Difficulties in nurse working relationships have concerned nursing leadership in the United States and internationally since the early 1980s. Research in this area has increased lately, focused primarily on the definition of the problem. Interpersonal conflict among nurses (R.N.), or horizontal violence, can include overt and covert hostile behavior from one nurse to another. Negative effects can be severe, leading to increased stress, emotional distress, physical and psychiatric illness (Jackson et al., 2002, Jezuit, 2002), reduced job satisfaction, burnout, and increased intent to leave the workplace (AbuAIRub, 2004, 2002, Farrell, 1999, Quine, 1999).

Costs to others include reduced quality of patient care, reduced patient satisfaction, and increased costs to health care employers due to increased turnover, absences due to stress, decreased efficiency, patient care errors and litigation. Researchers have routinely encouraged nursing leaders to implement effective strategies to increase cohesion, support, and aspects of horizontal caring among nurses. Advanced practice psychiatric nurses’ skills could be utilized in this process. A research demonstration project using Narrative Community R.N. groups (Schoessler & Tanner, 2003), where nurses gather in small groups to confidentially share stories from their practice, was implemented over a four-month span of time in a 400-bed medical center in the northwestern U.S. Responses to the intervention were positive. Horizontal caring, based on the presence of Watson’s (1979) Ten Carative Factors, was observed between participating nurses.
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HORIZONTAL CARING IN NURSING
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Introduction

Difficulties in nurse-to-nurse working relationships have been a focus of concern for nursing leadership for at least twenty years, as evidenced by E. E. M. Smythe’s (1984) work “Surviving Nursing.” Here, Smythe, an advanced practice psychiatric nurse, compassionately describes interpersonal conflicts between nurses, followed by suggestions to remedy the problem. Nurses’ relationship difficulties have gained significant attention in the British Isles, Australia and Canada since at least 1995. Although there has been less of a focus here, the United States (U.S.) has published increasingly on this topic in the last few years in conjunction with the early effects of the latest nursing shortage. A professional barrier to progress in this area may stem from nursing’s dominant historical and cultural view of the preeminence of the patient. As an example of this phenomenon, Peplau’s seminal text “Interpersonal Relations in Nursing: A Conceptual Frame of Reference for Psychodynamic Nursing” provides an exceptionally comprehensive exploration of nurse and patient relationships but does not make a single recommendation or reference concerning interactions between nurses themselves. While the patient’s needs are central to nursing, the other-focus of nursing education and practice has seemed to exclude nurses as important others to be considered or attended to. In the past we have not routinely trained nurses to pull together, empower one another, or support one another as a means to provide the best care to patients. It is becoming clear that while the patient will always rightly remain the focus of nursing care, nurses themselves are also in need of some care in order to be able to consistently meet patient needs.
Purpose

Most often, nursing relationship factors, including peer-to-peer, nurse manager-to-staff nurse, and experienced nurse to nurse-in-training, are studied as a small part of the many elements that impact the work environment or organizational culture of modern health care (Beaudoin & Edgar, 2003; Staten, Mangalindaa, Saylor, & Stuenkel, 2003). As such, less attention has been given to interpersonal nursing relationships than is deserved, especially in light of recent reports from nurses on the front lines (Nurses…, 1999; Strawbridge, 2001).

Fortunately, some effective strategies to repair troubled nurse-to-nurse relationships are being implemented and shared; including community building and providing opportunities for nurses to dialogue about their patient care (Koloroutis & Felgen, 2004; Medland, Howard-Ruben, & Whitaker, 2004). Schoessler & Tanner (2003) unexpectedly found that significant impacts were made on nursing relationships within workgroups during Narrative Community interventions. The study of Narrative groups was undertaken to determine their impact on the role, practice and learning of acute care nurses as they shared socially embedded knowledge with workgroup peers across shifts (Schoessler & Tanner, 2003). While the primary purpose of this study was to observe the transfer of clinical knowledge and learning as nurses shared stories directly from their clinical practice with others in their workgroup, the researchers discovered that interpersonal caring was evoked when nurses listen to each other’s stories and reflected on their own and others clinical practice.

A recent project, utilizing Schoessler and Tanner’s Narrative Community intervention for nurses, provides a similar demonstration of nurses within work groups caring for and learning from one another. This type of intervention supports nurse-to-nurse relationships and promotes horizontal caring. Jean Watson (1979), nurse philosopher and theorist, offered a philosophy of
nursing that rests on Ten Carative Factors (Appendix D) nurses can provide to patients during the work of nursing. These Ten Factors infuse nursing care with a holistic and humanistic focus that results in an improved and satisfying experience for the patient. These Carative Factors, when applied to fellow nurses and others in the workplace, as well as patients, during the workday, could potentially provide an environment that meets the basic psychological and social needs of all involved in nursing care provision. Watson (1979) has noted that caring behaviors "bring meaning to one's life through relationships with other people," indicating the significant power of "caring" to human beings.

The purpose of this research utilization project was to determine the feasibility, impact and benefit to nurses of shorter-term Narrative Community interventions on horizontal nursing group relationships within two in-patient nursing units in a Northwestern United States community medical center. A secondary purpose was to explore the potential benefits Psychiatric Mental Health Nurse Practitioners (PMHNPs) could offer to individual nurses and nurse work groups within health care systems, through Narrative Community interventions. Some additional areas a PMHNP or psychiatric Clinical Nurse Specialist (CNS) could assist nurses include training in assertiveness and conflict management and providing support groups for nurses.

Scope of the Problem

The problem of interpersonal dysfunction in nursing appears to be complex, owing to a variety of causes. United States nurses have called this phenomenon "eating our young" when the behavior is applied toward newer nurses (Giroux, 2001; Meissner, 1984), while it has been labeled interpersonal or inter-group conflict when a variety of nurses are involved. In the literature it has been called "horizontal violence" (Chaboyer, Najman & Dunn, 2001; Farrell,
2001; Smythe, 1984; Taylor, 2001) and internationally it has been identified as “bullying in nursing” (Field, 2002; Gilmour & Hamlin, 2003; Jackson, Clare, & Mannix, 2002; Quine, 1999; Stevens, 2002). Characteristics of the phenomenon include ongoing expressions of hostile overt behavior such as rudeness, intimidation, verbal abuse, humiliation in front of others, and undo criticism as well as covert behavior such as spreading rumors, withholding information, undermining, sabotage, and excluding (Dunn, 2003, Stevens, 2002; Farrell, 1999; Quine, 1999). In a recent study in the United Kingdom of 4,500 nurses, one in six reported they had experienced workplace mistreatment in the last twelve months and 33 % of these were intending to leave their workplace (Gilmour & Hamlin, 2003). Of this group 41% reported mistreatment by supervisors while 41% reported being mistreated by peers. Nurses are very unlikely to directly report abuse or hostility from a co-worker (Bouchard, 2003; Taylor, 2001). However, these types of behaviors reported by nurses in a variety of research surveys from England, Australia, Canada, and the United States have raised awareness of the reality of the problem.

The phenomenon of uncaring behavior to fellow nurses may have roots in the history of nursing itself. While acknowledging support for care of patients as the defining feature of nursing, Benner & Wrubel (1989) provide insight into nursing’s historical context where “caring has been associated with duty and subservience. Altruism has been associated with self-immolation... In this view concern for others competes with self-concern: Concern for others must always be at the expense of the self, and therefore ‘altruistic.’” (p. 367). They go on to point out that there is a more balanced view of caring where “concern for others may bring about mutual realization. Caring for others contributes to a world where one can care and expect to be cared for.” (p.367). They believe that caring and interdependence supersede personal autonomy as a sign of adult maturity. “Caring and needing care point up to the centrality of
Horizontal Caring

interdependence and our essential reliance on others.” (Benner & Wrubel, 1989). From the beginning of the profession, nurses have struggled to care for their patients in a context of limited resources for self-care or care from others (Taylor, 2001). Many have denied their needs and their needs were denied by others during the process of caring; resulting in depleted caregivers attempting to give autonomously from dangerously low personal reserves. The result has been “burn out” in many cases (Laschinger, Shamian, & Thomson, 2001; Benner & Wrubel, 1989). Due to this historical “Achilles heel” in nursing it is good for all nurses to be familiar with strategies to recover from burnout including rest, relaxation, empowerment and reconnection to relationships in order to heal from the alienation that has been experienced (Medland et al., 2004; Benner & Wrubel, 1989).

Nursing leaders are becoming more aware of the costs and consequences of hostility among nurses to the health care system and to individual nurses. Retention of nurses appears to be tied, in part, to workplace environmental factors including job stress and workgroup cohesion (Shader, Broome, Broome, West & Nash, 2001). It may cost up to two times the salary of a departed nurse to obtain and train a replacement, costs estimated to be between $42,000 to $145,000 depending on the specialty (Staten et al., 2003; Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; White & Rice, 2001). Considering the high cost of replacing a nurse and the difficulty of finding experienced nurses, administrators are highly motivated to retain nurses in their employ, and are seeking solutions to lower turnover rates.

Other consequences of disrupted relationships among nurses to health care include higher costs due to lower productivity and time off due to stress from conflict or maltreatment at work. Nurses who are targets of hostile behavior experience significant consequences. Not only does a nurse in this position experience personal distress and lowered job satisfaction; the work stress
may lead to anxiety, depression, and eventually to deterioration of physical health including suicidal thoughts for some (Jackson, Clare, & Mannix, 2002; Jezuit, 2002, Strawbridge, 2001; Brennan, 1999). Many recipients of workplace hostility have had long-term after effects that are characteristic of Post Traumatic Stress Disorder (Farrell, 2002; Scott & Stradling, 2001).

Additionally, the distress can lead to distractions in performing patient care duties, resulting in a negative impact on patients and the entire healthcare system (Staten et al., 2003; Forte, 1997). Nurses who are treated with hostility have more difficulty with job duties, feel “traumatized and rushed, are more likely to make mistakes and thus adversely affect the quality of patient care” (Lewis, 2001). Research by Baker (1989) confirms the perception that nurses believe patient errors are increased when the nurse is subjected to verbal abuse. “One negative patient outcome can be much more costly, both directly and indirectly, than the salaries of several staff nurses” (Gifford, Zammuto, & Goodman, 2002).

In recent years prominent U.S. nursing and healthcare organizations have called for improvements in nurse working environments. Nineteen influential nursing organizations formed a steering committee for nursing reform in 2001, and joining with 44 other key nursing organizations, developed “Nursing’s Agenda for the Future ~A Call to the Nation” published by the American Nurses Association (ANA) in April 2002 (American Nurses Association, 2002). In this document, they rally nurses to “embrace their professional responsibility and accountability, including: collaborating, mentoring, promoting diversity, and adhering to standards and ethical codes of professional practice” through strategies including: education, leadership development, and by promoting “a healthy environment of respect and caring for one another “ (p.15). The ANA also published two documents nurses can use to choose employers with positive work environments, Principles for Nurse Staffing published in 1999, and the Bill of
Rights for Registered Nurses published in 2001 (Blakeney, 2004). The American Association of Colleges of Nursing (AACN) published a White Paper, Hallmarks of the Professional Nursing Practice Environment in January 2002 (American Association of Colleges of Nursing, 2002) with recommendations for nurses work environments. Unfortunately these recommendations make no specific mention of nurses interpersonal relationships except to say nursing errors should be addressed by a peer review process. The U.S. Institute of Medicine (IOM) released Keeping Patients Safe: Transforming the Work Environment of Nurses (Page, 2003), an exploration of patient safety in the context of today’s healthcare environment, in November 2003. According to the IOM, problems such as inadequate R.N. staffing ratios, dependence on overtime using fatigued nurses to meet staffing needs, cultures that punish disclosure of errors, and poor team functioning have dominated nursing care environments for years, leading to increased errors in patient care. In addressing team functioning, the IOM determined that “interpersonal communication, regard for others, a strong focus on patient safety goals, and constant reassessment of the environment are important aspects of...team performance and care delivery outcomes.” (Page, 2003). The IOM has called for further research focusing on identification of interpersonal and group interaction processes that increase the delivery of safe care.

Historically nursing leadership has not focused significant attention on the prevention or correction of a hostile work environment. Tolerating poor treatment from coworkers and managers seems to have become a part of the nursing culture in many parts of the world (Jones, Bushardt, & Cadenhead, 1990; Najman & Dunn, 2001) and may date back at least 75 years (Stevens, 2002). Standard interventions to assist the targets of a hostile nurse workgroup are rare. Some anecdotal reports of successful interventions include support for nurses and setting
interpersonal ground rules with a troubled workgroup (Scofield & Salmond, 2003; Jezuit, 2002; Stevens, 2002; Kennedy & Barloon, 1997). There is very little research on the effectiveness of interventions to assist adversely affected nurses or a nurse work group with hostility issues (Farrell, 2001). In light of the significant costs of horizontal violence to nurses, patients, and health care systems, it is imperative to determine effective interventions for this problem. A paradigm in nursing that promotes “horizontal caring” between nurses is a constructive concept for health care leaders to seriously explore. In an effort to find an intervention that could lead to improved nurse-to-nurse relationships at the unit level, a demonstration project with staff nurse Narrative Communities, was provided to two nursing units in a community hospital in the United States in late 2003. This project had positive results among the staff who participated, leading to increased respect and sensitivity to coworkers and feelings of belonging, caring and interpersonal connections. This project will later be described in more detail.

Review of the Literature

The following review of the literature regarding nurse-to-nurse relationships includes: an overview of theoretical frameworks used by researchers on this topic, individual reviews of several studies elucidating the problems between nurses, and a review of solutions from the literature designed to bring nurses together. The literature revealed numerous anecdotal articles, a few texts, and a modest but increasing number of research studies.

Theoretical Groundings in the Literature

A small minority of the studies that were analyzed included a framework for the research. In her study of nurse perceptions of verbal abuse (of nurses) as health system stressors, and how these stressors effect RN delivery of patient care, Baker (1989) applied Neuman’s health care system model, which focuses on the means that must be available for nurses to provide quality

A respected organizational theory, the competing values framework of organizational culture, was used by Gifford, Zammuto, and Goodman (2002) to study the type of health care organization that will support quality of work life for nurses with the goal of improving nurse retention. Finally, an important theoretical framework that explains dysfunctional relationships between nurses was developed by Farrell (2001). He performed a critical analysis of over forty articles on nursing relationships and used them to create his conceptual framework. Farrell’s theory, in combination with Watson’s Philosophy and Science of Caring, were used as a basis for this endeavor.

The Problem Defined

The literature revealed over thirty studies performed in English speaking nations in the last fifteen years that addressed nurse-to-nurse working relationships in some way; most were published in the last five years. These studies were performed in the United States (U.S.), Australia, The United Kingdom (U.K.), and Canada. One large international study included several countries (Aiken et al., 2001). Most of these studies were based on nurses’ perceptions rather than objective data and utilized a quantitative design with a voluntary convenience sample of between 100-1,000 RNs who completed a variety of self-report questionnaires chosen by the researchers to answer specific questions. A summary table of 23 of these studies, including major findings with applicable survey tools and their psychometrics has been developed for
review (Appendix A). Several of the quantitative studies included qualitative open-ended questions (Fletcher, 2001; Gurley, Spence, Briner, & Edwards, 2003). One important study was purely qualitative (Taylor, 2001). To date, interventional research developed to determine the most effective strategies to improve nurses working relationships has not been published. However, several of the published studies had significant findings that can be used to promote improved nursing relationships, while others can be utilized to develop future research.

Leppa (1996) explored connections between nurse workgroup disruption and workgroup relationships in a quantitative study combining data on absenteeism, agency nurse use, and unit personnel changes obtained from hospital records with data from two work satisfaction self-report questionnaires. The questionnaires were completed by 908 RNs (response rates of 61-75%) in a variety of hospital settings. This voluntary RN sample was taken from four tertiary care hospitals in the U.S. She supported her study premises with a literature review demonstrating the preeminence of group work in hospital nursing and the importance of positive nurse workgroup interactions to ensure quality patient care and nurse satisfaction. Results showed that overall satisfaction with RN/RN interaction was fairly high, and concluded “nursing work group cohesion (nurse/nurse interaction) is the most important element of job satisfaction for RN respondents” (Leppa, 1993). When the data were broken down to the unit level, lower satisfaction with nurse/nurse interactions coincided with higher absenteeism and higher agency nurse use. Additionally, higher satisfaction with nurse-to-nurse working relationships correlated positively with patient safety and better patient quality of care. Higher agency use was associated with lower quality of patient care. The investigator advanced the idea that RN work groups should be supported and protected by managers, including avoiding staff floating and
agency nurse use, and by providing extra group support when the organization was experiencing 
major change.

British health psychologist and researcher Quine (1999), published a study on adult 
bullying behavior in the National Health System (NHS) in the United Kingdom. She defined 
bullying in five categories: 1) threats to professional status (e.g. belittling opinions, public 
professional humiliation), 2) threats to personal standing (e.g. name calling, insults, teasing), 3) 
isolation (e.g. withholding information, preventing access to training), 4) overwork (e.g. undue 
pressure to produce work, impossible deadlines), and 5) destabilization (e.g. failure to give credit 
when due, removal of responsibility without consultation, shifting of goal posts, demoralizing).

Her study utilized an anonymous, quantitative, mailed questionnaire with a convenience sample 
of 1,100 English National Health Trust employees who returned questionnaires (70% response 
rate); with the highest percentage of respondents, 36%, being nurses. Other employees included 
therapists (10%), administrators (12%), doctors (5%), psychologists (1%), other professionals 
(9%), and staff (27%). Nurses reported the highest amount of bullying –of 174 respondents, 
44%, reporting bullying: 33% categorized it as destabilization activity, 27% categorized it as 
isolation activities, and each of the other three types of bullying were in the range of 20% each.

As to the whole sample, women were bullied more frequently (65% women vs. 27% men), and 
the bully was a superior in 54% of the cases, a peer in 34% of cases, and a subordinate in 12% of 
cases. Employees who were bullied within the last year reported significantly lower job 
satisfaction levels, significantly higher job stress, higher propensity to leave, higher clinical 
depression, and higher clinical anxiety. Quine (1999) also found that a supportive work 
environment can protect people’s health against the assault of bullying.
Taylor (2001), an Australian professor of nursing, published a qualitative study based on reflective practice and action research processes carried out with a convenience sample of 12 experienced acute care RNs meeting one hour per week for 16 weeks. After meeting a few times the nurses voluntarily chose to focus on the area of dysfunctional nurse-to-nurse relationships. Taylor facilitated these group meetings. The primary purposes of the study were to promote improvements in patient care and also to empower nurses through professional growth by promoting gains in problem solving skills to reduce horizontal violence. Three reflection/action cycles were completed. Personal journals kept by participants were used later in data analysis. The group developed an action plan that had ten strategies to use with nurses who bully or behave in a dysfunctional manner. Varying degrees of success in improving the dysfunctional nurse relationships occurred. The researcher encouraged the use of groups of this type to bring about positive cultural change in nursing work groups.

An American nursing professor, Kathleen Cox (2001), studied RN intra-group conflict, team performance, job satisfaction and anticipated turnover in nursing units of an academic medical center. She focused on interpersonal and group conflict in nursing because previous research had shown it to be counterproductive to patients and negatively associated with job satisfaction and positively associated with turnover (Cox, 2001; Forte, 1997, Gardner, 1992). Her convenience sample of 141 RNs had been employed for at least 6 months in one of 13 inpatient units in a 600 bed medical center in the U.S. She used five self-report questionnaires including her own conflict scale and obtained a 49% response rate. Through data analysis she determined that workgroups that had a higher percentage of nurses had greater conflict, but that higher conflict was not associated with increased turnover. She also found that greater unit morale and better interpersonal relationships were associated with lower group conflict, less
anticipated turnover, and improved satisfaction with pay. She urged nursing leaders to make every attempt to improve unit morale and interpersonal relations and reduce unproductive conflict; developing groups of nurses into high functioning teams from nursing school forward.

Fletcher (2001), another American, examined stress in nurses and its association to illness. She utilized a quantitative mailed survey design, sending four surveys with a page at the end for comments that was to be analyzed qualitatively. Her large convenience sample of 1,780 RNs from 10 hospitals in the Midwestern United States represented a 34.5% response rate. Of this sample 28.6% (509) of the RNs contributed personal comments. Her quantitative findings were not surprising in that RNs were slightly satisfied with their jobs as whole and felt somewhat stressed. Most of the nurses surveyed were not intending to leave the workplace in the next year. The themes of the qualitative findings included a perception that hospital profits were more important than patient care, to leadership. Additionally, RNs were most unhappy due to: poor peer relationships, worsening patient care, insecurity of hospital jobs, lower pay and benefits than they felt they deserved, and poor management. The one positive theme in the notes was the reward nurses received from caring for patients. Fletcher (2001) advises nurse leaders to pay attention to the feedback nurses are providing and seek more of it in order to effect positive changes that will improve the day-to-day work life of nurses, thus promoting nurse retention. She also encourages interventions to increase staff nurses’ understanding of the nurse manager’s role and improve these managers’ understanding of the staff nurses’ role in order to promote understanding and good working relationships.

In a landmark study Aiken, Clarke, Sloane, et al. (2001) used a cross-national quantitative anonymous questionnaire survey design to study perceptions of a convenience sample of 43,329 acute care nurses from 711 hospitals in Pennsylvania (31.1%), Canada
(40.3%), England (11.6%), Scotland (10.9%), and Germany (6.2%). These data were combined with patient discharge information, other patient outcome information, and staffing information derived from hospital records. Although this was a preliminary report of a larger study, it had significant findings. The purpose of this study was to determine nurses’ perceptions of: their working environments, the quality of nursing care, job satisfaction, career plans, and burnout. Researchers received a 42-53% response rate across these national groups. Findings showed low morale in all nations except Germany. The United States scores were the most concerning with 41% of Pennsylvania’s nurses dissatisfied with their jobs and 43.2% at high risk for burnout.

Aiken et al. (2001) noted that in recent years only 10% of workers in other U.S. professions have reported dissatisfaction with their jobs. In spite of this, England had the highest intent to leave in next year with scores at 38.9%, while the U.S. had a score of 22.7%, demonstrating almost a quarter of the nursing workforce had intent to leave within the next 12 months. Although the area of nurse-to-nurse relationships and behavior was not directly assessed, a question was asked about administration listening to and responding to nurses’ concerns. The response was lowest for U.S. nurses; only 29.1% of U.S. nurses felt administrator support in the workplace.

Additionally, “a majority of U.S. (52.7%) and Canadian (61.2%) nurses indicated that patient and family complaints and verbal abuse directed toward nurses had also occurred with regularity in the past year” (Aiken et al., 2001) while over 44% of these nurses indicated that patient care had deteriorated. This report belies the extreme stress and concern that nurses are feeling within their workgroups on a daily basis.

Nurse burnout was researched in two recent studies from the United States. Kalliatb and Morris (2002) employed a quantitative design with a convenience sample of 203 nurses from the mid-west to study the relationship between R.N. job satisfaction and burnout levels. The nurses
Horizontal Caring in Nursing and a Narrative Community Experience

By

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Of the requirements for the degree of

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The members of the committee appointed to examine the research project and manuscript of Lesley L. Arle find it satisfactory and recommend that it be accepted.

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completed respected self-report questionnaires on job satisfaction and burnout. The results showed a link between reduced job satisfaction, emotional exhaustion, and depersonalization—resulting in burnout. Findings support the premise that lower rates of R.N. job satisfaction can be a predictor of R.N. burnout. In February 2004 Vahey, Aiken, Sloane, Clarke, and Vargas reported results of their study linking increased levels of nurse burnout with significantly decreased patient satisfaction scores. Their study of 820 nurses caring for AIDS patients in 40 different units, a convenience sample from 20 U.S. hospitals, and 621 patients from these units, used self-report questionnaires to measure nurses' perceptions of their work environments and of burnout levels. These results were compared with the patient scores from a patient-specific satisfaction scale. Nurse and patient response rates were each 86%, with results showing that adequate staffing, good support and good working relationships between doctors and nurses led to lower R.N. reports of burnout and twice the level of patient satisfaction with care on these units.

AbuAlRub (2004) recently used the Internet to access her convenience sample of 243 American nurses and 40 non-American nurses to study job stress, job performance and social support in hospital nurses via web-based self-report questionnaires. Although her response rate was low, 12%, her results confirmed that perceived social support from coworkers enhanced job performance and decreased work stress across both groups. She recommended that nurse leaders adopt strategies to ensure that coworker support is a cultural norm within their organizations, suggesting that this training could begin in nursing schools and then extend into the modern day work environments of nurses.

In summary, job satisfaction, work group cohesion, and intent to stay are closely associated with intra-group conflict on the job (Cox, 2001; Shader, 2001; Winter-Collins &
McDaniel, 2000; Leppa, 1996; Quine, 1999). Most studies revealed that a significant number of nurses were dissatisfied with their jobs, with rates up to 41% (Aiken et al., 2001; Shader et al., 2001; Quine, 1999). Also, many studies supported the premise that nurses experience a high degree of overt and covert abuse from their colleagues; reports sometime range from 30-40% (Chaboyer et al., 2001; Taylor, 2001; Farrell, 1999; Quine, 1999). Most of the researchers to date have used quantitative questionnaire survey methodologies, based on nurses’ perceptions, and many have not included sufficient information about the validity or reliability of their tools (Cox, 2001; Farrell, 1999; Quine, 1999; Leppa, 1996; Seago, 1996). Most of the studies have included a sufficient number of participants; one large international study had over 40,000 nurse respondents from five countries (Aiken et al., 2001; Chaboyer et al., 2001; Shader, et al., 2001;Quine, 1999; Leppa, 1996). Recent studies are confirming the value of social support between nurses in workgroups to improve job satisfaction, prevent burnout and improve patient satisfaction (AbuAlRub, 2004; Vahey te al., 2004; Kalliath & Morris, 2002). One gap in the literature is the lack of research on interventions to promote good working relationships between nurses, although several authors have called for this research (Cox, 2001; Farrell, 2001; Quine, 1999). Other gaps include research on nurse workgroup problems related to patient outcomes, cost effective methods to promote a positive work environment in nursing settings, and effective ways to help change the culture of nursing to be more humanistic, healthy, and reciprocal.

**Potential Solutions**

**Overview**

In spite of a lack of interventional research, nursing leaders have tried various methods to effect positive change in nurse relationships and their work environment. Some of these
Horizontal Caring

methods have been successful and have received attention in the literature. A few have been researched.

These methods include, but are not limited to: 1) providing extended orientation and mentoring programs, 2) providing continuing education for nurses in communication and conflict management skills, 3) providing ongoing support groups or supportive programs, 4) workgroup retreats, 5) establishing policies or ground rules that provide boundaries to, 6) promoting a shared leadership model of supervision, and 7) analyzing organizational characteristics that attract nurses.

In one of the first self-help books for nurses, “Surviving Nursing,” Smythe (1984) explains the reasons nurses have difficult relationships with one another and offers practical suggestions for them to use to improve relationships with co-workers. She describes both vertical conflicts between nurses and their nurse supervisors and horizontal conflicts between nurse co-workers. Referring to nurse working relationships she states “social support...can be an important and effective component of a comprehensive effort to reduce work stress and improve health, both physical and mental....” (Smythe, 1984, p. 220). Her strategies to improve workgroup relationships include: networking with other nurses, seeking and offering informational and emotional support to other nurses, welcoming the newcomer, mentoring other nurses, and developing peer support groups (Smythe, 1994).

Orientation and Mentoring

Connelly and Hoffart (1998) developed a holistic nurse-orientation model that supports all members of the workgroup, highlights the preceptor, and is based on their two-year naturalistic study of a nursing orientation program. They propose nurse researchers could utilize this model to evaluate nursing orientation programs. Wright (2002), focused on orientation
programs that would prevent nurses from "eating their young." She gives an overview of the literature and advises organizations to establish a formal "precepting" orientation program to ensure integration and acceptance of novice nurses within an established work group. She refers to sources that indicate these programs cost less than traditional orientation methods, provide greater personal growth and satisfaction to both preceptors and novices, and promote improved patient satisfaction and improved patient care outcomes. Nursing student and nurse manager views of leadership were studied by Wieck, Prydun and Walsh (2002). The students clearly wanted leaders who would nurture and mentor them as they entered the nursing profession. Kalliath and Morris (2002) performed a quantitative study with 203 nurses in the U.S. to determine their perceptions of the impact of job satisfaction on burnout in nurses, finding that poor job satisfaction is a significant predictor of nurse burnout. They conclude by echoing Wright's recommendations, encouraging organizations to provide nurses with comprehensive orientation and a "community" environment where peers support one another, supervisors are supportive, and work stresses and joys can be shared, as a measure to prevent depersonalization and burnout in nursing staff. Recently researchers have focused on the need to support preceptors by acknowledging their stressful role, providing training in the mentoring role, reducing their workload while they are supervising trainees, recognizing their efforts, supporting a partnership model between the preceptor and the trainee's supervisor, screening trainees and correcting any major deficits prior to placing them with a preceptor, and providing time off from the preceptor role as needed (Yonge, Krahn, Trojan, Reid, & Haase, 2002a; Yonge, Krahn, Trojan, Reid, & Haase, 2002b).
Conflict Management

Norbeck (1985), in a study of 180 critical care nurses from eight hospitals, discovered that their most distressing work-related stress symptoms came from communication problems with other unit nurses. She suggested that the most effective ways to reduce distress and burnout in these nurses was through reducing communication problems among nurses on the unit, offering peer support groups and stress reduction programs, and by teaching head nurses to provide high consideration and support to the unit staff nurses.

It is well known that interpersonal conflict often carries with it a great deal of personal discomfort. While some nurses attempt to avoid or protect themselves from conflict, it is a natural part of any caring, connected relationship. Some nurses use emotional numbing or distancing when relationships at work become complicated. Benner and Wrubel (1989) believe this strategy to avoid emotional pain in relationships will never be effective, pain evoked from the relationship will seep in. They recommend that “acknowledging (the discomfort) and supporting one another in confronting the threat, are the most fruitful long-term coping strategies” (Benner & Wrubel, 1989, p.377). Jones, Bushardt, and Cadenhead (1990) encouraged nurses to improve communication skills and offered nurses a conflict resolution model that promoted confrontation in the context of open and trusting relationships. Supportive of conflict resolution interventions, Kushell & Ruh (1996) proposed that “investing time, energy, and resources in building interpersonal relationships and improved communication” will have a positive impact on costs.

Milstead (1996a, 1996b) offered nurses excellent step-by-step instructions in assertiveness, conflict management and negotiation as continuing education opportunities in an international journal “Orthopaedic Nursing.” She pointed out the absence of education in these
horizontal caring

skills at nursing schools and workplaces since the 1970s. She provided a variety of practical examples demonstrating the benefit and necessity of nurses possessing and using these skills with patients, coworkers, and supervisors. Unfortunately, the title of the article and specialization of the journal in which “Basic Tools for the Orthopaedic Staff Nurse Part I (& Part II)…” (Milstead, 1996a; Milstead, 1996b) was published may have limited the audience to a single nursing specialty, while any nurse could benefit from Milstead’s presentation of these skills.

Eason and Brown (1999) used a descriptive design to study nurse perceptions of their use of conflict management strategies by completing self-report questionnaires. The convenience sample was a group of 217 nurses who attended a continuing education workshop in the U.S, 42% were staff nurses and 41% were supervisors. Past research during the 1980’s and early 1990’s had reported avoidance was the most frequent behavior staff nurses demonstrated when faced with interpersonal conflict on the job, while nursing supervisors utilized compromise the most (Eason and Brown, 1999). The results of this study revealed that both staff and supervisory nurses used the strategy of avoidance most frequently in conflict situations. Eason and Brown called for nursing leaders to initiate change to improve nurses conflict resolution skills through education, mentoring, support, and by providing opportunities for skill development. In 2001 Walczak and Absolon described the development of an internal education program to help outpatient nurses develop communication skills including conflict resolution and assertiveness. The attendees reported high satisfaction and increased skills after the education. Programs of this type could be researched to determine what aspects are most effective and to assess outcomes.

To be fair, some of the workplace conflict and hostility disrupting nurses’ lives is attributed to physicians, family members, patients themselves and others in the work
environment. Simms (2000) highlighted a creative intervention used by nurses to stop verbally abusive physicians who berate nurses on the job. When a nurse cannot walk away from the situation (which is the first choice) she calls “a ‘code pink,’ a personal signal to other staff members to stand beside the nurse” (Simms, 2000). As these coworkers demonstrate group support and disapproval for the abusive behavior, the physician often stops. Management is notified after the event. Simms (2000) offers a variety of assertiveness techniques and communication skills to help nurses stand up for themselves individually and as a group to take responsibility for their role in improving their workplace environment.

Jehn And Bendersky (2003), researchers in organizational behavior, performed a critical analysis of the literature regarding organizational conflict from the last fifty years. They determined that conflict can be a positive or negative factor for a workgroup, depending on the type of conflict and situational factors. In their model conflict is divided into three distinct types: relationship conflict (interpersonal incompatibilities among group members), task conflict (disagreements among group members about the tasks being performed), and process conflict (disagreements about the means or strategies to accomplish a particular task that has been agreed upon). They concluded, “in order to have high performance and creativity, without too much loss of satisfaction or consensus-building ability, a group needs to have low levels of relationship conflict throughout its lifecycle, moderate levels of process conflict at the beginning, and moderate levels of task conflict starting in the middle of a group’s project or lifecycle.” They encourage employers and employees to: deal quickly with relationship conflicts (these are always detrimental to group functioning), encourage the separation of emotion from the conflict (to improve team performance and employee satisfaction), and provide safe places for the expression of emotions that will inevitably arise in conflict situations. They also advise
employers to support socialization of employees outside of work to increase interpersonal trust among group members, but conclude that it is best to discourage subgroup and coalition formation because these will increase the negative effects of workgroup conflict and will impede the positive effects conflict can have on task accomplishment (Jehn & Bendersky, 2003).

Support Programs and Groups

A task-oriented peer-support group intervention to teach nurses communication and relationship skills called “Interactional Meetings-Peers Working and Caring Together” (IMPACT), was evaluated by Jung, Hartsell, and Tranbargar (1991) as a nurse retention strategy. The voluntary unit-based peer support groups met once a month for two hours with pay, were facilitated by non-unit nurses, and were implemented in about half of the units in the facility. The evaluation of 124 respondents (approximately 50% response rate) who had participated in the groups for between one and three years revealed that 60% of the nurses wanted the groups to continue with 34% unsure; additionally 53% felt the groups had helped to identify significant nursing unit issues and 13% indicated they would have left employment if the groups had not been available. A cost analysis included in this study indicated a $113,000 cost savings based on the prevention of turnover costs. Jung et al. (1991) concluded that “programs like IMPACT help staff take control of their work by guiding them toward quality communication, interpersonal and intragroup conflict resolution, and group cohesiveness.” While nursing leaders recommend support groups for nurses (Jezuit, 2002; Kennedy & Barloon, 1997) few are described in the literature. Interestingly, a grief support group for ICU staff nurses described by Lenart Bauer, Brighton, Johnson, & Stringer (1998) quickly developed into an action oriented team that implemented a variety of creative interventions to support fellow nurses following the death of a
Further research is needed to determine how many support groups for nurses are active in the U.S. and what features lead to their success.

Retreats

Koloroutis and Felgen (2004) have described the benefits of taking nurses away from the workplace and providing them with three days in the presence of others from their work setting to “reflect on their practice and it's meaning in their lives.” During this time participants share stories from their practice, become vulnerable and “experience the power of community and connection. They no longer feel lonely and isolated.” (Koloroutis & Felgen, 2004.) Felgen, (2003), a national leader advocating the revival of interpersonal caring in healthcare, provides narratives of the positive impact an off campus retreat made on the staff of a health center work group that included nurses. Another option, A Caregiver's Careshop© renewal event, is offered yearly to nursing staff in an Ohio health system to improve nurses ability to cope and improve workgroup cohesion (Fitzpatrick, Bunevich, & Jones, 2001). This “spa” day is held off campus at a hotel, providing the opportunity for nurses to receive a massage, and to participate in meditation, yoga, dance, and to enjoy entertainment. Funding for the program is obtained from grants (Fitzpatrick, Bunevich & Jones, 2001). Medland et al. (2004) describe the one day Circle of Care Retreat developed to create a healthier workplace environment on an oncology unit. This off campus event, offered five times that year to include all 150 of the unit staff, resulted in better interpersonal relationships among staff and improved job satisfaction. Similar retreats and programs for nurse work groups and other health system employees have been utilized successfully over the years to improve work group cohesion.
Policies and Ground Rules

Experts in horizontal violence consistently assert the need for organizations to establish policies that have zero tolerance for anti-social words, actions, and overt or covert threats in the workplace, as well as clear policy statements for appropriate interpersonal behavior (Farrell, 2002; Stevens, 2002; Lewis, 2001; Tehraui, 2001; Brennan, 1999; Davenport, Schwartz, & Elliott, 1999). Criteria for and examples of these polices are available and free for use to leaders who are dedicated to provide a safe and healthy workplace for their employees (Canadian Policy on Prevention and Resolution of Harassment in the Workplace, 2004; Scofield and Salmond, 2003; Davenport, Schwartz, & Elliott, 1999, p. 144; Brennan, 1999) (Appendix B). While research on the benefits of these policies to workers and organizations has been performed in European countries, no research of this type has been published in the U.S. making this an important area for future exploration.

Shared Governance

Empowering nurses through a shared leadership model of supervision at the unit level has been successfully implemented in some health care settings (George, Burke, Rodgers, et al., 2002; Walker, 2001). In this model nurses learn to work with each other based on strengths, learning that the quality of the working environment depends primarily on the nurse-to-nurse relationships. When it is successful, a community is built and the elements of a healthy work culture (Attachment C) are observed on the unit (Walker, 2001). Autonomy, empowerment, leadership, and accountability of nurses in moment by moment patient care decisions, resulting in improved patient care and nurse satisfaction are some of the proposed strengths of this model. George et al. (2002) reported three improvements in the workplace environment after shared governance was instituted: 1) improved team relationships with coworkers, 2) improved team
relationships with physicians, and 3) improvements in workflow. Barriers that were acknowledged by the nurses included a lack of collegiality in some units and negative feedback from some coworkers who were not ready to make the paradigm shift to the new model. After the staff had some time to adjust to the changes of shared governance the researchers determined “that it is essential to provide the supportive milieu in addition to the educational program to sustain leadership behaviors and autonomous nursing practice in the clinical setting” (George et al., 2002).

Recently, Anthony (2004) performed a critical analysis of the shared governance literature and questioned the value of this model to nursing. She determined that although there were improvements in financial indicators once shared governance was in place on a unit, still there were mixed or unimpressive results in the areas of improved working environments or nurse satisfaction when compared with matched units governed under the old paradigm. She called for future multi-site research on shared governance to answer some of the questions raised by the research as to the true benefits of this model (Anthony, 2004).

Organizational Characteristics

Organization structure and values have a direct impact on nurse interactions and their workgroup environments (Laschinger et al., 2001). In the early 1980’s insightful nursing leaders in the American Academy of Nurses (AAN) of the ANA began to look at characteristics of hospitals that were able retain nurses in the midst of a national nursing shortage (Aiken & Patrician, 2000; Havens & Aiken, 1999). Their research of 41 hospitals revealed several organizational traits that attracted nurses. These hospitals were identified as “Magnets” to nurses, due to their emphasis on collaboration, participation, flexibility and support (Stewart-Amidei, C., 2003), characteristics that led to improved nursing relationships, higher nursing
satisfaction, and reduced nurse turnover rates. With the next nursing shortage in the early 1990’s the American Association Credentialing Center (AACN) developed a certification process that made Magnet designation available to all institutions who qualified. “Magnet Status” certification, first offered in the midst of the managed care revolution, was quickly placed on the back burner as most healthcare providers tried to cut costs and redesign their services, often reducing nursing staff in the process (Havens & Aiken, 1999).

By 2000 less than 80 medical centers in the U.S. had attained Magnet Status and few nurses knew what Magnet certification signified. During this time, as another nursing shortage gained momentum, health care provider’s began to seek Magnet Status in an attempt to keep nurses and maintain market share in a competitive health care environment (Aiken, Havens, Sloane, & Buchan, 2000). Currently, 102 hospitals have achieved Magnet Status and 26 are in active review processes (American Nurses Credentialing Center, 2004), with many more preparing for review. While the researchers of Magnet Institutions have not frequently directed attention to nurse-to-nurse relationships, and their research questionnaires may not be focused on interpersonal nursing issues, important findings in this research point out organizational characteristics that provide a good environment where nurse workgroups prosper. Hillary Rodham Clinton, a strong supporter of nurses’ rights, in a commentary regarding Magnet hospitals stated, “The power of Magnet hospitals lies in respect” (Clinton, 2002).

Recently hospitals and health care systems have become eager to obtain Employer of Choice recognition, available to any employer meeting the high standards established by Employer of Choice, Inc. This award is obtained through an evaluation that demonstrates excellence in leadership, culture, and practices that attract and retain high quality employees (Employer of Choice, 2004). The evaluation includes education on principles that retain
employees including respect for the individual, flattening of the organization through removal of status barriers, and having fun in the workplace. Care of people is emphasized. Anonymous surveys of employees are a key part of the evaluation. A nursing leader, Connie R. Curran (2003) supports the idea of Employer of Choice equating it with Magnet Status, but on a broader scale because it involves all employees in the organization. She states this recognition will benefit nurses by creating an organizational culture “that centers on teamwork, a learning environment, rewarding challenges, accountability, trust, and respect” (p.57). This environment would enhance nurse-to-nurse relationships and those with members of other healthcare disciplines.

In summary, overall research evidence indicates that many nursing workgroups are faced with significant interpersonal conflict and co-worker hostility that detracts from nurses’ ability to provide optimal patient care. The nurses in these groups have difficulty maintaining satisfaction with their work experience. The literature also provides a significant number of articles that discuss a wide variety of strategies to improve nurse workgroup cohesion, although most were anecdotal rather than research-based.

Little research regarding interventions to improve nurse-to-nurse relationships in the workplace has been performed. Interventional research in this area is needed to determine the most effective ways to reduce R.N. exposure to nurse-related hostility and to increase R.N. exposure to more nurturing work environments. From numerous accounts in the literature this research should demonstrate the value of a work setting where nurses can depend on co-workers and supervisors to support and advocate for their fellow nurses.
Conceptual Framework

*Horizontal Caring*

The conceptual framework for this project was developed through the integration of Watson’s (1979) Philosophy and Science of Caring with Farrell’s (2001) insightful composite describing three foundational reasons for the development and maintenance of poor nurse interrelationships. Watson, who has a background in psychiatric mental health nursing (Chitty, 1993), focuses on caring as the foundational concept that differentiates nursing practice from other health care disciplines. Her theory brings humanistic and healthy altruistic value systems into daily nursing care decision-making. Her ten carative factors (Appendix D) describe a philosophy of nursing that emphasizes human dignity and transforms healthcare with a holistic influence (Watson, 1979). She describes the nurse-client relationship as transpersonal and therapeutic, leading to a feeling of union with the other through empathy and sensitivity to the other. Kennedy and Barloon (1997) point out that a similar type of therapeutic relationship based on providing the carative factors to coworkers could become the goal for nurse-to-nurse relationships. They implemented a successful peer support program to prevent burnout in nurses, which was based on Watson’s caring model.

Farrell (2001), the head of the Tasmanian School in Nursing in Australia, has researched reasons for difficulties in nurse-to-nurse relationships throughout his career. His theory effectively clarifies many of the complicated reasons nurses have conflicted and hostile working relationships. He describes three levels of explanation for nursing hostility and powerlessness that have led to a culture of horizontal violence. The macro level focuses on oppression theory (where nurses are less powerful than physicians and administrators) in conjunction with gender bias based on the acquiescing feminine role of nursing. The meso level encompasses health
care’s characteristically hierarchical organizational structure (leaving nurses near the bottom of the pecking order) and the time and task dependent structure of nurses’ daily work. The micro level portrays a nursing culture that has covertly supported or ignored problems between nurses. The micro level also includes the individual choice of the nurse within that culture (Farrell, 2001). The three levels of explanation of nursing interpersonal conflict and hostility described by Farrell form the structural framework for a model developed to show the interacting factors that make up a nurse’s work environment (Appendix E). Negative effects upon nursing work group culture resulting from the existence of the three levels previously described include: the impact of ineffective management strategies, difficulty coping and hostility that develops within individual nurses, alliances and cliques that are formed as defenses to a weakened position, the phenomenon of “eating one’s young”, personal anxiety, personal depression, dissatisfaction with work, increased intent to leave progressing to burnout and eventually to resignation from a nursing position. Both long-term nurse employees and new graduates are impacted and affected by this stressful environment. Fortunately, within each level, positive changes, such as those Watson (1985) describes within her philosophy of caring could be implemented. This would effect change to the whole model, including increased R.N. intra-group cohesion, improved R.N. coping, increased job satisfaction, and strengthening nurses intent to stay in the profession with a current employer. Overall, every effort counts, all incremental changes that are made toward optimal treatment of nurses will move us closer to the development of a healthier workplace for nurses.

Farrell’s and Watson’s theories work well together to provide a clear picture of the reasons for troubled nurse-to-nurse relations and a powerful energizing philosophy that, when applied to nurses themselves, can lead to a healing work environment, decreased stress,
improved job satisfaction and reduced turnover in nursing. Questions that arise when reviewing this theoretical framework include: Will the application of Watson’s Carative Factors as applied to nurses themselves lead to increased workplace satisfaction and decreased intent to leave the workplace? How can the Carative Factors be effectively infused into a nursing workgroup? Will education of individual nurses to Watson’s philosophy of caring and the factors behind troubled nurse-to-nurse relationships cause any harm? Where would be the best place to provide education regarding the Carative Factors? In nursing schools? At conferences for nursing leadership? In the health care setting? What sorts of interventions would be most helpful to promote horizontal caring between nurses? These questions reveal the need for nursing research of educational and interventional models that are based on Watson’s and Farrell’s combined theories. This research utilization project rests on the combined theories of Farrell and Watson as a foundational context to explore the impact and benefit of short Narrative Communities with established nursing work groups.

**Narrative Community**

*Overview*

The term Narrative Community was introduced in Schoessler and Tanner’s (2003) qualitative research with nursing groups and is described as “a dynamic, nurturative, and evocative community of individuals who...share their accounts of practice, learn from each other’s stories, come to describe common practice issues, build on shared knowledge, and define and support one another’s practice.” It was derived from two separate literary concepts: “narrative” and “community,” and was used to describe the reflective learning that takes place when nurses tell stories of their practice to one another (Schoessler, 1995). This concept has some similarity to the reflective practice groups used by teachers to create supportive
professional environments (Cady, Distad & Germundsen, 1998), differentiated by reduced structure and a focus on stories related to practice.

**Narrative Meanings**

Narrative concepts were applied to psychology when Sarbin (1986) proposed that stories organize our lives, give meaning to events, and guide thought and actions. Robinson and Hawpe (1986) agreed and pointed out that experiences do not automatically take a narrative form; it is in our reflection of the events after the fact that stories are created. They attested that stories are easier to remember and apply than generalized rules or principles and therefore do guide thoughts and action in the real world. Ricoeur (1989), a distinguished philosopher, speaks of the significance of the personal historical narrative (telling others the life experiences one has had), equating the experience of human life with one or more life stories. According to Frank (1995), Ricoeur believes a self-identity (or narrative identity) is formed through story telling; *it is in the telling of the events of our lives that we come to know who we are and as a result a sense of self emerges*. Dauenhauer (retrieved 2/22/04) states further that with the narrative Ricoeur emphasized primacy of the other over the self (the drive we have to respond faithfully and thoughtfully to others), our need for involvement with others to make sense of ourselves, and our knowledge that while some changes are possible for ourselves and others, some changes are not possible. Group socialization and cohesion are maintained through storytelling where “the simplest form of maintaining group values is accomplished through the exchange of narratives...” (Linde, 1993). Frank (1995) in *The Wounded Storyteller* expresses the importance of people telling their stories to others so that the past can be connected to the present, creating a coherence of what was before and what they are living now. He equates personal story telling with creating memories of the past and expectations for the future through expressing, reliving
and more completely coming to know personal truths. When nurses share meaningful stories from their practice they connect the present and the past as well. Through this practice coherence and meaning in the work of nursing are created and affirmed for the individual nurse and for the team as whole. Difficult, painful, joyful, and even crazy situations make more sense and take a notable place in the memories of those who describe them for those who listen.

Creating Community

Community is a somewhat mysterious concept describing a group that has achieved interpersonal connectedness beyond the norm. Peck (1987) describes community as “a group of individuals who have learned how to communicate honestly with each other, whose relationships go deeper than their masks of composure, and who have developed some significant commitment to rejoice together, mourn together, and to delight in each other, (making) others’ conditions (their) our own.” Words that characterize community include safety, genuineness, inclusiveness, joy, humility, commitment, awareness, and wonder. Diekelmann (2002), a Wisconsin Nursing School professor, advocates that skills in the art of community building could be taught and experienced during nursing school, resulting in better learning experiences for students and improved satisfaction for the educator as well. Diekelmann (2003) later described the value of nursing school students, teachers, and clinicians meeting together for storytelling as a means to engender characteristics of “community” in nursing schools. Benefits of this include increased intra-group respectfulness, inclusiveness, and fairness. As a result, a safe environment is created for learning. Additionally, the community-building skills that are learned in nursing school could be carried over into the nurses’ workplace.

Real communities are not conflict free, superficially happy, or perfectly peaceful for any length of time. Hampton (2003a), with years of experience in leading groups, asserts that in any
true community a time of uncomfortable group “chaos” will be experienced as people move
closer to becoming connected to one another. During the time of chaos, emotions can be strong
and conflicts will arise. Eventually, as the group remains committed to one another, the struggle
felt during the chaos will be left behind for a time. Soon after that, he believes, it becomes clear
that deeper interpersonal connections have been formed as a result of the chaos. Hampton also
describes the need for each person to go through the process of “emptying” themselves of
internal barriers, including exposing personal weaknesses, or failings, that have prevented them
from being genuine with others in their community. This sometimes frightening and painful
experience of exposing oneself within the safety of the committed group can result in greater
self-acceptance and a deep feeling of acceptance from the others present, leading to improved
interpersonal connectedness. Personal “emptying” can occur throughout the community building
process. This is why it is so important for members to be committed to the group, they need to
experience one-another’s moments of emptying to be able to connect to the people in their work
community. Hampton’s (2003b) “Principles of Community” are summarized in Appendix F.

Stein (2002), a specialist in principles of adult education, believes that participating in a
“community” strengthens individuals as they realize their own vital role in a group, while the
group is concurrently strengthened through the uncovering and development of meanings that
come to be shared by its members. He states “members share teaching and learning roles, and it
brings about change in the individual, but primarily in relation to the community...A thriving
learning community continually creates and improves the physical and social environment and
expands those community resources that enable people to help each other perform all the
functions of life and develop their highest potential” (Stein, 2002). A “community” of nurses
abiding by these principles as they work together on a unit, or in any workgroup, would be in an environment that promotes and enhances horizontal caring among all workgroup members.

**Narrative Reflections in Nursing Literature**

A veteran staff nurse who has since left bedside nursing, provides a moving narrative that many nurses could empathize with during the current nursing shortage (Bringham, 2002). In an excerpt from his account of a day on a neonatal unit he states:

I arrived at work, looked over the census, and saw an overflowing unit with too few nurses. I was assigned to our sickest patient - a full-term, three day old infant named Dan. Baby Dan's condition had deteriorated so badly during the previous night that he had been placed on a heart-lung bypass machine. A treatment known as extracorporeal membrane oxygenation, or ECMO...functionally replaced Dan's failing heart and lungs....I had to test his clotting every ten minutes to adjust his heparin infusion...he was on two other medication infusions to address his falling blood pressure...he was receiving several antibiotics...and he required constant sedation to keep him from fighting us...Around midmorning I received her (Marie's) call in the back bay of the unit ...I barely got started (on the report) when she interrupted me..."But the ECMO kid is stable now, right? ...Good. I'll be out the rest of the day." She cut me off and...hung up...Over the course of our shift, as Amy and I started to rein in his many problems, Baby Dan slowly improved...I did not fare so well myself...weeks (later) Marie removed my name from the roster of ECMO specialists to shave the extra costs involved in training part-time staff...Soon after...I attended a hospital-sponsored educational session on reorganization titled ironically 'Delivering Exceptional Customer Care.'...(After this session) I wrote a letter to my fellow nurses..."Our patients depend on us for clear, honest, caring communication...I am skilled at a difficult, demanding, and stressful job that not many people can hack. That is the profession of nursing. That is my value to this organization. And to my job I try to bring caring, gentleness, honesty, and humanity. Not 'customer service.' I feel polluted." The next day our head nurse called me into her office and placed an official reprimand in my file. The following month I stood at the front desk of our unit one last time...I don't know how many nurses like me have left the profession over the past decade...I love nursing. I just can't do it anymore.

In contrast, this excerpt is from another nurse who was caring for a family through the death of twins in a different practice setting (Schoessler, 1995, p. 318-319).

The day was a real hard one for everybody on our unit. A couple of other nurses who are good friends to me really supported me a lot. We made decisions like, we gave the family, they (the couple) have quite an extended family, they came in to visit and they had a little room where they could hold the babies. We wrapped them up in warm blankets so that they would feel warm, which is something we try to remember to do for a Mum who has lost a child. And we took the babies to see them, the patient, and that was real hard...I had the support of my peers that day. They helped me out tremendously. They didn’t leave me alone, you know. It’s hard to take a dead baby into another room and get them dressed to see their parents and that’s what I had to do. She (the Mum) picked out the sleeper she wanted them to be in, their hats. We took pictures of them for them. And the other two nurses that helped me, they never left me, they stayed right
with me and I don’t know what I would have done if I didn’t have them cause that was probably the hardest thing to do.

In the second piece, as the nurse tells a story of her practice, she has taken a positive stance on what is beneficial instead focusing on what is missing in her work as a nurse. Working from the security of connected relationships with others in their group, nurses can realize the positive more easily. This support enables them to function at a high level, inspiring creativity in their work with patients and improving personal satisfaction.

The caring tradition of nursing can be passed on through the art of storytelling in a safe and confidential setting. Benner and Wrubel (1989) have proposed that managers use narrative forms of expert nursing care to “support and facilitate excellence in caring practices” (p. 399). They believe that while the nurse must possess expert technical knowledge to perform her work, this “knowledge is dangerous if divorced from caring” (p. 400). Garrett and McDaniel (2001) also advocate for maintaining positive “social networks” in nursing work groups to prevent burnout, enhance patient care, improve patient satisfaction, and improve retention of nurses.

Definition of Terms

The following terms were used in the creation and implementation of this research utilization project.

- Care: To demonstrate benevolence, attention and honor of another through thoughts, words and actions that are well-matched to the situation at hand.
- Nursing Care: To demonstrate benevolence, attention and honor to a person in need of medical services through informed thoughts, words, and actions that are well-matched to the person’s needs.
- Workplace satisfaction: The state of contentment with employment environment.
• Horizontal Violence: Harmful actions and words directed at a colleague that indicate a lack of respect for the other’s fundamental humanity.

• Horizontal Caring: Respectful actions and words in congruence with the carative factors directed at a colleague that indicate a respect for the other’s fundamental humanity.

• Carative Factors: Ten humanistic principles, grounded in science and central to caring for another human being, used by a nurse in the delivery of healthcare (Watson, 1979).

• Narrative Community: A group of peers from a clinical setting who voluntarily meet together to share stories about their professional practice for a period of time, in confidentiality.

• Reflective Practice: Thinking back on time spent in the practice of nursing, considering the meanings in what took place in the past, and discussing these experiences and meanings with other nurses.

• Dialogue: Open communication that includes a give and take from equally powered participants and results in increasing understanding of the subject of conversation.

Narrative Community Demonstration Project

A demonstration project involving short-term Narrative Community groups of staff nurses from two inpatient units at a Northwestern U.S. community medical center with over 400 beds was developed and implemented in late 2003. The group participants attended without pay and on their own time, however they were given the opportunity to earn credit towards their clinical ladder for attendance during six group sessions. Participation in this project and completion of the other clinical ladder requirements would result in a significant pay raise for each participant. Two group meetings, (one during day shift, one during evening shift), were
offered to each unit every two weeks for approximately eight weeks. Each group had a primary R.N. facilitator. One, with a Ph.D. in Education, had worked extensively with Narrative Community groups in a previous qualitative research study (Schoessler & Tanner, 2003) while the other, a BSN prepared nurse, had training and experience in small group facilitation. The purpose of the current demonstration project was to determine the feasibility, impact and benefit to the nurses of participating in an abbreviated version of the previous Narrative Community study, taking particular interest of the participant’s time. A secondary purpose was to explore the benefits of Narrative Communities to advanced practice psychiatric nurses’ work and benefits Psychiatric Mental Health Nurse Practitioners could offer nurses and nurse work groups within health care systems.

This project was developed as a form of research utilization of the previous work “The Effects of Narrative Community on Nursing Practice in a Managed Care Environment” (Schoessler & Tanner, 2003). The original study, of interpretive phenomenological design, encompassed Narrative Community groups from three different nursing units. That study had twenty nurse participants; ten nurses from an oncology unit participated in 21 groups over a year, five medical nurses participated in nine groups over nine months, and five nurses from a cardiac unit participated in eight groups over six months. These nurses completed a unit culture survey prior to and after the group intervention and also participated in individual interviews after the groups had concluded. Findings from this study included: reports of increased patient advocacy on these nursing units; increased learning, support, and assistance between nursing staff; increased R.N. satisfaction through learning the end of the story about a patient; deeper levels of openness and vulnerability developed among group members; an increase in peer communication about “touchy” subjects such as patient suicide; expressions of several areas of
concern related to the role of a nurse in the health care continuum; and increased trust between workgroup members with a new sense of possibility that extended into the greater workgroup was developed. The quantitative survey results revealed no significant difference in unit culture and there was no change in retention, before and after the groups, which may be attributed in part to the small sample size. Included in the findings were factors that facilitated or were barriers to attendance in the groups, which is important to consider for future Narrative Community interventions (Schoessler, 2003; Schoessler & Tanner, 2003).

Staff R.N.s from the two in-patient nursing units volunteered to participate in this project. Fourteen nurses from the maternity, labor and delivery unit’s day and evening shifts participated and eight nurses from the respiratory unit, participated, (seven from the respiratory unit’s day shift and one nurse from the evening shift). Thirteen of these nurses attended enough meetings to receive a letter certifying credit toward their clinical ladder for participation. Demographic information was not collected on participants from either unit. Meetings were held on or near each of the units in conference rooms.

In the months prior to the intervention the facilitators met several times for approximately one hour each time, to plan and prepare. Literature reviews on narrative concepts, community building, and reflective practice were completed. During one of the health center’s nurse manager’s meetings, the PhD facilitator for this project, presented the opportunity for staff R.N.s to participate in this Narrative Community research utilization project. The units of the two nurse managers who expressed interest immediately were chosen as the units for this intervention. Both facilitators attended 0700 and 1500 change of shift staff meetings on each of the two units to offer the opportunity for nurses from every shift to participate in the narrative community project. The project was explained, a summary of group ground rules (Appendix G)
were provided, questions were answered and a sign up sheet was posted for those who might want to take part. Additionally, a survey (Appendix H) was placed in each team member’s mailbox requesting feedback regarding their interest in attending the groups. Five surveys were returned and fifteen nurses signed up as interested on the maternity unit, while thirteen surveys were returned and ten nurses signed up as interested on the respiratory unit. These nurses indicated what times they would prefer to meet and provided their phone numbers as requested. The facilitators met to review the sign-up sheets and surveys, determining together the best times to offer meetings. Telephone calls were made to relay the times of the first two meetings on each unit to the nurses who expressed interest. A dayshift meeting and an evening shift meeting was offered each two weeks to each unit.

One week prior to each meeting personal invitations with meeting times and locations were placed in the mailboxes of those who had signed up. Also, flyers inviting the whole unit with meeting information were posted a week ahead of time. Each session was started with a reminder of Narrative Community ground rules (Appendix G) including a commitment to confidentiality of group content. The initial meeting was started with an explanation of the facilitator role and the history of Narrative Community research with the benefits that had been experienced by groups in the past (Appendix I). The groups were encouraged to discuss clinical situations that had an impact on their lives, in a story format if possible. The groups met for one hour, two groups on each unit every two weeks for eight weeks. Meeting schedules were adjusted after the initial meetings to better fit group members’ needs. The BSN facilitator attended two of the maternity groups to observe the facilitator role and was observed for three sessions as a facilitator before becoming independent with the respiratory unit’s group. After the groups were completed members from each group received an E-mail with a feedback survey
(Appendix J) and were requested to complete it electronically or to print and complete it on paper and then mail back to the facilitators.

Ten feedback surveys were returned by participants; six from the maternity unit (42% response rate) and four from the respiratory unit (50% response rate). Both groups answered questions similarly as a whole. Regarding the question “How valuable were the Narrative Community sessions for you?,” the participants responded with a mean of four on a one-to-five likert scale with five being the high score. To the question “What made the sessions valuable for you?” their areas of comment included: 1) listening to others experiences, 2) realizing we all have a lot in common, 3) being able to vent about stressful patient situations, 4) verbal affirmations from other nurses, 5) liked the experience of being heard, 6) the safe environment to share and evaluate my practice, 7) a sense of connectedness to others, 8) able to support and be supported, and 9) clinical ladder credit. Many of these comments correlate well with the presence of Watson’s Ten Carrative Factors (1979) including interpersonal sensitivity, a supportive environment, trusting present in relationships, acceptance of both positive and negative feelings, creative problem-solving, transpersonal teaching/learning, and meeting human needs (see Appendix D & Appendix E). There were no comments indicating the sessions were not valuable, except to note that the meeting times needed to be as convenient to schedules as possible. Two persons did comment that the sessions were best when they focused on direct nursing practice, not medical conferences.

As to the format, most agreed 45 to 60 minute meetings offered six times over three months was ideal, although one respondent would have preferred four to five meetings total. Several requested ongoing meetings for their unit. All ten of those who turned in surveys recommended the groups to other nurses. As a group they thought a mix of newer and more
experienced nurses would be beneficial. Several of the nurses noted that any nurse who was stressed or had a personal interest in the groups would benefit, indicating the importance of the voluntary nature of the group. All but one nurse felt it was critical for the facilitator to be from outside the workgroup, and four expressed an interest in learning to facilitate. All of the nurses felt the groups should continue on their units, meeting once a month on average; while two people wanted meetings twice a month. Three of the ten were willing to help organize the Narrative Community meetings for their units, although they did not want to serve as facilitators. All of the nurses wanted to meet at a convenient location within the medical center near their floor.

The known risks to participants of this project included risk of confidentiality violations between group members and risk of interpersonal conflict or emotional distress experienced as a result of participating in the Narrative Community groups. The requirement to keep group membership and group discussion confidential was addressed in printed advertisements for the project and was addressed verbally at the beginning of group meetings to minimize this risk. The risk of distress related to the group process was ameliorated by informing participants they could confidentially and privately utilize Employment Assistance Program (EAP) counselors who had been given information about this project and were prepared to assist any participant. Additionally, the facilitators were available to participants throughout the study to discuss of any concerns. Approval for this demonstration project was obtained from Washington State University and Providence Portland Medical Center nursing departments.

Potential benefits to the participants included learning from their own and other’s practice through the retelling of stories about their work, support from others in their workgroup, an
increased awareness of the impact of nurse-to-nurse work relationships, and increased group cohesion through improved interpersonal relationships.

Limitations to this demonstration project included the small number of group participants, the offering of the groups to only two units at the medical center, the inclusion of participants of convenience and the lack of control in the project. Each unit had a different facilitator, one was experienced with Narrative Community work and one was not. Self-report feedback questionnaires were not anonymous and were not completed by all group members. Those that did not return surveys may have negative feedback that was not reported. Also, the volunteer participants were asked to attend on their own time with no monetary incentive, which likely limited the group.

The Narrative Communities were very well received by the nurses who participated in them. These groups met some previously unmet needs for connection, support, and information sharing between nurses within the same workgroup. Additionally, these interventions promoted learning about nursing care, nursing values and ethics in medical care. The outcomes closely match outcomes that were observed in the previous study on Narrative Communities (Schoessler & Tanner, 2003). These outcomes were also predicted in the theoretical model that demonstrated when holistic care inclusive of Watson’s Ten Carrative Factors (Watson, 1979) is applied to fellow nurses as well as patients, nurses experience more effective coping, improved workgroup cohesion, and increased job satisfaction (See appendix E). Nurses who participated want to see Narrative Community groups continue to be offered within their workgroups. From a facilitator’s perspective, these nurses as a whole reflected beauty, complexity, courage, intelligence, and vulnerability at every session. They laughed with one another and empathized with each other. There was an atmosphere of equality and respect. They continuously expressed
a deep concern for their patients, and a desire to provide the best care possible. It was profoundly moving to be present with these groups; it is difficult to describe the experience adequately. With this in mind, these groups seem to evoke a positive response in facilitators, leading to increased respect and concern for nurses who provide direct care.

One drawback of the groups is that they are voluntarily attended at the nurses’ own personal expense. Some nurses cannot afford to give up the time or money to attend due to the expense of children in daycare or other responsibilities. Some cannot spare the time away from spouses, children or other relatives they care for outside of work. It is difficult to schedule the groups in a manner that allows members of all shifts to intermix with one another in a single group, which is a purpose of the intervention. It would be helpful to find a way to provide all nurses in a healthcare facility the opportunity to attend Narrative Community groups with their coworkers. Previous research has shown a definite need for interventions to improve nurses’ working relationships (Aiken et al., 2001, Cox, 2001; Taylor, 2001; Quine, 1999). The research has also demonstrated that nurses who report more supportive and cohesive working relationships are more satisfied with their jobs, are less likely to leave employment, are more likely to provide better quality care, and are thus more effective and cost effective to health care systems (AbuAlRub, 2004; Vahey et al., 2004; Kalliath & Morris, 2002).

**Significance to Nursing**

Nursing relationships would be benefited by interventions that allow nurses within workgroups the opportunity to meet and share stories about their practice with the direction of a trained facilitator. Jean Watson, a psychiatric nurse theorist, offered support for this type of intervention recently. She commented “I encourage you to use … group process, giving folks
Due to the importance of group process to this intervention, it may be beneficial to utilize an advanced practice psychiatric nurse experienced with group process as a consultant or group facilitator for the narrative groups. A Psychiatric Mental Health Nurse Practitioner (PMHNP) could assist with these groups as an expanded role within the traditional Psychiatric Nurse Liaison position or in a unique Nurse Liaison/Advocate role bridging a gap between staff nurses with interpersonal conflict and between staff nurses and nursing management. The Nurse Liaison/Advocate role has been integrated successfully in several U.S. medical centers resulting in improved relationships between nurses on all levels in the organization, improved RN job satisfaction, increased retention of nurses, and an overall cost savings to the hospital (Advisory, 2003). In addition to the narrative groups, a PMHNP or Psychiatric CNS could offer training for nurses in assertiveness and conflict management. Also, specialized support groups for nurses could be developed, focusing on areas of need such as grief support, parenting skills, or stress management. In light of the negative effects the current health system may have on a nurse including increased stress, hostility, anxiety and depression (see Appendix E), a PMHNP could provide confidential individual therapy including prescription of medication for depression and/or anxiety management if needed. A nurse therapist would likely be able to understand, empathize with, and support a fellow nurse with expertise gained in part from the mutual experiences shared by all nurses. The Narrative Community groups could provide a way for nurses to develop confidence and trust in a mental health expert, reducing the stigma associated with psychiatric care and improving access to support for nurses.
Narrative communities promote nurse-to-nurse respect and raise awareness of the good work that nurses do every day. They provide a safe place for nurses to be vulnerable with one another, and to receive and give support and affirmation. They allow interpersonal relationships to develop, encourage interdependence within the team, and prevent or repair misunderstandings. Research has shown that Narrative Communities promote horizontal caring in nursing as well as improved clinical learning among teammates (Schoessler & Tanner, 2003). This current project demonstrates that many of Watson’s Ten Carrative Factors are noticed and appreciated by nurses as a significant benefit of the Narrative Community experience (see Appendix D & Appendix E).

Continued research with Narrative Communities is needed to determine cost-effective, efficient, and effective ways to reach more nurses with this valuable intervention. Also, research questions such as “Do Narrative Communities impact nurses retention rates?”, “Does participation in this type of group shorten the time form novice to expert?”, and if so, “under what conditions?”, “What are the benefits of facilitating a Narrative Community group?” and “How can this intervention be integrated into nurses everyday work life?” could be answered in the research setting. Additional research could be performed on the benefit of including an advanced practice psychiatric nurse, including a PMHNP or a CNS, in nursing leadership teams in larger health care settings.

Summary

This demonstration project provides some insight into the effectiveness of Narrative Community group interventions to nurses’ interpersonal working relationships. The participants involved in our 2003 Narrative Community groups provided feedback that supported a positive impact on nursing work group relationships. Integration of narrative community interventions within groups of nurses may provide an environment that dramatically improves relationships
between nurses who work together as is proposed by the model integrating Farrell’s (2001) and Watson’s (1979) theories (Appendix E). Some of the other ideas presented here have already proven to be helpful in the development of improved nurses’ working relationships. Further study is needed to determine what interventions and strategies are the most effective and least costly means to improve nursing workgroup relationships, including those interventions that can be initiated during formal nursing school education (AbuAlRub, 2004).

Nurses have had a long history of caring for patients with respect, sensitivity and empathy. Benner (1984), a qualitative researcher in nursing, states “nurses... have offered us glimpses of the nature of the power that resides in caring. They have used their power to empower their patients- not to dominate, coerce, or control them....To abandon the power inherent in caring relationships is...to become alienated from our own identity and to thwart our own excellence.” Our power is in our caring. As nurses, we urgently need to search for effective ways to support and empower each other through “horizontal caring” in an effort to strengthen the members of our invaluable profession.
References


Nursing Education, 42(6), 243-244.


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http://www.employerofchoice.com/


http://orlando.bizjournals.com/orlando/stories/2002/03/18/focus1.html


Seago, J. A., Culture of troubled work group. JONA, 26(9), 41-46.


Schools.


Appendices

Appendix A
Critical Analysis Table

Appendix B
Organizational Anti-Harassment Policy

Appendix C
Elements of a Healthy Work Environment

Appendix D
Watson’s Ten Carative Factors

Appendix E
Farrell and Watson Integrated Conceptual Model

Appendix F
Community Principles and Characteristics

Appendix G
Ground Rules for Narrative Community Meetings

Appendix H
Pre-Narrative Group Participant Survey

Appendix I
Initial Narrative Group Facilitator Comments

Appendix J
Post-Narrative Group Participant Survey
## Appendix A

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<td><strong>BMJ</strong>&lt;br&gt;Quine (1999)&lt;br&gt;Article: “Workplace bullying in NHS community trust: Staff questionnaire survey”&lt;br&gt;Quine, 1999</td>
<td>To Determine the prevalence of workplace bullying and association to occupational health outcomes, and to investigate the relationship between support at work and bullying</td>
<td>Quantitative Questionnaire Survey-performed 1996</td>
<td>Convenience Sample 1,100 National Health Trust employees (396 nurses) in southeast England sent surveys via mail (outpatient and inpatient)</td>
<td>Self report Questionnaires: Bullying at Work, Quine, 1999 Overall Job Satisfaction Scale Quine &amp; Staines 1979 Support at Work Scale Bosma et al. 1997 Propensity to Leave Scale Camman et al., 1979 Hospital Anxiety &amp; Depression Scale Zigmund &amp; Smith, 1983 Job Induced Stress Scale House et al. 1972</td>
<td>Cronbach α .81</td>
<td><strong>70% survey return rate, (36% RNs) &amp; 44% of these nurses reported being bullied</strong>&lt;br&gt;38% employees experienced bullying&lt;br&gt;42% witnessed bullying of others&lt;br&gt;Bullied staff had ↓ job satisfaction, ↑ job stress, ↑ depression, ↑ anxiety, and ↑ intent to leave job&lt;br&gt;Support at work helped bullied employees, more research is needed</td>
<td>Good support at work coincided with improved job satisfaction, reduced propensity to leave, and reduced depression and anxiety, with no change in job stress for those who were bullied.</td>
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<td>Health Affairs Aiken, Clarke, Sloane, et al. (2001)</td>
<td>To determine nurses perceptions of: their working environments, quality of nursing care, job satisfaction, career plans and feelings of burnout.</td>
<td>Cross-national Quantitative Questionnaire Survey - performed 1998-1999</td>
<td>Convenience Sample 43,329 nurses from Pennsylvania, Canada, England, Scotland, and Germany working in acute care hospitals</td>
<td>Self report Questionnaires: Core Nursing Questionnaire Maslach Burnout Inventory Maslach, 1986</td>
<td>Not noted- these are preliminary study results of a larger study to be reported in the future.</td>
<td>42-53% response for surveys across all countries</td>
<td>Nurses job dissatisfaction &amp; intent to leave is high in all countries except Germany. USA-Job dissatisfaction 41%; Intent to leave 27.7%/yr USA &amp; Canadian Nurses stated verbal abuse to nurses was regular in last year.</td>
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<td>Journal of Advanced Nursing Farrell (1999)</td>
<td>To explore nurses views of aggression in clinical settings</td>
<td>Empirical Quantitative Questionnaire Survey- performed 1996 *This was a follow-up study to a previous qualitative study.</td>
<td>Convenience sample, 270 participants; Nurses in the public and private sector of Tasmania, Australia hospitals and school of nursing</td>
<td>Self-report Questionnaire developed by the author for his dissertation Farrell, 1996</td>
<td>Not done due to non-random sample of participants</td>
<td>Nurse to nurse aggression was the most distressing type of aggression to deal with, yet doctor, patient &amp; relative to nurse aggression were still frequent</td>
<td>Nurse to nurse aggression is the most difficult type of hostile behavior for nurses to deal with, needs further research to validate findings</td>
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<td>Journal of Advanced Nursing Farrell (2001)</td>
<td>To develop a conceptual framework to account for interpersonal conflict in nursing</td>
<td>Extended Literature Review - Critical Analysis</td>
<td>Literature on interpersonal conflict in nursing</td>
<td>N/A</td>
<td>N/A</td>
<td>Three levels of horizontal violence make up the conceptual framework that accounts for interpersonal conflict in nursing.</td>
<td>Research is needed (in the context of this conceptual framework) on interventions that will reduce interpersonal conflict among nurses and that will help nurses to support one another</td>
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Article: “From tall poppies to squashed weeds*: why don’t nurses pull together more?”
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<tr>
<td>Journal of Advanced Nursing</td>
<td>To investigate relationships among individual and contextual variables-in intra-group conflict &amp; job satisfaction, team performance, and anticipated turnover</td>
<td>Quantitative Questionnaire</td>
<td>141 RNs; Non-random sample employed in 13 inpatient units in a 597 bed medical center in southeastern U.S. employed at least 6 mos in their position</td>
<td>Self-report Questionnaire – 12 item unit technology scale revised Mark and Hagen Mueller, 1999 Cox Conflict Scale (Cox, 1997) Work Satisfaction Scale Hinshaw and Atwood, 1983 Effectiveness of Team Performance Weismetal, 1993 Anticipated Turnover Scale Hinshaw and Atwood, 1985</td>
<td>Internal consistency reliability- 0.78 Coefficient α 0.94 Coefficient α 0.87 Coefficient α 0.88</td>
<td>49% Response rate Intra-group conflict was higher in smaller units with a higher RN-to staff ratio Both ↑ing Unit morale &amp; interpersonal team effectiveness, were asso. with ↓ group conflict, ↓ anticipated turnover, and ↑ satisfaction with pay.</td>
<td>Unit morale &amp; interpersonal relationships were the mediating variables to group conflict. Interventions suggested: need to focus on unit morale and interpersonal relationships and teamwork to reduce intra-group conflict Nurse managers should strive to create an environment that supports a team related culture through collegiality &amp; collaboration; further research in this area is needed.</td>
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| **International Journal of Nursing Practice**  
Taylor (2001)  
*Article:* “Identifying and transforming dysfunctional nurse-nurse relationships through reflective practice and action research”  
To raise critical awareness of practice problems, use problem solving to uncover constraints, and improve quality of care by nurses | Qualitative Action Research | 12 experienced female RNs aged 25-50 yrs in a large Australian rural hospital convenience sample of those interested in reflecting on their practice and improving it. | Analysis of journals (written by participants to gather & analyze data); Group critical reflection, Group problem solving. Description of participant observations analyzed using reflective analysis method & group discussion | Three action research cycles, Group Process for analyzing data | Thematic concerns of dysfunctional nurse-nurse relationships was identified (horizontal violence) varying degrees of success in solving problems in this study | Horizontal violence was freely chosen by participants as the practice problem to research, indicating it is a significant problem in nursing |
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<td>Journal of Nursing Scholarship AbuAlRub, 2004 Article: “Job Stress, Job Performance, and Social Support Among Hospital Nurses”</td>
<td>To investigate (a) the effect of job-related stress on job performance among hospital nurses, and (b) the effect of social support from coworkers on the stress-performance relationship.</td>
<td>A correlational descriptive survey</td>
<td>Convenience sample of 263 American hospital nurses and 40 non-American nurses (Britain, Canada, &amp; others), all accessible via the Internet</td>
<td>Web-based Self-report questionnaire including- A demographics form Nursing Stress Scale (Gray-Toft &amp; Anderson, 1981) with 8 questions from Expanded NSS (2002) Schirian Six Dimension Scale of Nursing Performance, (1978) McCain &amp; Marklin Social Integration Scale, (McCloskey, 1990)</td>
<td>Descriptive statistics, Pearson product-moment correlations, &amp; hierarchical regression techniques were used Coefficient α 0.92 Coefficient α 0.95 Coefficient α 0.70</td>
<td>12% response rate via Internet Perceived social support from coworkers enhanced reported job performance &amp; decreased work stress for both groups Low or high levels of stress in the nurses workplace improves performance while moderate levels detract from work performance</td>
<td>Nurse leaders need to ensure coworker support among nurses is characteristic of their workplace. Strategies should be adopted to demonstrate more social support for nurses in the nursing schools &amp; workplaces. Social support from coworkers is important to nurses, enhancing their ability to provide patient care. Detractions or blocks to social support for any members of a work group need resolution if possible.</td>
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<td>Medical Care Vahey, Aiken, Sloane, Clarke, Vargas (2004) Article: “Nurse Burnout and Patient Satisfaction”</td>
<td>To study the effects of nurse work environment on nurse burnout, the effects of nurse burnout and nurse work environment on patients’ satisfaction</td>
<td>Quantitative Questionnaire Survey- (performed in 1991 as a part of a larger study) Cross-sectional surveys of nurses and patients from 40 units in 20 hospitals across the U.S.</td>
<td>Convenience Samples (data collected 1991) 820 nurses caring for AIDS patients in 40 units dispersed over 20 U.S. hospitals 621 patients with AIDS on these units</td>
<td>Self report Questionnaires: Nurses: 3 subscales of revised Nurse Work Index-R (Kramer &amp; Hafner, 1986; rev Aiken, 2000) Maslach Burnout Inventory (1986) Patients: Modified La Monica—Oberst Patient Satisfaction Scale (1986) STRATA version 7 statistical software used</td>
<td>Cronbach á 0.87-0.96 Cronbach á 0.71-0.941986) Cronbach á 0.93</td>
<td>86% RN survey return rate 86% patient response rate Nurses on units with: adequate staff, had good support, and good relations between doctors &amp; nurses had: significantly lower burnout and patients were twice as satisfied. The overall level of nurses burnout negatively affected patient satisfaction</td>
<td>Improvements in nurses’ work environments in hospitals can potentially reduce nurses burnout, improve nurses retention, and increase patient satisfaction simultaneously</td>
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<td>JONA</td>
<td>To assess the impact of different levels of job satisfaction on burnout among nurses</td>
<td>Quantitative Questionnaire Survey using the Structural Equation Modeling methodology</td>
<td>Convenience Sample, (voluntary &amp; confidential) 203 nurses in a community hospital in the mid-western U.S.</td>
<td>Self report Questionnaires: Maslach Burnout Inventory (1986) Job Satisfaction Scale (Katzell, 1992) Factor Analysis was performed with LISREL</td>
<td>Cronbach α 0.71-0.84 Cronbach α 0.80</td>
<td>60% response rate Job satisfaction has a significant direct negative effect on emotional exhaustion Emotional exhaustion has a direct positive effect on depersonalization Job satisfaction effects burnout Job satisfaction is significant predictor of burnout</td>
<td>Nurses, administrators and educators could collaborate to research and test models to improve job satisfaction in order to raise RN job satisfaction and prevent burnout. Ideas to prevent burnout include: Education to upgrade job skills, comprehensive orientation programs, support from peers and supervisors to encourage a sense of community</td>
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*Article: “Job Satisfaction Among Nurses A Predictor of Burnout Levels”*
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<td>Journal for Nurses in Staff Development Eason &amp; Brown (1999)</td>
<td>To study the current conflict management strategies used by nurses</td>
<td>Descriptive Research Design</td>
<td>Voluntary &amp; anonymous convenience sample of 217 RNs who attended continuing education workshops in southeastern U.S.</td>
<td>Self report Questionnaires: Demographic form Thomas-Kilmann Conflict Mode Instrument (1977)</td>
<td>Coefficient α 0.60</td>
<td>100% response rate The study results indicated Avoidance as the most common conflict management strategy used by the nurses sampled; accommodation was the second most common strategy used.</td>
<td>Conflict resolution skill development and education must be initiated to enhance conflict resolution behaviors in nurses</td>
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<td>JONA Seago (1996) Article: “Culture of troubled work group”</td>
<td>To begin to identify the characteristics of the culture of troubled or conflicted work groups (TWG), and to identify strategies to successfully modify the culture of a TWG</td>
<td>Quantitative Descriptive Questionnaire Survey</td>
<td>Voluntary Convenience Sample of 115 Nurse managers and administrators attending American Organization of Nurse Executives annual meeting 1995 and 1995 Organization of Nurse Executives - California annual meeting</td>
<td>Self-report Questionnaire developed by author (1995) with 2 open ended questions</td>
<td>Items in questionnaire were reviewed by 3 administrators for content validity</td>
<td>88% of respondents had managed a TWG</td>
<td>72.2% of respondents had been successful with managing their TWGs</td>
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</table>

Characteristics of TWG include 2-3 significant employees with poor attitudes, difficulty changing, high anger, stressful environment, eat their young, complex heavy workload.

Recommended: ↑communication ↑staff governance & setting clear expectations for staff

~(These interventions support the previous data regarding groups with horizontal violence)
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<tr>
<td>JONA</td>
<td>Explore links between nurse workgroup disruption and work group relationships</td>
<td>Quantitative Questionnaire Survey</td>
<td>908 RNs Voluntary convenience sample, nurses</td>
<td>Self report questionnaires Stamps &amp; Piedmonte Index of Work Satisfaction</td>
<td>Cronbach α 0.71-0.82</td>
<td>61-75% response rates</td>
<td>Focus on RN-RN work group relationships is needed in future research</td>
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<td>Leppa (1996)</td>
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<td>in four comprehensive tertiary care hospitals in the Midwest and south U.S.</td>
<td>Index of Work Satisfaction (Data on absenteeism, agency use, &amp; unit personnel changes collected from hospital records)</td>
<td>No information</td>
<td>RN work group cohesion, nurse-nurse, is the most important element in job satisfaction for RN respondents</td>
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<td>Article: “Nurse relationships and work group disruption”</td>
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<td></td>
<td>MANAGERS should support and protect their RN work groups to see high RN satisfaction, improved patient care and higher patient safety</td>
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<td>Journal of Advanced Nursing</td>
<td>To examine the extent to which hospital nurses view their working environment positively as a cohesive group</td>
<td>Quantitative Mailed Questionnaire Survey</td>
<td>555 respondents, RNs (1 third targeted were Critical Care Nurses) employed in three large tertiary Australian hospitals</td>
<td>Self report questionnaire CANS Cohesion Amongst Nurses Scale</td>
<td>Cronbach α 0.91, test-retest Pearson correlation coefficient 0.84</td>
<td>56% response rate</td>
<td>Nurses perceived their work groups as fairly cohesive, indicating horizontal violence is not a significant problem, yet, some behaviors present in the workplace indicate horizontal violence</td>
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<td>Chaboyer et al. (2001)</td>
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<tr>
<td>JONA Shader, Broome, Broome et al. (2001)</td>
<td>To examine the Relationships between work satisfaction, stress, age, cohesion, work schedule, and anticipated turn-over of nurses in an academic medical center</td>
<td>Quantitative Cross-sectional Survey Design</td>
<td>246 RNs 241 staff RNs 5 RN Managers</td>
<td>Self report questionnaire Modified Version of Job Stress Scale Index of Work Satisfaction Bryne Group Cohesion Scale Anticipated Turnover Scale</td>
<td>Coefficient α 0.86 Cronbach α 0.82 Theta reliability 0.78; alpha 0.81 Cronbach α 0.86</td>
<td>63% response rate ↑ Job Stress is associated with ↓ work satisfaction, ↓ group cohesion, and ↑ weekend Overtime; all these are all predictors of anticipated turnover</td>
<td>The nursing shortage motivates future research in these factors that lead to turnover, with the goal of lowering turnover and increasing retention</td>
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"Factors influencing satisfaction and anticipated turnover for nurses in an academic medical center."
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<tbody>
<tr>
<td>Journal for Nurses in Staff Development Winter-Collings, McDaniel (2000)</td>
<td>To investigate the relationship between sense of belonging and job satisfaction in the new graduate</td>
<td>Quantitative Mailed Questionnaire Survey</td>
<td>Random Selection of 250 new graduate RNs from Indiana Health Professions Bureau mailing list</td>
<td>Self report questionnaire, anonymous; Workplace environment survey; Interpersonal relationships survey; Job Satisfaction Scale Mueller, McCloskey</td>
<td>Pearson correlation used to examine the degree and direction of relationship</td>
<td>38% response rate</td>
<td>Results support need for a nurturing environment for new graduates; also the quality, rather than the quantity, of coworker interaction may influence the new grads sense of belonging Future research: Does small group interaction influence a sense of belonging &amp; satisfaction in work settings?</td>
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Article: “Sense of Belonging and new graduate job satisfaction.”
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<th>SAMPL METHOD/ CRITERIA</th>
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<th>RESULTS</th>
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</table>
| Journal of Healthcare Management Gifford, Zammuto, Goodman & Hill (2002). Article: “The Relationship Between Hospital Unit Culture and Nurses Quality of Work Life” | To investigate relationships between unit organizational culture & important job-related variables for nurse retention in L & D units of 7 large urban hospitals in 5 western U.S. cities. | Quantitative Questionnaire Survey  
human relations model  
Ends: Cohesion & Morale  
Means: Training & Development through Human Resources | Convenience sample from a larger project; questionnaires were distributed through the corporate mail systems at the 7 hospitals. Approximately 280 participants from L & D units returned surveys | Self report questionnaire.  
Competing Values Framework Survey Zammuto & Krakower (1991)  
QWL Survey Gifford, Zammuto, Goodman & Hill (2002) | no data | 32.8 % response rate  
The human relations model has strongest statistical relationships with QWL measures & is + related with commitment, job involvement, empowerment, & job satisfaction. ~ It has a negative relationship with intent to leave | Findings suggest that further development of a human relations model culture may enhance nurses QWL. Nurses working in this type of org report ↑ org commitment, ↑ empowerment, ↑ job satisfaction, ↓ intent to leave |
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<tr>
<td>Western Journal of Nursing Research Gardner (1992)</td>
<td>To examine levels &amp; type of conflict perceived by new grad RNs in first year of work and to investigate the relationship of conflict and job satisfaction, performance, and turnover in these nurses</td>
<td>Quantitative Questionnaire Survey at 6 mos and 12 mos from time of hire (respondents down to 63 for the second survey)</td>
<td>Convenience sample 97 of 166 new grads volunteered to participate, were employed in a large Midwestern hospital in a 15 month period</td>
<td>Self report questionnaire Perceived Conflict Scale</td>
<td>Coefficient α 0.80</td>
<td>58% response rate</td>
<td>Enhance individual coping support for new grads in their first year</td>
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<td>McCloskey-Mueller Satisfaction Scale (1990)</td>
<td>Cronbach α 0.89</td>
<td>Intra-personal conflict had highest score for new grads at 6 and 12 months</td>
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<td></td>
<td>Six Dimension Scale of Nursing Performance Schwirian, 1978</td>
<td>Cronbach α 0.90</td>
<td>Also, ↑ conflict scores correlated with ↓ job satisfaction</td>
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<tr>
<td>JONA</td>
<td>To examine whether stress in RNs was associated with their illnesses or injuries</td>
<td>Quantitative Mailed Questionnaire Survey with Qualitative Comment Page</td>
<td>Convenience sample- 1,780 RNs employed by 10 hospitals in southern Michigan</td>
<td>Mailed self-report questionnaires- Hackman and Oldham’s Job Diagnostic Survey (Specific Satisfactions Subscale) (1980).</td>
<td>Cronbach α 0.90</td>
<td>34.5% response rate ~RN mean job satisfaction was “slightly satisfied” (5.04 on 1-7 scale with 7 high) ~Supervisors matched descriptions per RNs ~RNs jobs stressed ~RNs likely to stay overall</td>
<td>Nurse leaders, employers, educators, &amp; policy makers should seek feedback from dissatisfied nurses &amp; address with positive changes in order to preserve the public trust in health care by ensuring an adequate supply of nurses to care for the ill.</td>
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<td>Article: “Hospital RNs’ Job Satisfactions and Dissatisfactions”</td>
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<td>*Give attention &amp; interventions to improve staff RN expectations of RN managers (NM) regarding workloads/responsibilities, &gt; understanding of RNs and NMs to various roles</td>
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<td>Thesis: Eastern Washington University Baker (1989)</td>
<td>“Perceptions of Verbal Abuse in Selected Nurse Groups: A Comparative Study”</td>
<td>To examine the perceptions of the extent, and lasting effects, of verbal abuse on critical-care &amp; medical-surgical RNs in acute care settings. To examine the perceptions of nurse managers’ view of their role in addressing this abuse.</td>
<td>Level II Descriptive Study, comparing and describing two groups of acute care nurses’ Perceptions. Additionally, perceptions of nurse managers were described</td>
<td>Convenience sample 96 critical care RNs, 76 med-surg RNs, 28 RN managers from 2 metropolitan hospitals in the inland Pacific Northwest</td>
<td>Self report questionnaire- Helen Cox ‘s modified questionnaire (1987)</td>
<td>Perceived incidence of verbal abuse was from 87-90% with physicians being the primary source of abuse. ~All 3 groups reported 1-3 incidences of verbal abuse/month ~21% CC RNs left job after verbal abuse, ~7.4% others left job after verbal abuse</td>
<td>Verbal abuse in nursing leads to: negative effect on morale, ↑’d staff turnover, ↑’d errors, &amp; ↑’d nursing shortage. Nursing Needs: 1) Conflict resolution skills taught in nursing schools/ as CE 2) mental health professionals to support/resolve verbal abuse sits. 3) policies agst. verbal abuse 4) physician Ed</td>
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<tr>
<td>The Health Care Manager Gurley, Spence, Briner, &amp; Edwards (2003) Article: “Ideal and Perceived Satisfaction of Patient Care Providers”</td>
<td>To identify &amp; compare ideal &amp; perceived satisfaction &amp; retention levels of nursing staff from 5 pt care settings: L&amp;D, CICU, Pediatric Outpt, Perioperative, Med/Surg</td>
<td>Quantitative Questionnaire Survey with Qualitative Questionnaire attached</td>
<td>Anonymous convenience sample-112 patient care providers (88) RNs, 12 LPNs, 10 Mas/PCAs, 1 scrub tech, 1 ? unknown -in a SE state of the U.S.</td>
<td>Self report questionnaire</td>
<td>46% response rate</td>
<td>~mean ideal sat was 88.7% &amp; mean perceived sat was 65.65% - Recognition from mgmt &amp; monetary compensation imp to retain ~ + Co-worker relationships was the primary reason for staying.</td>
<td>1) Increase mgmt verbal &amp; written recognition and support to staff, 2) Improve monetary compensation, 3) Support good coworker relationships to retain</td>
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<td>JONA Garrett &amp; McDaniel (2001)</td>
<td>To explore the relationships among environmental uncertainty, nurse characteristics, social climate, and burnout among staff nurses.</td>
<td>Cross-sectional exploratory study design.</td>
<td>Convenience sample 77 Full-time staff RNs from an acute care hospital in the mid-western U.S.</td>
<td>Self-report questionnaire-Work Environment Scale (relationship portion) Moos, (1994). Maslach Burnout Inventory Scale (1996). Perceived Environmental Uncertainty in Hospitals Scale Salyer (1996).</td>
<td>26.4% response rate No other data</td>
<td>Overall, these participants perceived themselves as having above-average relationships in the work setting. A positive social climate in the workplace was negatively associated with burnout</td>
<td>Perceived support form supervisors &amp; supportive social networks are important during times of change and uncertainty in work environments- To reduce burnout: ~encourage staff feedback on unit decisions ~be clear about expectations on job performance ~involve nurses in the development of procedures of nursing work ~a supportive workplace can protect against burnout</td>
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<td>AORN Journal Dunn (2003) Article: “Horizontal violence among nurses in the operating room”</td>
<td>To determine if there is a relationship between self-perception of the degree that sabotage (and therefore horizontal violence) exists in the workplace and the degree of job satisfaction in peri-operative nurses</td>
<td>Descriptive correlational design</td>
<td>Random selection of 500 RNs from a pool of 1523 peri-operative nurses with AORN memberships living in New Jersey, 145 responded</td>
<td>Self report Questionnaires: Sabotage Savvy questionnaire (Briles, 2000) Sabotage Saboteur Cronbach α 0.72 Index of Work Satisfaction (no ref)</td>
<td>Demographic Information survey</td>
<td>29% Response Rate</td>
<td>The nursing profession and society need to acknowledge that horizontal violence exists in the peri-operative setting, and steps need to be taken to eliminate it</td>
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</table>

Sabotage is common in the OR, including: expected to do another’s work, reprimand in front of others, not acknowledged for own work, talking ceases when entering room, and complaints of others with out discussing it with them first. ~37% of respondents left qualitative comments: describing anger & frustration with administrators, MDs & other nurses.
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<tr>
<td>The Health Care Manager Hern-Underwood &amp; Workman (1993)</td>
<td>To determine the relationships of nurse managers' leadership effectiveness to retention of staff.</td>
<td>Comparative - two groups studied</td>
<td>Convenience sample</td>
<td>Self-report questionnaire-Fielder's Leader Match Scales Instrument (1984).</td>
<td>No data</td>
<td>No data on manager response rate.</td>
<td>Leaders need to set a positive group climate among staff to improve or maintain retention of staff RNs. Nurse managers who show sensitivity to RN staff's human needs may save costs to health systems by maintaining a stable staff.</td>
</tr>
<tr>
<td>Article: “Group Climate: A Significant Retention Factor for Pediatric Nurse Managers”</td>
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<td>A nurse manager group &amp; a larger group of their nurses</td>
<td>34 first-line nurse managers in 7 pediatric hospitals in the mid-western U.S.</td>
<td>176 staff RNs responded of those identified by one of the 34 NM from the first group</td>
<td></td>
<td>86.3% of staff RNs responded</td>
<td>RN Perception of group climate is an important retention factor</td>
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Appendix B

Organizational Anti-Harassment Policy

As an employee of this Organization, you are expected to adhere to acceptable conduct at all times. This involves respecting the rights and feelings of others and refraining from any behavior that might be harmful to your co-workers.

The Organization strongly supports the rights of all employees to work in an environment free from vertical and horizontal violence or interpersonal harassment.

Vertical and horizontal violence are verbal or physical conduct from a supervisor (vertical) or peer (horizontal) employee, can include a concerted effort with collusion between two or more people, and over a period of time, continuously and systematically:

1. Intimidates, shows hostility, threatens, and offends any co-worker
2. Interferes with a co-worker’s performance
3. Otherwise adversely affects a co-worker

Horizontally violent conduct includes, but is not limited to:
- Threatening, intimidating or hostile acts directed at a co-worker
- Generally abrasive behavior
- Using obscene, abusive, or threatening language or gestures
- Discrediting a co-worker
- Prohibiting due process
- Slander
- Withholding information vital to the co-worker’s job performance
- Acts of physical isolation

These guidelines are fundamental in nature and are matters of judgment and common sense. The organization prohibits vertical violence, horizontal violence and interpersonal harassment. Any violation of the organization’s Anti-harassment policy should be reported immediately to either your supervisor, the office manager, Human Resources, or the Executive Director.

All complaints will be treated confidentially to the maximum extent possible and will be promptly investigated.

The organization prohibits any form of retaliation against an employee filing a bona fide complaint under this policy or for assisting in a complaint investigation. If the result of the investigation indicates that corrective action is called for, such action may include disciplinary measures up to and including immediate termination of the employment of the offender(s), when the organization believes, in its sole discretion, such action is warranted. (Adapted from Davenport, Distler, & Elliott, 1999, p. 144-145).
Appendix C

Elements of a Healthy Work Environment
(Walker, 2001, Table 1).

- Continuous learning
- Support for learning from mistakes
- Honoring the personhood of each other
- Connecting people through shared purpose and meaning
- Forming partnerships with colleagues to do the work
- Openness to understanding others' points of view
- Respectful supportive relationships
Appendix D

**Watson’s Ten Carative Factors** (1979)

1. Formation of a Humanistic-altruistic system of values
2. Instillation of faith-hope
3. Cultivation of sensitivity to one’s self and to others
4. Development of a helping-trusting, human caring relationship
5. Promotion and acceptance of the expression of positive and negative feelings
6. Systematic use of a creative problem-solving caring process
7. Promotion of transpersonal teaching-learning
8. Provision for a supportive, protective, and/or corrective mental, physical, societal, and spiritual environment
9. Assistance with gratification of human needs
10. Allowance for existential-phenomenological-spiritual force
Causes for Poor Staff Relationships Among Nurses – Farrell, 2001

Integrated Theoretical model: Farrell’s Theory of RN Interpersonal Work Relations with The Ten Carative Factors of Watson’s Philosophy and Theory of Caring
Appendix F

Community Principles (Hampton, 2003)

- Community is inclusive. Individual differences are celebrated. Soft individualism, rather than rugged, can flourish.
- Community is realistic and multi-dimensional. Each member is free to experience his or her own facet of reality.
- Community facilitates healing once its members stop trying to heal or fix one another.
- Community is reflective, contemplative and introspective.
- A community’s members can fight gracefully.
- A community is a group of all leaders who share equal responsibility for and commitment to maintaining its spirit.
- A community is a highly effective work group.
- A community is the ideal consensual decision making body.
- In a community a wide range of gifts and talents are celebrated.

~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Characteristics of Community Members (Adapted Hampton, 2003)

- Authenticity~ Heightened creativity~ Increasing acceptance of self and others~
  - Feeling of belonging to the group and to the world~
  - Better listeners~ Better speakers~ Considers compassion more often~
  - Think before talking more often~ increased quality, productivity, and creativity~
  - Have let go of shoulds for self and others~
- Harmful ego states fade away~ Good personnel retained due to better work environment~
- Decreased need to judge or criticize~ Improved awareness of self and the group~
- Tolerance of ambiguity~ Problems are surfaced and resolved~ Better understanding of change~
Ground Rules for Narrative Community

Purpose of the group: to listen to each other’s stories

1. Everything said in the group is confidential, not to be shared with others who are not present. (Each person can share only their own stories outside of the group).

2. Focus on stories and events that relate to your personal nursing practice, not staffing issues.

3. Use “I” language, tell your story in your words.

4. Listen carefully, we aren’t looking for what was right or wrong, we’re just looking for the experience.
Unit RN
Pre-Narrative Community Group Survey

1. How interested are you in participating in the 6 week RN Narrative Community Group?
   (1-10 scale: 10= very interested 1= not interested)
   1 2 3 4 5 6 7 8 9 10

2. What times would be best for you to attend the one-hour meeting?
   (occurs every two weeks for 6 weeks)
   Best time_________ Second best _____________
   Third best_________

3. What times will definitely not work for you to attend the meetings?
   __________________________________________________________

4. What are your main reasons for your interest in the Narrative Community Group?
   (e.g. clinical ladder credit, personal interest, team building, etc)
   __________________________________________________________
   __________________________________________________________

5. Do you have questions or want to be contacted regarding this unique opportunity? (if yes, include contact information below).
   Name: ___________________________
   Shift: __________________________
   Day Phone:______________________ Best time to call: ____________

Thank you for participating in this survey
Appendix I

Initial Narrative Group Facilitator Comments

**Purpose:**  
- An opportunity to talk about experiences with one another  
- Review past research with groups  
  “need time to talk about experiences within the department”  
-1 When you get to talk you see things you have not realized before  
-2 Your story might help someone else & their story might help you - “shared learning”  
-3 Deeper level of relationship with other nurses - rapport built  
-4 Across shifts - develop more understanding and trust for others

- **Describe Facilitator Role:**  
  -1 Listen to the stories  
  -2 Make sure group stays on track  
  -3 Ask the dumb questions

- **Ground Rules:** passed out and reviewed  
  - Everything in group is confidential, not to be shared with others who aren’t present

  - Stories focus on your own nursing practice, patient care - “short staffing focus” not helpful

  - Use “I” language, your story! Your patients! Your experiences!

  - Listener Role: Listen carefully, we aren’t looking for what is right or wrong, just... looking for the experience - respond back, questioning, supportive

- **“Tie Up the Loose Ends”** - themes & highlights at end of sessions
Appendix J

Post-Narrative Community Participant Survey

As I promised, I am sending out a survey to gather information from you about your experience with the 3K narrative community process. I tried to keep it short. I would appreciate you taking some time to respond. Any and all comments are appreciated. You can fill this out and return it on e-mail or print a hard copy and send it to me via snail mail in the nursing education department. Thanks.

Values of the process:
- On a scale of 1-5 (with 5 being most valuable) how valuable were the Narrative Community sessions for you?
- What made the sessions valuable for you?
- What did you not find valuable about the sessions?

Format:
- Please comment on the meeting 6 times over a 3 month period. Was this enough, too much, too little?
- Was an hour the right length for the meeting?

Would you recommend this to others:
- Would you recommend this process to others?
- Who would most benefit from this process?

Facilitation:
- How valuable was it to have an outside facilitator?
- Would you like to learn to be a facilitator for this or another group?

Should this process continue:
- Would you like to see this process continue on 3K in some form?
- If yes, would you be willing to organize the group?
- Would you like someone from the outside of the unit to serve as a facilitator?
- How frequently would you like to meet? Twice a month? Once a month?
- Where would you like to meet? At work? Some other location? Thank You!