The Enduring Silence of Violence in the Nursing Workforce: An Emerging Phenomenon

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This phenomenological study aims to understand the lived experiences of nurses dealing with workplace violence in two tertiary hospital settings. Participants include nurses who had personally experienced two or more instances of bullying behaviour within the workplace and whose job statuses were classed as regular, casual, or job hired. Transcribed data collected form interviews with these participants revealed five common themes, including (a) "Workplace violence happens to anyone": workplace violence is becoming rampant in the health care industry; (b) "Damaging circumstances surround the nursing profession": impacts of the workplace for nurses; (c) "Unpleasant experiences are better forgotten": how nurses survive workplace violence; (d) "I am a Nurse and I stand by my profession": why nurses opted to stay despite their workplace violence experiences, and (e) "I long for a better workplace": striving for better working environments for nurses. These interviews reveal that informants experienced unforgotten disruptive behaviours like fear, frustration, verbal abuse, humiliation, threats and abuse of power, resulting in helplessness and demoralisation that directly affected nurses' feelings of dignity and self-respect. These legitimate occupational issues within the nursing workplace require attention and subsequent intervention to discontinue the silence surrounding healthcare workplace violence.

Key words: *Enduring silence, nurse, phenomenology, and workplace violence.*

Introduction

Given the central focus of caring within the nursing profession, it is ironic that evidence of violence has become a common healthcare workplace issue. Griffin (2004) defines horizontal violence as both overt and covert actions conducted by nurses towards each other, and especially towards those deemed less powerful. A US-based study showed this prevalence affecting new nursing graduates, nursing students, and even those nurses who had worked at a health facility for a long rime (Roy, 2007). Griffin further explains that because most communication is nonverbal, covert behaviours are highly impacting. Lateral Violence (LV) manifests itself in a variety of unkind, antagonistic interactions that occur among nurses in the same organisational hierarchy. The lack of a universal term to contain these actions makes integrating research on LV a difficult process (Bartholomew, 2006).

Lateral violence is so widespread in the nursing industry that at one point or another, all individuals, regardless of age, sex, employment status or religion, have been affected in some way. This workplace violence facing the nursing workforce is much less known in the Philippines (de Castro, Cabrera, Gee, Fujishiro, & Tagalog, 2009) as it is assumed that Filipino nurses do not report incidences of workplace violence. Such disruptive or bullying behaviours may involve physical assault or verbal threats, either covert or overt, that nurses may experience in the tour of duty from peers, nursing aides, laboratory technicians, supervisors, physicians, patients, or their significant others.

Overt and covert behaviours are generally a summation of personality and comprise of characteristics that may be either seen or unseen. Overt behaviours encompass traits that are observable and readily perceived through an individual's sense. These surface impressions exemplify how an individual is seen through his or her overt attributes. Covert behaviours, on the other hand, include those traits that are deeply hidden, those that an individual keeps to him or herself for some reason (Magalona & Sadsad, 2008).

The American Nurses Association (ANA) recognises that workplace violence is a prevalent issue in the health care industry and strives to provide protective resources for nurses in the US. In 2009, more than 50% of emergency centre nurses experienced violence inflicted by patients. A reported 2,050 assaults and violent acts required an average of four days away from work. Of these acts reported, 1,830 were inflicted with injuries by patients or residents, and from 2003 to 2009, eight (8) registered American nurses were fatally injured at work (Bureau of labour Statistics [BLS], 2013).

Nurses may experience workplace violence for a number of reasons. Murray (2009) attributes this violence to a perpetrator's need to control all aspects of the work environment. The bully may have a personality flaw, such as being stubborn to the extreme of displaying

psychopathic tendencies, like being inappropriately charming; portraying an exaggerated sense of self, or lacking the ability to feel remorse or guilt over the harm inflicted upon others.

Disruptive behaviours may also exist due to a white *wall of silence* that often protects the bully. In some cases, senior managers insinuate these behaviours and often protect the perpetrator rather than the victim (Longno, 2007). Another study on American student nurses reported that 53% had reported being insulted by a staff nurse (Longno. 2007), while 52% reported having been threatened or having experienced verbal abuse at work (ANA, 2011). In another study, De Castro et al (2009) describe work-related problems among a sample of nurses in the Philippines. Cross-sectional data were gathered through a self-administered survey during the 2007 convention for the Philippine Nurses Association. The four survey categories included 1) work-related demographics; 2) occupational injury or illness; 3) reporting behaviour, and 4) safety concerns. About 40% of surveyed nurses had experienced at least one injury or illness in the past year, with 80% experiencing back pain. Most nurses who had experienced such injuries, however, did not report them for various reasons. Additionally, the top-ranking concerns of the study's participants were stress and overwork. Filipino nurses continue to encounter significant health and safety concerns that are similar to those faced by nurses in other countries. It is recommended in this study that future research should examine the workplace organisation factors that contribute to these concerns in order to strengthen policies that promote health and safety.

The Philippine Nursing Act of 2002 (R.A. 9173 Section 2 in Vinzon, 2007) hereby declares that it is the policy of the State to assume responsibility for the protection and improvement of the nursing profession. Measures must be implemented to instigate relevant nursing education, humane working conditions, better career prospects, and a dignified existence for all nurses.

Epistemology

The epistemology of constructivism and the theoretical perspective of interpretivism frame this study. Interpretivism refers to understanding something within its specific context. A person may respond in a number of ways to a particular stimulus since people's actions are context-bound and dependent on time, location, and the minds of those involved. In other words, people create and associate their own subjective meanings as they interact with the work around them (Holloway, 1997). Interpretative research attempts to understand phenomena through assessing meanings that the key informants assign them.

A proponent of Social Learning Theory, Albert Bandura (1969) highlights the significance of observing and modelling the behaviours, attitudes and emotional responses of others as a way to

understand a particular group. Much of the learning to direct interpersonal situations is a product of following the behaviours one observes in the group to which one wants to be accepted as a member. When maltreatment of a nurse occurs, members of the work unit may model the perpetrators' negative behaviour as a means of social acceptance (Griffin, 2004).

This qualitative study aims to achieve three key points in relation to healthcare workplace violence: (1) to describe the lived experiences of Filipino nurses exposed to violence in tertiary hospitals in Iloilo City; (2) to understand the significant memories and insights of nurses as they look back at their experiences of such violence, and (3) to analyse the meaningful feelings and views towards workplace violence. It is assumed that nurses experience some kind of violence from their peers, colleagues, patients, families, or from other members of the health care team.

Methodology

Creswell (2003) describes phenomenological research as a strategy associated with the qualitative approach, in which the researcher identifies the essence of human experiences concerning a phenomenon. This type of research is used to study areas in which there is little knowledge (Donalek, 2004). The nursing literature, mainly stemming from Western countries, features clinical articles about bullying, harassment and horizontal violence in the workforce, though actual empirical research remains limited.

Data sources

The study was conducted in December 2015 in two of Iloilo City's ten hospitals. Two tertiary hospitals carrying a Level 4 status as teaching and training hospitals (Department of Health, 2015) were considered as the venues of the study, one a government institution and the other privately owned. As tertiary hospitals, nurses were regularly rotated to different general wards and specialty units, and were provided with opportunities to handle greater responsibilities during these shifts.

Work-related demographics

An accompanying work-related demographic data sheet was employed to gather information on the nurses' personal and public characteristics, such as age; sex; religious affiliation; marital status; type of hospital worked at; area of assignment; position held; educational qualifications; employment status, and number of years of nursing experience held.

Table 1: Nurses personal and non-personal characteristics

Nurse (in Pseudonym)	Characteristics
Teresita	30 years old, single, and has worked as a staff nurse in a semi-private general ward of a government hospital for nine year. She currently occupies a permanent nursing position.
Orly	The most senior informan who served at a government hospital for 31 years and is the present Nurse Supervisor of the Operating Room complex.
Loraine	A 39-year-old mother of a young boy and working at the general wards of a government hospital as a permanent staff nurse.
Lorenzo	28 years old, single, and has worked at several health care units before becoming a permanent staff nurse in one of the city's government hospitals. He is assigned to the general wards.
Pedy	A 42-year-old single nurse assigned with a permanent position to the pediatric department. She has served as the Head Nurse of this tertiary institution's unit for 6 years.
Ice	A job-hired employee of a privately-owned tertiary hospital in the city and has been assigned to the Intensive Care Unit for 2 years.

Workplace Violence Survey Questionnaire (Dumont and Colleagues, 2012)

The modified survey used in this study consists of 18 statements surrounding workplace-related disruptive behaviours and identifies key informants for in-depth interviews. Survey measures included three categories: (1) frequency of experiencing workplace violence or disruptive behaviours; (2) how a nurse is personally affected by these behaviours, and (3) the perpetrators of disruptive behaviours. Under the frequency of experiencing of workplace violence or disruptive behaviours, statements like: (a) harshly criticising someone; (b) belittling or making hurtful remarks to others; (c) complaining about a co-worker; (d) raising eyebrows or rolling of eyes at a co-worker, and (e) pretending not to notice a co-worker struggling with his or her workload. As to category two how a nurse personally is affected by these behaviours, statements were: (a) "I was discouraged because of lack of positive feedback"; (b) "I have not spoken up because of fear of retaliation"; (c) "I hesitated to ask question for fear of being ridiculed"; (d) "I left work feeling bad about myself because of not so good interaction with certain co-workers," and (e) "I had physical symptoms because of

bad interaction with a co-worker". Lastly, the perpetrators of disruptive behaviours include: (a) nurse peers; (b) supervisors; (c) physicians; (d) other professionals such as laboratory technicians, respiratory therapists and physical therapists; (e) other staff members like secretarial, security and housekeeping personnel; (f) patients or clients, and (g) visitors or relatives.

The frequency of workplace violence was determined with a 5-point Likert scale which included the following descriptions: *1 = never,* meaning that workplace violence was not experienced at all within the period of 12 months; *2 = once,* meaning that workplace violence was experienced only once within the period of 12 months; *3 = monthly,* meaning that workplace violence was experienced every month within the period of 12 months; *4 = weekly,* meaning that workplace violence was experienced every week within the period of 12 months, and *5 = daily,* meaning that workplace violence was experienced every day within the 12-month period.

The self-test for "Type A" personality

Carver and Scheier (2000; in Magalona & Sadsad, 2008) define personality as a person's inner dynamic organisation comprised of psycho-physical systems. These systems combine to create an individual's characteristic patterns of behaviour, thoughts and feelings which convey personality, internal causality and personal distinctiveness. The self-test for the "Type A" personality checklist was used to determine each nurse's personality type. Understanding character traits is important in the workplace as everyone has different features that make up their distinct personality type, with some personalities working together more effectively than others. The self-test for the Type A personality is a published standardised instrument adapted from Guzman (1981; in Posecion, 1998). Using the semantic differential scale, the test is composed of twenty (20) pairs of adjectives and phrases. Each pair is chosen to represent two contrasting behaviours. The nurses were asked to circle the option they deemed most accurately represented their own temperaments and behavioural choices. Scores were then obtained by adding all the circled numbers for each participant, after which personality type was determined using these score intervals.

Type A personality behaviour is described as an action-emotion complex that can be observed in any person who is aggressively involved in a chronic, incessant struggle to achieve goals quickly and, if required, at the expense of others. Type A personalities are characterised by ambition, control, high competition, status preoccupation, addiction to work and lack of patience. This type of personality implies a stress-prone temperament concerned with time management, efficient at multitasking, feeling guilt when relaxing and unable to easily accept failure. Type A1 has a high risk of cardiac illness and other stress-related disorders, especially those individuals who smoke and who are over 40 years of age.

Type A2 is also a typically cardiac-prone personality but does not have as high a risk of heart disease as Type A1. Conversely, people with Type B personalities are relaxed, less stressed, flexible, emotional and expressive, and have a generally laid-back attitude. Individuals with this personality type are less concerned about time, are mild mannered, do not brag, focus on quality rather than quantity, enjoy achievement and show thoughtful and creative tendencies. Type AB is a mixture of Type A and Type B personalities, which is a healthier pattern than either Type A1 or A2. AB individuals have the potential to fall into Type A behaviour.

The key informants for the in-depth face-to-face interview were six nurses who consented to take part in the study. All key informants had various experiences with workplace violence, totalling at least 43 cases in a year. Two participants had experienced workplace violence on a daily basis, while the other four experienced weekly disruptive behaviours. The majority of informants were calculated as Type A2 personalities.

Interview Guide Questions

The developed guide was used as a key tool when interviewing informants. Krueger and Casey (2001) mention that when the issues at hand are sensitive and highly confidential, the interactive processes can be compromised. In this case, individual interviews were appropriate in gathering the necessary information related to disruptive behaviours in the nursing workplace. The interview techniques of probing (both verbal and non-verbal) were used effectively. The researcher explored all information about the nurses' experiences until answer redundancy or saturation point was reached and all the topics on workplace violence were covered. When similar patterns emerged in each informant's responses, or when little to no new information was received from the interview process, the researcher ended the interview.

Procedure

Ethical considerations

Ethical permission for the study was obtained from the West Visayas State University Bio-Medical Research Ethics Review Committee. Confidentiality was assured by no personal or identifying information being included in the transcript. Informants who qualified for the interview were assigned pseudonyms to hide their real identities, thus strengthening this confidentiality. The potential risk of psychological distress from informants recalling incidents of workplace violence was also acknowledged. The researcher, who is a fellow nurse, was experienced in debriefing and possessed useful knowledge of referral services for those participants experiencing on-going psychological distress. Relevant contact numbers

were included in the cover letter of the survey questionnaire with an invitation to discuss any psychological distress caused by the interview.

Data collection

Permission to conduct the study was sought from the two Hospital Directors. 53 nurses from the private institution and 55 from the government hospital participated in the survey to identify the key informants using the modified workplace violence survey questionnaire (Dumont & Colleagues, 2012). The obtained scores were used to identify the frequency with which a nurse experiences workplace violence. Nurses who had personally experienced two or more bullying behaviours in the last 12 months and whose job statuses were regular, casual, or job-hired were considered as key informants for the in-depth interview. Of the 108 nurses who participated in the survey, 13 fit with these criteria, and interview invites were personally delivered to these nurses by the researcher. 6 nurses consented to take part in the in-depth interview; 3 nurses did not respond to the invitation for reasons relating to imminent retirement or sabbatical leave; 2 were unavailable for the required time period, and 2 nurses refused to participate in the in-depth interview. All 6 key informants had various experiences with workplace violence, with a total of at least 43 cases per year. 2 informants also reported having experienced disruptive behaviours on a weekly basis. The majority of the informants were found to have Type A2 personalities, with driven, competitive, impatient and aggressive traits. These individuals could also be short-tempered, hostile, goal-oriented and prone to stress-related cardiac problems.

Each interview session was conversational in nature and was recorded for data gathering purposes. Voice recorders enabled the researcher to maintain eye contact with the informant and to preserve the informants' testimonies during data collection. Bracketing was used to improve the rigor and lessen the bias in this qualitative research. Bracketing aims to keep what is already known about the description of the phenomenon separate from the informants' description. This technique creates awareness and brings forward the researcher's prejudices, allowing for openness regarding individual experiences (Kvale, 1996). At the outset of the study, the researcher asked a colleague to interview her using the same interview guide questions intended for the key informants. A narrative description was transcribed and included as part of the researcher's subjectivity statement that assisted her to maintain an open approach when interviewing the key informants in analysing the data.

Data analysis

Inductive data analysis was utilised in this phenomenological study in order to construct themes by categorising the data into increasingly more abstract elements of information. The steps involved were based on data analysis according to Colaizzi 1978 (in Creswell, 2009)

that included transcription, horizontalization, coding, textual description, structural description and interpretation.

Demonstrating trustworthiness of the study findings

Qualitative research must demonstrate trustworthiness in order to maintain a study's validity and reliability in all stages of the research process, including data collection, data analysis and descriptions. A research project is trustworthy when it accurately reflects the reality and ideas of the key informants. Holloway (1997) stipulates that throughout the research process, trustworthiness approaches like credibility, dependability, conformability and transferability should be employed and supported by triangulation, experts consultation and member checks or evaluations of data.

Trustworthiness in this study was supported by triangulation, or multiple sources of data as evidenced by consultation with experts, and member checks, or arranging for those who provided data to evaluate conclusions (Merriam, 2009). The researcher ensured trustworthiness by laying aside her preconceived ideas about the phenomenon under investigation and by returning to key informants to establish whether the description was a true reflection of their experiences.

Key triangulation strategies were employed in the study, such as conducting face-to-face in-depth interviews with individual informants, having the key informants review the transcription of their audio-recorded interviews and conducting peer interviews to substantiate the information gathered. The researcher validated informants' statements by interviewing peers who were present during the described workplace incident. These peers were asked to confirm and describe the actions, facial expressions, statements and behaviours of the key informants as they experienced these episodes of violence, and to liken each experience to other recent encounters.

Findings and Discussions

The nurses provided candid responses and specific examples to open-ended qualitative questions like, "What do you feel about workplace violence and how are you affected? What has made you remain in situations where bullying behaviour is a great possibility? What do you think should be changed or improved to prevent workplace violence?" The following themes were generated as results of the nurses responses: (a) "Workplace violence happens to anyone": Workplace violence is becoming rampant in the health care industry; (b) "Damaging circumstances surround the nursing profession": Impacts of the workplace for nurses; (c) "Unpleasant experiences are better forgotten: How nurses survive workplace violence; (d) "I am a nurse and I stand by my profession": Why nurses opt to stay despite

their workplace violence experiences, and (e) "I long for a better place": a better workplace for nurses. Each theme provided in-depth observations that reflected important insights, ideas and feelings of the key informants.

"Workplace violence happens to anyone": Existence of workplace violence in the healthcare industry

Within the complex healthcare industry, workplace violence is accepted as a common and destructive problem and a persistent occupational threat within the nursing workforce. When asked about their experiences with workplace violence, all six informants acknowledged that they had experienced disruptive behaviours in their respective places of work. The nurses who responded to this question were reflective in their comments and spoke from victimised perspectives. Below are Teresita's and Ice's responses:

> Teresita: *I think it happens to everyone, especially if you are working in a public workplace, so we are at risk.*

> Ice: *Bullying of nurses is rampant even in the private hospital; it is a natural workplace happening.*

These nurses voiced disappointment in their inability to keep their frustrations in check, sometimes resulting in behaviours that defied their personal and professional standards. This theme is aligned with suggestions put forward by the American Nurses Association (2011 and De Castro et al. (2009) that workplace violence in the healthcare industry is so widespread, particularly in the nursing profession, that at one point or another everyone is affected to some degree.

"Damaging circumstances surround the nursing profession": Impacts of workplace violence for nurses

Comments related to perpetrators included examples of disruptive behaviours, as illustrated by Teresita's statement:

> Teresita: *Maybe with the doctor it is moderate, but with the folk it's severe. The patient's folks put me to shame in front of the surgical resident. He was a nurse, as I was, and he put me to shame and humiliated me repeatedly.* [At this point of the interview, she could not hold back her anger and burst into tears.] *There are folks that understand, but there are also those terrible ones.*

When recalling certain incidents, nurses mentioned that job performance and social strata were negatively affected as a result:

> Teresita: *I am a silent type, so I become more silent. As if I am shameful, as if I don't interact easily. I minimise interaction. I am like that for weeks; I don't stay at the bedside.*

> Lorraine: *It is not right just because we are nurses and they are doctors; we secure the consent and prescribe the materials, even when it is their job. Most of the time it is the nurses who do things for the patient…but I don't know.*

> Lorenzo: *Violence need not be in the form of physical behaviour; sometimes it can inflict verbal or emotional distress. If satisfied with what you report, she would stand up, throw the chart away, look for other charts, then throw the chart away again and play silent.*

Pedy stated that she experienced bullying from supervisors or Head of Unit staff. She believed this incident did not directly impact on her work, though her relationships with her superiors were affected.

> Pedy: *I still remember what they did to me: they bullied me. They are stepping on my rights. I told myself, just because I am just like this, they do this to me? Despite the threat I received, I pursued my case. I asked for legal advice and they asked, "Why do you need to seek legal advice?" I said, "Because you don't listen to me, you even bullied me." I have received threats from my superiors; somebody will approach me and say, "Be careful, they are watching you."*

Ice also expressed his bullying experience after several years of working in the Intensive Care Unit (ICU):

> Ice: *After years working in ICU and encountering harsh physicians, you just learn how to deal with them. Usually bullying in the workplace with regards to nurses depends on the performance of the nurse. If you do not perform well, you will be bullied.*

As evidenced in the informants' testimonies, the nursing profession requires constant quality care for patients and the appreciation from both patients and peers is highly valued. Regardless of the aforementioned demeaning incidents and disruptive behaviours, however, nurses still continued their work and opted to stay and practice their profession with compassion and honour for human services.

The second major theme that arose from interviews was fear of retaliation. Informants expressed passionate feelings about workplace violence, and some stated that if a physician, peer or observer reported the incident, the nurse would lose her job. This threat of fear is indeed disturbing and highlights that although nursing is a profession that advocates for and protects patients, nurses are afraid to advocate for themselves.

"Unpleasant circumstances are better forgotten": How nurses survive the workplace violence experience

Informants were given the opportunity to share any disruptive or bullying behaviours they had personally experience and which did not fit into the category of behaviours previously described. While no new categories of behaviours were recognised, detailed incident descriptions were provided. Five of the six informants verbalised that the majority of disruptive behaviours were verbal in nature. Griffin (2004) conversely explains that because most communication is nonverbal, covert behaviours often have the biggest impact. Reported verbal abuse ranged from "being embarrassed in front of colleagues and other member of the health care team," to "yelling hostilely", resulting in the informant feeling the effects of such abuse but choosing to "laugh it out". While no physically aggressive behaviours were aimed at individuals, Lorenzo recounted that "objects were being tossed around the nurses' station". Five informants interestingly reported that these "unforgotten experiences helped them through bad times." Nurses also believed that whatever had occurred in the past must remain in the past and that hoping for change was futile, as stated by Pedy and Ice:

> Pedy: *This is common knowledge, yes, but it's helpful to acknowledge there is always another time to get it right.*

> Ice: *After years in the ICU, after encountering harsh behaviors from physicians and other folks, you just learn how to deal with them. We just shrug it off and put it out of our mind.*

A major contributing factor to workplace violence was identified by the informants as a lack of respect, support or positive recognition from management, to which informants maintained the missive, "Let go and get over it…this too shall pass."

"I am a nurse and I stand by my profession": Why nurses opt to stay despite their workplace violence experiences

When Teresita was asked if there was anything she would like to add, or if any information had yet to be provided, she stated:

303

> Teresita: *I think the rights of the caregivers; if you work here in the station of the hospital, you are not completely legally aware. Every time somebody asks, "Would you like to lose your job?" we are startled. Those words were like the end of the world. However, despite those experiences, I decided to stay as a nurse because, of course, I am a patient advocate; I am there to perform my job.*

Typically, nurses have the most interpersonal contact with patients of all healthcare professionals. The nurse may therefore be in the best position to act as a liaison between the patient and his or her family, and other healthcare and inter-department team members. To perform this function adequately, a nurse must have sufficient knowledge of each case and should be involved in all aspects of the a patient's care. Nurses should also have positive working relationships with other members of the healthcare team to facilitate effective communication. As evidenced in the informants' responses, however, not everyone appreciates nurses stepping forward on a patient's behalf. Orly expressed such a concern in relation to the surgeons at his workplace:

> Orly: *He [the surgeon] he asked me, "Why you are the only one assisting me in my surgeries?" and I replied, "Doc, who would assist you? Everybody else is afraid of you." The staff would ask what the problem was with doctors as they would just reprimand you. I would reply with, "That would not be the case if you have a good reason. We are nurses." We chose nursing…some staff nurses…they just keep quiet. They are afraid as they look upon them [the physicians] as persons of authority.*

Some related descriptions were more specific, such as Lorenzo's response:

> Lorenzo: *It is irritating sometimes since you are both staff nurses. You have to be level-headed when answering questions in the nurses' station. It is not a competition, but rather the kind of work we can offer in order to render quality patient care.*"

After having experienced and witnessed violence in the workplace on several occasions, Lorenzo requested several times to be transferred to the Outpatient Department (OPD) during the first months of working in the service ward:

> Lorenzo: *Ma'am, can I transfer to Outpatient Department (OPD)? I am not happy with this environment.* [Frowns and lightly strikes fingers on the table]. *Ma'am, it is not about workload. What I don't like is the group dynamics of*

the team, they are all insulting. There are different personalities in that group that make it bad.

However, a patient's significant other made Lorenzo opt to stay by conveying that he was a much needed team member in the patient's care plan. Pedy also reflected on her reasons for staying in the department:

> Pedy: *I love public service. I am there for my patients, not for anyone else. I feel happy with paediatric patients.*

The six informants defended their nursing positions and wished to uphold the quality patient care and interpersonal attention. These vital components in the development of a professional nurse are emphasised in the Philippine Nursing Act of 2002.

"I long for a better place": A better workplace for nurses

When asked to share their feelings, memories and suggestions about ways to lessen the amount of violence in their workplace, nurses spoke of their sincere attempts to improve dealings with their colleagues and with other staff. The responses to this question were understood as a desire on the part of the nurses to be active in conflict resolution. The role of higher management in generating and promoting an appropriate work environment was discussed, with informants stating that co-workers or immediate superiors like the Head Nurse should be approachable with work-related problems. Below are reports of incidents that informants had shared with their co-workers or immediate superiors. It is evident in their responses that they are longing for a better workplace, as typified by Teresita's comments:

> Teresita: *If you have a problem, the person you can talk to is your colleague or your Head Nurse. That's why we don't report* [referring to higher hospital authorities] *that kind of incident anymore. It's hard if you report it. They are not the kind of people who can give time to those under their stead. If they have their own problem, your issues will not even be entertained. I suggest they conduct seminars focusing on personal and professional growth, specifically about ethics, attitudes of the workers, hospital staff, hospital heads, and those who work under them. The hospital Human Resource (HR) Office is for hiring only. They used to provide seminars about the Civil Service (CS) policy that includes ethics, but that was years ago, only for newly-hired staff. It is sensible to have a counsellor since it is an everyday happening, but it is is not given much attention.*

The informant even considered quitting her job as one of the senior nurses in a tertiary institution.

> Orly: *One doctor made a letter of complaint about nurses which was signed by all members of the surgery, including orthopaedics and anaesthesia staff.*

When asked if he could share the outcome of the complaint letter, the informant opened his arms and stated:

> Orly: *Nothing. The Nursing Service Office (NSO) and Human Resource (HR) are pointing back at each other.*

> Lorraine: *I said, "Doc, isn't it a protocol? We should follow the protocol." If I complain here in the hospital administration office, no one would listen to me. I fought back following due process, I sought legal advice and got myself a lawyer.*

> Ice: *There are residents who are unkind. Our head nurse is aware of it, though tells us it is natural in the workplace. I feel that the Nursing Department should address an official letter to the Medicine Department, so that their chief can make their own policies for the attending physicians. Mostly there are no policies that govern attending physicians, only residents and nurses. It is difficult to be employed in other hospitals because of competition and few slots left, so since I am already employed here, I will push through it.*

Two basic factors were described within this theme. One was that the leaders (supervisors, charge nurses, directors of nursing, administrators and physicians) often use their power or position to intimidate and threaten subordinates. These results support the finding of Longo (2007) on senior managers insinuating these kinds of behaviours and protecting the bully instead of the victims. Secondly, these leaders often ignore workplace violence perpetrated around them and violence they themselves may perpetrate. The nurses stated that when they reported the behaviours, nothing was done about them. The bully was often felt to be friends with the leader. The nurses' comments reflected the strong belief that all levels of management should be involved in solving the problem of workplace violence in their particular workplace. Two of the six informants want a better workplace, should the opportunity for such reform exist.

Essence of the phenomenon

Disruptive or bullying behaviours may be in the form of physical assault or threats, either covert or overt, that nurses may experience from peers, nursing aides, laboratory technicians' supervisors, physicians, patients or significant others during their tour of duty.

This study has given rise to two prevalent issues. Firstly, workplace violence is rampant in the nursing profession, and the experience of this behaviour is psychologically upsetting, threatens patient safety, and affects nurses' self-esteem. Strong emotions were evident in the telling of these stories, whether they occurred recently or in the past. These testimonies were distressing and broadened one's understanding and appreciation of the impact of workplace violence on nurses.

In the responses, it was clear that despite being aware of violence in the workplace, many nurses preferred to endure such behaviour in silence rather than report them to authorities. Moreover, individual responses to the qualitative questions provided rich descriptions of the nurses' experiences as victims of this phenomenon.

Based on the responses of the informants, the researcher learned that workplace violence can happen to any nurse in both private and public healthcare establishments regardless of rank or position. This workplace violence reportedly affected job performances, relationships with superiors and even nurses' personalities and natural behaviours. Despite such unfortunate occurrences, however, nurses have continued to perform well in their jobs. They have become accustomed to such circumstances and have learned to let them pass. The informants also reportedly chose to stay regardless of workplace violence in order to stand by their profession and maintain their much needed patient care. Nurses voiced their longing for better workplaces, suggesting that such environments should limit incidents of violence and promote healthy and fair relationships between colleagues, supervisors and and other healthcare staff members.

Comments related to supervisors included examples of disruptive behaviours being ignored, as shown in Lorenzo's statement, "I informed a couple of incidents to my supervisor and nothing was done." While no nurse reported being aware of overtly aggressive behaviours aimed at her or him from a supervisor, the majority of informants reported feeling they were recipients of negative covert behaviours. These included being ignored by a supervisor, not encouraged to apply for advancement or recommended for promotion, and not mentored professionally in line with other peers. Two of the six key informants reported incidents to unit supervisors, while the rest preferred silence for fear of retaliation. The various experiences about numerous types of disruptive behaviours in the workplace affected the way nurses perceived the future. When asked to share their thoughts and recommendations about

ways to lessen violence in the workplace, the nurses spoke of their sincere commitment to improve relationships with their colleagues and other members of the health care team, to include patients and their significant others. The commonality of responses to this question was interpreted as a desire on the part of the nurses to be active in the solution. Finally, Ice said every nurse should focus her responses on the necessity of encouraging personal responsibility, stating, "Handling staff well and trying to lessen working short staffed so people do not feel burned out and give themselves an alibi to be concerned with self over others."

Conclusion

This study provided an avenue through which nurses could safely voice feelings and apprehensions regarding workplace violence, providing them with the opportunity to share their experiences and be listened to and understood. In the complex healthcare industry, workplace violence is accepted as a common destructive problem and a persistent occupational threat. Experienced nurses are often the perpetrators; novice nurses are most likely the victims. Administrators often ignore these disruptive behaviours in the workplace, despite a facility-wide policy designed to address the problem. A trickle-down effect was portrayed in the reports presented in which the leadership set the attitude. It can be concluded that disruptive behaviour is commonplace in healthcare workplaces and is seemingly tolerated by upper management, enforcing a debilitating work environment upon inflicted nurses. Rather than feeling safe and supported in reporting such acts, nurses endure the silence of violence permeating the healthcare workplace, thus allowing it to remain a highly problematic phenomenon that requires continued reform.

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