



[Visionary Leadership for Psychiatric-Mental Health Nurses Around the World](#)

INTERNATIONAL SOCIETY OF PSYCHIATRIC-MENTAL HEALTH NURSES

White Paper, March 2014

Disruptive Behaviors in Nursing Practice and Education

I. Statement of Position

Disruptive behaviors in healthcare organizational and educational settings are a threat to the well being and retention of nurses, the quality of patient care, and a culture of safety. These negative and persistent behaviors are the antithesis of the ideals stated in the nursing code of ethics. Evidence suggests that changes in policy alone are not sufficient to change the behavior. Eradicating disruptive behaviors must begin with nursing leaders and involve each member of the nursing profession. Psychiatric-Mental Health Nurses possess the knowledge and skills needed to develop evidence-based strategies for eliminating disruptive behaviors within healthcare settings and academe.

II. Purpose

The purpose of this white paper is to provide information, guidance and support to members of the International Society of Psychiatric-Mental Health Nurses (ISPN) as well as to nurse colleagues, nursing faculty, student nurses, and other health care professionals.

III. Definitions of Specific Disruptive Behaviors

1. Lateral Violence

- Nurse-on-nurse aggression between individuals at the same level on the nursing hierarchy. These verbal and nonverbal behaviors inflict psychological pain. (Griffin, 2004; Stanley, 2010)

2. Vertical Violence
 - Nurse-on-nurse aggression between individuals at different levels on the nursing hierarchy, directed downwards (e.g., NM or charge nurse to staff nurse) or upwards (e.g. staff nurse to NM or charge nurse). They are intimidating and/or undermining behaviors that reflect either an abuse of legitimate authority or abuse of informal power. These verbal and nonverbal behaviors inflict psychological pain. (Stanley, 2010)
3. Incivility
 - “Low-intensity deviant behavior with ambiguous intent to harm the target, in violation of...norms for mutual respect.” (Andersson & Pearson, 1999)
 - Rude, disruptive, intimidating and undesirable behaviors that are directed toward another person (Clark & Ahten, 2011)
 - “...disregard and insolence for others causing an atmosphere of disrespect, conflict and stress. “... an assault on our human dignity and an injurious affront on our self respect (Clark, 2013, p. 10)
4. Bullying
 - “Bullying refers to repeated, offensive, abusive, intimidating or insulting behaviors; abuse of power; or unfair sanctions that makes recipients upset and feel humiliated, vulnerable, or threatened, creating stress and undermining their self-confidence,” (Vessey, DeMarco, Gaffney, & Budin, 2009, pp. 299-300). Additionally, “a real or perceived power differential between the instigator and recipient must be present in bullying”(Ibid.).
 - “...to qualify as workplace bullying, the conflict needs to occur repeatedly, at least weekly, over at least a six month period”(Johnson & Rea, 2009, p. 85).
5. Harassment
 - “...harassment is generally associated with the notion of difference – whether due to gender, race, ethnicity, age or disability” (Vessey, DeMarco, Gaffney & Budin, 2009, p. 300).

IV. Background

Disruptive behavior in the workplace addresses a broad spectrum of staff behavior among and between levels of providers. Behaviors described as verbal abuse, horizontal or lateral violence and bullying have been reported in the international nursing literature for many years (Cox, 1987, 1991; Farrell, 1997, 1999; McCall, 1996; McKenna, Smith, Poole & Coverdale, 2003; Randle, 2003; Skillings, 1992; Quine, 1999, 2001).

Early pioneer work in the United States began in 1983 when Roberts, a nurse educator and researcher, published an analysis of oppressed group behavior in nursing. Oppressed group behaviors (OGB) were first

described by Fanon (1963) and Freire (1971) and identified as horizontal violence. Characteristics of oppressed groups include the indirect expression of aggressive behavior, internalized hostility, and divisiveness. OGB was used by Roberts, DeMarco, and Griffin (2009) to explain and predict nursing workplace behaviors.

DeMarco and Roberts (2003) used their understanding of OGB to describe a cycle they observed in the nursing workplace. Stanley and Martin (Martin, Stanley, Dulaney, & Pehrson, 2008) used the concepts proposed by DeMarco and Roberts to develop an Applied Model of Oppressed Group Behavior to Explain Lateral Violence in Nursing (see Figure 1). Specific points in the cycle may be targeted for interventions that have the potential for improving work relationships and teamwork. An example of a strategy designed to increase nurses' support for one another is the 'code pink' technique described by Trossman (2014).

**Stanley/Martin Applied Model of Oppressed Group Behavior*
To Explain Lateral Violence in Nursing**

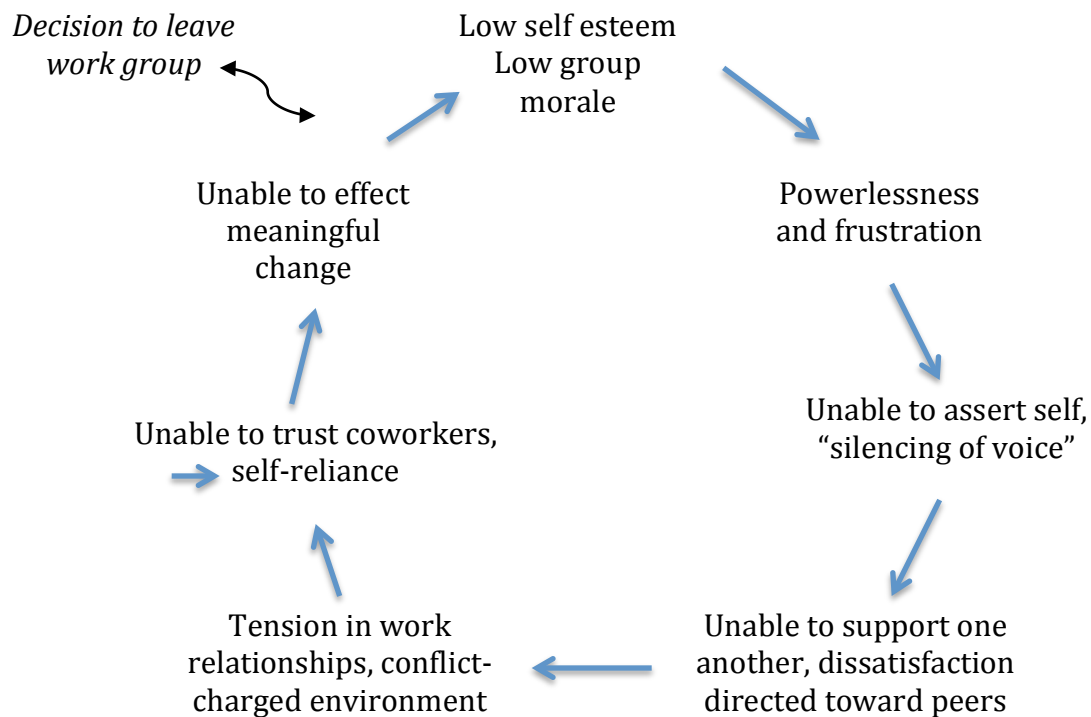


Figure 1. *Applied Model of Oppressed Group Behavior using concepts Proposed by DeMarco and Roberts (2003).

Many nurse researchers and scholars have employed OGB theory in their examination of horizontal or lateral violence in both the nursing workplace and academe (Bartholomew, 2006; Cox, 1991; Dunn, 2003; Farrell, 1997,

1999; Freshwater, 2000; Geller, 2013; Griffin, 2004; Longo & Sherman, 2007; McCall, 1996; Purpora & Blegen, 2012; Purpora, Blegen & Stotts, 2012; Skillings, 1992; Stanley et. al, 2007; Woelfle & MacCaffrey, 2007).

As a subset of disruptive behavior, workplace bullying has been studied in Norway (Einarsen & Skogstad, 1996), Sweden (Olweus, 1978; Leymann, 1990) Australia (Hutchinson, et al., 2008) New Zealand (Foster, 2004) and the United Kingdom (Quine, 2001; Randal, 2003). Nursing research of workplace bullying in the U.S. has been a more recent area of study and scholarly publication (Center for American Nurses, 2007; Dellasega, 2011; Johnson, 2011; Johnson & Rea, 2009; Simons, 2009; Vessey et al., 2009). Vessey, DeMarco, & DiFazio (2010) have suggested that individual descriptive terms for disruptive behaviors, i.e., bullying, harassment, and horizontal violence (BHHV), overlap and can be viewed and examined as a single concept.

Incivility has likewise become a focus of nursing study and publication. (Felblinger, 2008; Heinrich, 2006; Hutton, 2006; Lashinger, et al., 2009; Luparell, 2004a, 2001b). Clark (2013) has addressed incivility in academe and has provided examples of mission statements, a statement of civility, shared values, and policies.

The occurrence of disruptive behaviors identified as bullying, incivility, lateral and vertical violence in academe has been reported to negatively affect both students and faculty (Clark, 2013; Clarke, et al., 2012; Cooper, et al, 2009; Cooper & Curzio, 2012; Geller, 2013; Heinrich, 2006; Hinchberger, 2009; Jackson et al., 2011; Longo, 2007; Randle, 2003; Stevenson, Randle & Grayling, 2006; Thomas & Burke, 2009). Geller's extensive analysis of the literature revealed "...student nurses are common targets of BHHV during clinical education, regardless of demographic characteristics, disability, sexual orientation, geography location, academic institution or program type" (Geller, 2013, p. 22).

V. Disruptive Behaviors and Patient Safety

The Institute of Medicine report *To Err is Human* advised that poor inter-professional communication increases the potential for errors in patient care settings (Kohn, Corrigan & Donaldson, 2000). According to the Joint Commission (n.d.), almost 70% of sentinel events subjected to root cause analysis were related to communication. Disruptive behavior that undermines patient safety includes a variety of identifiable poor communication patterns (Joint Commission, 2008.).

Poor communication is often the result of verbal abuse. Verbal abuse has been documented in the international nursing literature for a quarter of a

century and has been identified as the most common form of disruptive behavior experienced by professional nurses (Budin, Brewer, Chao & Kovner, 2013). Nurses may be the perpetrator or the victim of verbal abuse. Manderino and Berkey (1997) examined the effects of verbal abuse of nurses by physicians that was perceived as humiliating, degrading, and disrespectful. In a study of verbal abuse from nurse colleagues, nurse colleagues had verbally abused 49% of the study participants. The most common types of abuse were 'being ignored' and 'being spoken to in a condescending manner' (Budin et al., p. 4).

The Joint Commission 2008 report arose from a series of health workplace surveys on nurse and physician perceptions of disruptive behavior and its effect on communication, collaboration, and quality of patient care. Almost 20% of respondents believed they had seen adverse events occur because of disruptive behavior, including errors, patient safety threats, effects on quality of care, and patient mortality (Rosenstein & O'Daniel, 2008).

Prompted by a concern for patient safety and quality of care, The Joint Commission enacted a Leadership Standard (LD.03.01.01) on January 1, 2009 for all accredited programs. Hospitals and organizations were required to have a code of conduct that defines acceptable and disruptive and inappropriate behaviors (EP 4), and leaders were required to create and implement a process for managing disruptive and inappropriate behaviors (EP 5). Further requirements included training, accountability, policies, reporting processes, monitoring, and help for offenders. (www.jointcomission.org/assets/1/18/SEA_40.PDF)

VI. Recommendations

1. Healthcare organizations

- Enact or refine codes of behavior and no-tolerance policies that will ensure compliance with The Joint Commission's published recommendations: "To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten performance of the health care team" (The Joint Commission Sentinel Event Alert Issue 40, 2008).
- Provide organization-wide interactive educational programs on disruptive behaviors that require participation by all staff in every discipline, and at every level within the healthcare setting.
- Set expectations that individual unit managers will develop ways to educate and support their staff. Rationale for this expectation: The consequences of an oppressive work environment can be significant. Disruptive behaviors may become a unit norm, and the result may be a work culture where coworkers are hesitant to ask each other for help and where offers of help are often withheld.

2. Academe
 - Provide disruptive behavior education for all faculty, and set clear expectations about faculty members' responsibility for supporting and intervening with colleagues and students who may be the recipient of a form of disruptive behavior.
 - Incorporate disruptive behavior education into the curriculum that will prepare nursing students to identify and manage incidents of abuse in any circumstance where they occur.
 - Develop policies for reporting incidents, disciplinary action and/or counseling for perpetrators, and protection from retaliation for those reporting incidents of disruptive behavior.
3. Nursing research
 - Develop and refine instruments that provide information about frequency and types of disruptive behavior, causes of the behaviors, reasons for not reporting or confronting the problem, and effects of the behaviors on individuals and the work culture.
 - Identify and disseminate evidence-based strategies designed to eliminate disruptive behaviors within the profession of nursing.
 - Identify and disseminate evidence-based strategies that provide structured approaches nurses can use to manage disruptive behaviors.
 - Utilize new methods of technology to reach nurses in healthcare and academe, e.g., a web-based interactive educational course that functions as a training course, raises awareness, identifies language to describe the experiences of disruptive behavior, proposes strategies for resolving conflict, whether seen on the individual level as oppressed group behavior or in the broader ecological context with organizational and system features.
 - Evaluate the impact of disseminating evidence-based interventions related to disruptive behaviors on select nursing satisfaction and patient safety outcomes.
4. Interdisciplinary research
 - Develop and refine instruments that may be used to provide information about frequency and types of disruptive behavior among all healthcare providers, the causes of the behaviors, reasons for not reporting or confronting the problem, and effects of the behaviors on individuals, groups of providers, patients, and the work culture.
 - Identify and disseminate evidence-based strategies to eliminate disruptive behaviors among all disciplines and levels of caregivers.

VI. Conclusion

Disruptive behaviors create demoralized staffs, undermine efforts at recruitment and retention, threaten patient safety, and limit an

organization's ability to thrive in severe economic downturns. The International Society of Psychiatric-Mental Health Nurses (ISPN) supports the position of the Center for American Nurses that "there is no place for lateral violence or bullying in professional practice environments" (2008, p. 7).

The frequency and severity of disruptive behaviors has been studied and well documented. In addition, the nursing literature is awash with anecdotal reports of proposed measures to deal with disruptive behaviors. It is time now to shift the focus of study onto evidence-based strategies that will actually bring about behavior change, reduce the incidence of disruptive behaviors, and help nurses and other healthcare providers manage and cope with incidents of abuse. Until this challenging research is successfully undertaken, completed and disseminated, we will not solve the ongoing problem of disruptive behaviors in nursing practice and education.

We believe our ISPN members are in a unique position to encourage nursing and the healthcare system to openly address the problem of disruptive behaviors that are often kept secret or ignored. This can be done by assisting our professional colleagues in applying existing research to their settings, and by providing new insight through innovative research that focuses on structured interventions designed to eliminate disruptive behaviors and their negative effect on nurses, patients, and the workplace culture.

We support a culture of respect and ethical behavior where committed individuals thrive as they fulfill their roles as providers of healthcare, administrators, faculty, or students.

VIII. References

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