health and Medical Sciences. I am conducting a research project that will culminate in my dissertation.

Purpose: You are invited to participate in this study because you are a nurse educator. You are asked to complete the survey if you fit the requirements. The requirements are being a nurse educator with a master's degree. Studies have demonstrated that there is a phenomenon in the profession of nursing referred to as "horizontal violence" (HV) which has been defined as negative acts and interpersonal conflict that occur between nurses in what are described as toxic environments. Literature demonstrates that this is a widespread problem in the profession of nursing. Studies have demonstrated that nurses first describe experiencing HV in nursing school; however there have been no published studies identified of nurse educators. This research study will attempt to bridge a gap in the literature and add to the body of knowledge on HV in the profession of nursing.

Procedure: You are asked to complete the questionnaire that can be accessed by following the link below. This link will connect you to the survey instrument. Clicking on this link signifies your consent to participate in this study. You are asked to also complete both a brief demographic questionnaire that will gather information related to your age; gender; years as an educator; highest degree attained; type of program you teach in and the state you teach in. Please complete all questions. It should take no longer than 20 minutes to complete the questionnaire**.**
https://www.surveymonkey.com/r/NEKAP-HV

Voluntary Participation: Participation in this survey is entirely voluntary. You may decide not to participate at any time. Consent to participate is demonstrated by your completion of this survey.

Anonymity: You will not be identified by name or any affiliation (including URL address) in any reports or publications about this study.

Confidentiality: All data from this study will be kept strictly confidential at all times. All data will be stored on a locked USB device that will be locked in a box in the principal investigators office and the principal investigator, Brenda Petersen, is the only person who will have access to this data for a period of three years. After three years the data will be destroyed. As there is with anything online, there is a risk (although remote) of hacking.

Risk: There is no foreseeable risk in completing this survey**.**

Benefit: There are no proposed benefits to participating in this research. Results of this research will provide healthcare leaders with information regarding HV in nursing.

Compensation: There is no compensation for participation in this research study.

Alternate procedures: There are no alternative ways to participate in this study.

Contact information: You have the right to ask any questions at any times. If you have any questions about this study, please contact the principal investigator, Brenda Petersen through the office of Dr. Deborah DeLuca at Seton Hall University School of Health and Medical Sciences. Dr. DeLuca can be reached at 973-275-2842. In addition, you may contact Dr. Mary Ruzicka, in the office of the Institutional Review Board at 973-313-6314.