

Cognitive Rehearsal Training to Prevent Lateral Violence in a Military Medical Facility

Karen M. O'Connell, PhD, RN, CEN, NEA-BC, René L. Garbark, BSN, RN,
Kelly Cavanaugh Nader, DNP, RN, CCNS, CNOR

Purpose: *This study's purpose was to determine the prevalence of lateral violence in a military facility and the effect of cognitive rehearsal training on its occurrence.*

Design: *A preintervention/postintervention study was conducted.*

Methods: *A quantitative exploration of nurses' perceptions of lateral violence occurrence within a military setting and the effect of an intervention was planned using the Negative Acts Questionnaire—Revised. The intervention of cognitive rehearsal training was provided to perioperative nurses.*

Findings: *Six and nine negative acts occurred daily or weekly preintervention and postintervention, respectively. However, two negative acts significantly decreased postintervention. Cognitive rehearsal training provided participants confidence to respond to perpetrators.*

Conclusions: *Overt lateral violence was identified in nursing working in a military medical facility. Cognitive rehearsal training did not significantly reduce lateral violence. Further studies with larger groups comparing interventions would provide a better understanding of the value of rehearsal training among perioperative military nurses.*

Keywords: *lateral violence, military nursing, cognitive rehearsal training, negative acts, horizontal violence.*

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LATERAL VIOLENCE is any repetitive behavior among peers that is considered offensive, abusive, or intimidating by the target. As a result, targets feel inadequate, ineffective, vulnerable, and stressed.¹ Apathy and tolerance allow these behaviors to perpetuate within a workplace.² Although lateral violence can occur in any occupational setting, it is common place in hospitals.³

Lateral violence is an international problem that affects nurses at all levels and in all venues. Several other terms are used to describe this behavior: horizontal violence, harassment, workplace incivility, workplace violence, disruptive behavior, and mobbing.³⁻⁵ Prevalence of lateral violence in nursing has been reported as high as 85% in the United States.⁶ Frequently targeted are nurses who lack self-confidence, such as students,

Karen M. O'Connell, PhD, RN, CEN, NEA-BC, Department of Nursing, Northern Kentucky University, Highland Heights, KY; René L. Garbark, BSN, RN, Education & Training, Wright-Patterson Air Force Base, OH; and Kelly Cavanaugh Nader, DNP, RN, CCNS, CNOR, Department of Medicine, Dayton Veterans Administration Medical Center, Dayton, OH.

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Address correspondence to: Karen M. O'Connell, Department of Nursing, College of Health Professions, Northern Kentucky University, 1 Nunn Drive FH 461H, Highland Heights, KY 41099; e-mail address: oconnellk@nku.edu.

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novices, and nurses entering a new specialty.⁵ Nurses in high-intensity specialties such as medical-surgical, critical care, emergency departments, and perioperative areas appear to experience these negative behaviors more frequently.¹ Multiple studies have examined the occurrence and effects of lateral violence in nurses working in civilian hospitals; however, lateral violence among military nurses is understudied.

Background

As a profession, nursing has tolerated and been indifferent to the lateral violence behaviors that occur among colleagues.⁵ The frequent comment that nurses eat their young has become an accepted and often comical phrase used to describe a nurse's rite of passage into the profession. Lateral violence behaviors are intentional and demeaning with a desire to discredit and negatively impact the target.^{1,7} These behaviors are overt or covert behaviors and include sabotage by withholding information, being hypercritical or finding fault, derogatory remarks, gossip, rumors, revealing information that had been shared in confidence, eye rolling, snide remarks, infighting, and using others as a scapegoat.^{3,8} Perpetrators of these negative behaviors perceive a power over the target, and workplace cultures that do not enforce repercussions allow the violent behaviors to flourish.¹ Tolerance of this cycle of abuse across generations of nurses has perpetuated this uncivil behavior that is wreaking havoc on the health of the nurses, their patients, and the profession.¹

Verbal abuse among nurses was identified over 2 decades ago and continues to be the most common yet under-reported type of lateral violence in nursing.^{3,7,9} Although verbally abusive behaviors may feel innocuous to the perpetrator, research findings support that verbal abuse can be emotionally devastating to the target.¹⁰

Lateral violence affects individuals, units, and facilities. Targets report physical and psychological symptoms that can negatively impact patient safety and nurse retention. Physical symptoms reported included weight fluctuations, palpitations, hypertension, headaches, insomnia, and fatigue. Psychological symptoms included anxiety, depression, feelings of worthlessness, and suicidal

thoughts.^{2,10-14} These symptoms result in poor communication among colleagues, decreased job satisfaction, commitment to the organization, autonomy in practice, and increased intention to leave.^{6,10,14-16}

Tolerance of lateral violence creates a hostile workplace. Coworkers may be concerned for the target; however, they may feel helpless to stop the behavior and try to avoid behaviors that will make them targets.⁷ In hostile work environments, nurses exhibited decreased cognitive abilities and work productivity.¹⁷ Hostility increases nurse burnout and exhaustion resulting in substandard and unproductive nursing care for patients.¹⁸ Patient satisfaction has been shown to positively correlate with nurses' work satisfaction.³

High turnover rates and impacts to patient care and safety are some facility-level casualties of lateral violence. Turnover increased with occurrence of lateral violence, and in one study, 42% of nurses intended to leave their position within the next 3 years.¹⁰ Poor nurse retention is expensive for facilities as replacement costs can exceed two times a nurse's salary.¹⁹ Nurse absenteeism and vacancies pose a challenge to staffing and safe competent nursing care. Individual studies and literature reviews identify that up to 41% of nurses felt that lateral violence impacted their productivity and identified a significant positive relationship between violence and medical error.^{4,14,19} In addition, patients and families who witness these behaviors among nurses reported a decrease in staff credibility, an increase in feelings of helplessness, and a change in their consumer opinion.³ Every aspect of the health care system—the nurse, the patient, and the organization is impacted by lateral violence.

An approach to eliminate this behavior from a profession that takes pride in compassion and advocacy is desperately needed. Several interventions have been attempted in civilian facilities with mixed results. Zero-tolerance policies, education on lateral violence, and cognitive rehearsal therapy to learn conflict reduction strategies have been studied.^{2,8,13,20,21} Results from these studies point to a synergistic combination of several interventions to include educating nurses on what constitutes lateral violence; teaching appropriate responses to the violent behaviors;

enforcing a zero-tolerance policy for disruptive behaviors; implementing safe reporting systems with protection from reprisal; and providing an effective orientation for new nurses.¹³

Although much research has been conducted in the civilian health care system, little evidence has been published to support or deny the existence of lateral violence among military nurses. A major concern for civilian medical facilities is nurse turnover related to lateral violence and hostile work environments.^{10,15,16} Unlike their civilian counterparts, military nurses who are targets of lateral violence do not have the option of leaving employment because of their service obligation. Physical and psychological symptoms caused by lateral violence in military nurses may lead to exhaustion, increased sick days, impaired clinical performance, and reduce the readiness of the military nursing force. Military nurses may feel trapped, have poor attitudes, and potentially target other nurses.

Frequent targets of lateral violence are newly graduated nurses. Up to 30% of newly graduated nurses leave their first position or consider leaving nursing within the first year because of stress and episodes of lateral violence.¹⁷ The study facility receives an average of 15 newly graduated registered nurses each year. Therefore, we chose to model our study and intervention on the work of Griffin.⁸ The purpose of her study was to highlight the negative impact of nursing incivility throughout the profession. She recommended cognitive rehearsal as a means to empower the target and instill a sense of confidence in the nurse dealing with an oppressive colleague.²¹ At 1 year postintervention, the new nurses reported fewer episodes of lateral violence.⁸

During the last 10 years, numerous researchers have replicated Griffin's intervention and used cognitive rehearsal resulting in several positive outcomes. Increased awareness of what constitutes lateral violence; improvement in communication; and a sense of empowerment and confidence in addressing nurse on nurse incivility were some positive results noted by researchers.²¹ These studies highlighted cognitive rehearsal as an evidence-based approach to different methods to address uncivil or bullying behavior, ultimately

improving communication and positively influencing patient care.²¹

Decreasing the incidence of lateral violence among nurses will improve morale, retention, and the quality of patient care provided by nurses. The aim of this study was to describe the incidence of lateral violence in a military medical treatment facility and evaluate the effect of a behavioral intervention on the occurrence of lateral violence.

Methods

The study was conducted in three phases and used an exploratory design. Approval for the study was obtained from the medical treatment facility leadership and the institutional review board. During the first phase, all registered nurses in a large Air Force medical treatment facility were invited to complete the Negative Acts Questionnaire—Revised (NAQ-R) electronically. The original NAQ was created by Einarsen et al²² and has been used internationally. Einarsen et al²² created a shorter version, the NAQ-R, in English and tested the reliability and validity in 70 British organizations with 5,288 participants. Cronbach's α indicated an excellent level of internal consistency at 0.90. Factor analysis revealed that all 22 items loaded onto three dimensions—work-related bullying, person-related bullying, and physical intimidation with scores above 0.70.²² Simons²³ validated the findings of Einarsen in a sample of 511 newly licensed registered nurses in Massachusetts. The NAQ-R was deemed reliable with a Cronbach's α of 0.88 and was significantly correlated ($r = 0.51$; $P < .001$) with the intent to leave scale administered in the study.

A survey was created on the facility's intranet site using the NAQ-R questions and Likert scale answers. Internet address tracking was turned off for the survey to increase confidentiality of responses. Participants were able to easily complete the survey from their workstation. In the second phase, nurses from the perioperative area within the facility were invited to participate in a 2-hour cognitive rehearsal training intervention. The third phase occurred 3 months after the intervention. All registered nurses were again invited to complete the NAQ-R electronically, and those who participated in phase II were asked to complete an evaluation of the intervention. Phase II

participants were asked to complete the NAQ-R hard copy to allow data analysis between the intervention group and the rest of the participants.

Sample size for each phase varied: phase I sample ($n = 76$) was drawn from the registered nurse population ($N = 308$) of a large Air Force military treatment facility, and phase II sample ($n = 11$) was drawn from registered nurses working in the perioperative area—operating room, postanesthesia care unit, and ambulatory care unit. Phase III sample ($n = 39$) was drawn from the entire registered nurse population. A power analysis conducted before the study revealed the need for 20 participants.

An intervention modeled after Griffin's study⁸ was conducted. Education on lateral violence followed by cognitive rehearsal training that ended with participant role play was planned (Appendix 1). A 30-minute didactic lecture explaining the background and definition of lateral violence, its prevalence within nursing, and its potential impact on nursing practice began the intervention. Mental health providers, a psychologist and two psychiatric mental health nurse practitioners, then conducted cognitive rehearsal training during the next 90 minutes. Beginning with a brief explanation of cognitive rehearsal and a demonstration of how it could be used, participants role played multiple scenarios, and the intervention ended with time for questions.

Findings

Phase I participants were predominately females (79.2%), had more than 20 years of nursing experience (33.8%), and were active duty military (61%). In terms of experience, 62.4% of our sample reported at least 10 years' experience; 33.8% of which were nurses with more than 20 years' experience. This study included 61% active duty participants compared with 33.8% civilian staff with 3.9% who did not identify with either group. The intervention group that consisted of operating room, ambulatory procedure unit, and postanesthesia care unit nurses made up 27.3% of the total sample. Clinic nurses comprising 20.8% and inpatient nurses comprising 24.7% and 26% declined to answer this question (Table 1). To determine the occurrence of lateral violence in the sample, individual answers on the NAQ-R were rescored.

Table 1. Participant Demographics (N = 76)

Characteristic	Sample (%)
Work department	
Clinic	20.8
Operating room	15.6
No answer	156
Inpatient	14.3
PACU/APU	11.7
Family birthing unit	10.4
Nursing	10.4
Status	
Active duty	61
Civilian	33.8
Other	3.9
Gender	
Female	79.2
Male	13
Prefer not to answer	6.5
Experience	
More than 20 y	33.8
15-20 y	15.6
10-15 y	13
5-10 y	16.9
Less than 5 y	18.2

PACU, postanesthesia care unit; APU, ambulatory procedure unit.

NOTE. 1.3% (one participant)—no answer to demographic questions except experience.

Answers of never, now and then, or monthly were scored zero, whereas answers of weekly or daily were given one point.

Six items on the NAQ-R were scored as occurring weekly or daily by at least 10% of the sample (Table 2). Three of the six fall into work-related bullying and three in person-related bullying factors described by Einarsen et al.²² Interesting differences were discovered when the mean scores for the negative acts were sorted by the department worked or military status. Nurses who either declined to input their department or gave a generic answer of nursing for their department reported more frequent occurrences of the negative acts than those who identified their work area. Nineteen negative acts were reported more frequently by civilian nurses than the active duty nurses. Repeated reminders of mistakes and being humiliated or ridiculed in connection with your work were reported more frequently by the active duty nurses; however, the differences were very small. Three items on the NAQ-R occurred less

Table 2. Preintervention NAQ-R Results (N = 76)

Question	Daily or Weekly, <i>n</i> (%)	Never; Now & Then; or Monthly, <i>n</i> (%)
1. Someone withholding information that affects your performance	13 (17.0)	63 (83.0)
2. Being humiliated or ridiculed in connection with your work	5 (6.6)	71 (94.4)
3. Being ordered to do work below your level of competence	15 (19.7)	61 (80.3)
4. Having key areas of responsibility removed or replaced with more trivial or unpleasant tasks	8 (10.5)	68 (89.5)
5. Spreading of gossip or rumors about you	10 (13.2)	66 (86.8)
6. Being ignored, excluded, or ostracized	9 (11.8)	67 (88.2)
7. Having insulting or offensive remarks made about your person (ie, habits & background), your attitudes, or your private life	5 (6.7)	70 (93.3)
8. Being shouted at or being the target of spontaneous anger (or rage)	3 (3.9)	73 (96.1)
9. Intimidating behavior, such as finger-pointing, invasion of personal space, shoving, blocking/barring the way	2 (2.6)	74 (97.4)
10. Hints or signals from others that you should quit your job	1 (1.3)	75 (98.7)
11. Repeated reminders of your errors and mistakes	4 (5.3)	72 (94.7)
12. Being ignored or facing a hostile reaction when you approach	4 (5.3)	72 (94.7)
13. Persistent criticism of your work and effort	4 (5.3)	72 (94.7)
14. Having your opinions and views ignored	12 (15.8)	64 (84.2)
15. Practical jokes carried out by people you do not get on with	0	75 (100)
16. Being given tasks with unreasonable or impossible targets or deadlines	2 (2.6)	74 (97.4)
17. Having allegations made against you	1 (1.3)	74 (98.7)
18. Excessive monitoring of your work	5 (6.6)	71 (93.4)
19. Pressure not to claim something which by right you are entitled to (eg, sick leave, holiday entitlement, travel expenses)	3 (3.9)	73 (96.1)
20. Being the subject of excessive teasing and sarcasm	0	76 (100)
21. Being exposed to an unmanageable workload	4 (5.3)	72 (94.7)
22. Threats of violence or physical abuse or actual abuse	0	76 (100)
23. Have you been bullied at work? We define bullying as a situation where one or several individuals persistently over a period perceive themselves to be on the receiving end of negative actions from one or several persons, in a situation where the target of bullying has difficulty in defending himself or herself against these actions. We will not refer to a one-off incident as bullying. Please state whether you have been bullied at work during the last 6 mo?		
No		54 (71.1)
Yes, but only rarely		5 (6.6)
Yes, now and then		15 (19.7)
Yes, several times per week		1 (1.3)
Yes, almost daily		1 (1.3)

NAQ-R, Negative Acts Questionnaire—Revised.

than daily or weekly in our sample: practical jokes carried out by people you do not get on with; being the subject of excessive teasing and sarcasm; and threats of violence or physical abuse or actual abuse.

Three months after the intervention, participants who received cognitive rehearsal training (phase II) were asked to evaluate the intervention pro-

vided (Table 3). Overall, the intervention group felt that the training was positive and should be offered to all personnel in the facility. Half of the intervention group had used the training and felt that the occurrence of lateral violence had decreased in their unit.

Response rate for phase III was much smaller than phase I ($n = 39$). Nine items were reported as

Table 3. Intervention Evaluation (N = 6)

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I learned techniques to respond to instances of lateral violence during the training	0	0	0	3	3
I feel the training I received was beneficial	0	0	0	3	3
I feel that the training should be made available to all personnel in the facility	0	0	0	2	4
			No		Yes
Have you used any of the techniques learned in the training?		3			3
	Increased	No Change	Decreased		
Since the training, do you feel the amount of lateral violence has	0	3	3		

occurring weekly or daily by at least 10% of the sample (Table 4). Comparison of phase III results with phase I results shows a difference in the most frequently reported items. Unlike the results from the preintervention survey, civilians reported more frequent occurrence of negative acts in only nine of the 22 acts listed. Again, the differences in frequency were small between the civilian and active duty nurses.

Using the raw scores, *t* tests were conducted to determine statistical significance between the mean scores for each item and the mean total scores on the NAQ-R. In the intervention group, a statistically significant difference was seen on two items. Postintervention scores on item 17, "Having allegations made against you" statistically significantly decreased from *now and then* to *never* (mean [M] = 1.38, SD = 0.67 to M = 1.00, SD = 0.00; $t[20] = 2.61$, $P = .02$ [two-tailed]). A medium effect size was seen in this difference according to Cohen's *d* analysis ($d = 0.64$). "Pressure not to claim something which by right you are entitled to" (item 19) was also statistically significantly decreased from preintervention: *now and then* (M = 1.38; SD = 0.74) to postintervention: *never* (M = 1.00; SD = 0.00; $t[20] = 2.36$; $P = .03$), with a medium effect size ($d = 0.57$). Higher mean scores on the NAQ-R are associated with increased health complaints, decreased performance, and greater intention to leave a job.²² Mean total scores preintervention (M = 37.1; SD = 10.67) were higher than mean total scores postintervention (M = 33.17; SD = 12.81); however, the difference

was not statistically significant ($t[25] = 0.453$; $P = .76$).

t Tests were also conducted to determine if there were statistically significant differences in mean item and mean total scores between the preintervention group and the postintervention control group using raw score. Statistically significant differences were noted neither in the mean scores (before: M = 35.24, SD = 11.52; after: M = 34.72, SD = 12.86; $t[25] = 0.22$; $P = .83$) nor for any of the items on the NAQ-R.

Discussion

Lateral violence has been studied in the civilian nursing community during the past 20 years. Our research sought to determine if lateral violence occurs in the military medical setting.

Our results indicate that lateral violence does occur among nurses in a military medical center. Most of the incidences reported in this study were covert and verbally abusive actions that could be influenced by the target's perceptions. However, perception is reality in the eyes of the target.

According to Vessey et al,¹ lateral violence is increased in work areas that have significant hierarchical structures. Because the military community is a hierarchical system with its own culture, one would expect it to be a work environment ripe for lateral violence. Military culture differs

Table 4. Postintervention NAQ-R Results (N = 39)

Question	Daily or Weekly, <i>n</i> (%)	Never; Now & Then; or Monthly, <i>n</i> (%)
1. Someone withholding information that affects your performance	8 (20.5)	31 (79.5)
2. Being humiliated or ridiculed in connection with your work	3 (7.7)	36 (92.3)
3. Being ordered to do work below your level of competence	6 (15.4)	33 (84.6)
4. Having key areas of responsibility removed or replaced with more trivial or unpleasant tasks	4 (10.3)	35 (89.7)
5. Spreading of gossip or rumors about you	3 (7.7)	36 (92.3)
6. Being ignored, excluded, or ostracized	4 (10.3)	35 (89.7)
7. Having insulting or offensive remarks made about your person (ie, habits & background), your attitudes, or your private life	0	39 (100)
8. Being shouted at or being the target of spontaneous anger (or rage)	0	39 (100)
9. Intimidating behavior, such as finger-pointing, invasion of personal space, shoving, blocking/barring the way	1 (2.6)	38 (97.4)
10. Hints or signals from others that you should quit your job	0	39 (100)
11. Repeated reminders of your errors and mistakes	1 (2.6)	38 (97.4)
12. Being ignored or facing a hostile reaction when you approach	5 (12.8)	34 (87.2)
13. Persistent criticism of your work and effort	3 (7.7)	36 (92.3)
14. Having your opinions and views ignored	4 (10.3)	35 (89.7)
15. Practical jokes carried out by people you do not get on with	0	39 (100)
16. Being given tasks with unreasonable or impossible targets or deadlines	2 (5.1)	37 (94.9)
17. Having allegations made against you	1 (2.6)	37 (97.4)
18. Excessive monitoring of your work	7 (17.9)	32 (82.1)
19. Pressure not to claim something which by right you are entitled to (eg, sick leave, holiday entitlement, travel expenses)	3 (7.9)	35 (92.1)
20. Being the subject of excessive teasing and sarcasm	1 (2.6)	37 (97.4)
21. Being exposed to an unmanageable workload	4 (10.3)	35 (89.7)
22. Threats of violence or physical abuse or actual abuse	0	39 (100)
23. Have you been bullied at work? We define bullying as a situation where one or several individuals persistently during a period perceive themselves to be on the receiving end of negative actions from one or several persons, in a situation where the target of bullying has difficulty in defending himself or herself against these actions. We will not refer to a one-off incident as bullying.		
Please state whether you have been bullied at work during the last 6 mo?		
No		20 (55.6)
Yes, but only rarely		6 (16.7)
Yes, now and then		8 (22.2)
Yes, several times per week		2 (5.6)
Yes, almost daily		0

NAQ-R, Negative Acts Questionnaire—Revised.

from the civilian nursing community in several ways that increase the cause for concern. In the civilian community, nurses can and do quit their jobs within the first year of nursing, and some leave the profession completely.⁸ However, a military member is required to complete a 4- to 6-year commitment despite a possibly hostile work environment. Military nurses may also be dealing with

the stress of a previous or upcoming deployment to a war zone. Physical and psychological symptoms may occur in these nurses, which lead to exhaustion and impaired clinical performance.²⁴ Some nurses have developed post-traumatic stress disorder from recurrent deployments, which can impact their perception of and reactions to lateral violence in their workplace.²⁵

Prior studies in lateral violence have been predominately conducted with novice nurses,^{8,17} whereas our study included most of the experienced nurses. Evidence supports that nurses in areas with higher levels of technical expertise, such as the operating room, emergency department, and critical care units, will experience more lateral violence.¹

During phase I, the most common areas of lateral violence identified were as follows: being ordered to do work below your level of competence (19.7%), someone withholding information that affects your performance (17%), and having your opinions and views ignored (15.8%). The next most common issue was spreading of gossip and rumors about you (13.2%). Interestingly, the post-intervention results included three more items occurring daily or weekly compared with the pre-intervention survey. Possibly, staff became more aware of these occurrences after completing the NAQ-R during phase I. Data collected in phase III identified a change in the percentage of behaviors occurring most often. The top four behaviors reported during phase III were as follows: someone withholding information that affects your performance (20.5%), excessive monitoring of your work (18%), being ordered to do work below your level of competence (15.4%), and being ignored or facing a hostile reaction when you approach (12.8%).

Our results did not support the use of cognitive rehearsal training to decrease lateral violence as no significant difference in NAQ-R results between the intervention and the control group was found. Intervention group participants reported that the training was an effective method to empower nurses to respond to lateral violence and should be offered to all staff in the facility. Recent evidence suggests that after 10 years of use, cognitive rehearsal therapy does empower nurses to stand up against this type of workplace violence.^{21,26} Preparing nurses through cognitive rehearsal practice benefits the individual and organization, impeding the consequences of these events. The process of educating nurses about negative workplace behaviors may help individuals become more aware of their own behaviors, which may help prevent workplace violence in the next generation of nurses.^{21,27} Based on our results and evidence from Griffin's 10-year look at cognitive

rehearsal as an intervention, a continuing education program was created using the intervention and offered quarterly at the facility.^{26,27}

Limitations

Our study had three main limitations. The hierarchical structure of the military system resulted in concerns, per anecdotal comments shared with researchers, about the anonymity of the study participants. Staff members expressed concern that higher ranking officers or supervisors could see their answers and identify them, which may affect their career. This may have limited the number of respondents for both surveys.

A second limitation of working with the military community is the frequent moves of staff members between facilities. This study was conducted during the permanent change of duty station season, which limits the strength of the postintervention results. The nurses who completed the initial survey may not have been the same nurses who completed it postintervention.

All nurses who worked in the perioperative area were invited to participate in the intervention group. During the intervention, the researchers realized that both management and clinical staff attended the intervention together. The third limitation identified was that the clinical staff did not appear to fully engage in the role play when the management staff was present. For future studies, the research team decided to either restrict the participants in the intervention to clinical staff only or to have two intervention groups, one for management and one for clinical staff.

As a result of the three limitations, our results do not support the use of cognitive rehearsal training as an intervention to decrease lateral violence. However, our small experimental group reported positive results after the intervention when confronted with lateral violence.

Conclusion

Our findings are the first to support that lateral violence does occur in military settings. Our study supports the need for additional research in the military setting especially because of the unique challenges our military nurses face, as part of a service

agreement combined with the physical and psychological effects of almost 20 years of continuing contingency operations. Additional studies in a variety of military health care settings both in garrison and deployed locations may reveal additional information on the occurrence of lateral violence. Future studies should include larger samples and more than one intervention to reduce lateral violence. Results of future larger studies could assist the military health system to develop a targeted intervention strategy to reduce lateral violence.

Supplementary data

Supplementary data related to this article can be found at <http://doi.org/10.1016/j.jopan.2018.07.003>.

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Appendix 1

Cognitive Rehearsal Training Study Intervention

Two hours was allotted for the study intervention. The intervention included education about lateral violence (LV), and the effect on targets, patients, and the organization. Next, the organization's policies were reviewed along with strategies to prevent or mitigate LV. The intervention concluded with small group discussion and exercises to practice responses to LV.

Education Objectives and Outline

1. Define LV and its prevalence in the workplace
 - i. Definition per literature
 - ii. Verbal and nonverbal actions that demonstrate LV
 - iii. Terms used to describe LV
 - iv. Prevalence among coworkers and management
2. Discuss the consequences and root causes of LV
 - i. Psychological and physical consequences for the target
 - ii. Consequences for the organization including patient safety and poor nurse retention
 - iii. Root causes of LV including:
 - a. Relational aggression
 - b. Nurses are an oppressed group
3. Summarize policy statements from health care organizations
 - i. The Joint Commission Sentinel Event Alert Issue 40
 - ii. American Nurses Association policy statement on incivility bullying and workplace violence
4. Review the Air Force instructions and medical group instructions
 - i. Air Force Instruction 44-119—*Medical management*
 - ii. Medical Group Instruction 40-140—*Medical group code of conduct*
 - iii. Discuss how to report violations
5. Discuss prevention/mitigation strategies
 - i. Requirement for codes of conduct per The Joint Commission
 - ii. Organizational policies that stress zero tolerance for LV
 - iii. Accountability and consequences for perpetrators published and enforced
 - iv. Communication strategies
6. Cognitive rehearsal training exercises⁸
 - i. 90 minutes practicing responses to LV via small groups (four to five people per group)
 - ii. Cueing cards⁸ used to facilitate practice responding to the most common types of LV
 - iii. Two badge cards with the following information:
 - a. Side 1—most frequent forms of LV
 - b. Side 2—statements that can be used as a reply to items on side 1
 - c. Single card—statements regarding positive professional conduct.