

Revisiting Cognitive Rehearsal as an Intervention Against Incivility and Lateral Violence in Nursing: 10 Years Later

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Objectives

- Describe the value of cognitive rehearsal as an appropriate framework to use in addressing uncivil encounters.
- Explain the effects of incivility and lateral violence on individuals, teams, and organizations.

Disclosure Statement

Neither the planners nor the authors have any conflicts of interest to disclose. Dr. Clark has disclosed authorship of the book *Creating and Sustaining Civility in Nursing Education*.

abstract

Ten years ago, Griffin wrote an article on the use of cognitive rehearsal as a shield for lateral violence. Since then, cognitive rehearsal has been used successfully in several studies as an evidence-based strategy to address uncivil and bullying behaviors in nursing. In the original study, 26 newly licensed nurses learned about lateral violence and used cognitive rehearsal techniques as an intervention for nurse-to-nurse incivility. The newly licensed nurses described using the rehearsed strategies as difficult, yet successful in reducing or eliminating incivility and lateral violence. This article updates the literature on cognitive rehearsal and reviews the use of cognitive rehearsal as an evidence-based strategy to address incivility and bullying behaviors in nursing.

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According to a recent survey conducted by the Workplace Bullying Institute (2014), 27% of Americans have suffered abusive conduct or incivility at work. Another 21% have witnessed such behaviors, and 72% are aware that workplace incivility happens. The impact of these behaviors can be devastating and lasting. For example, workplace incivility can negatively impact employee physical and mental health, job satisfaction, productivity, and commitment to the work environment

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(Clark, 2013a; Spence-Laschinger, Wong, Cummings, & Grau, 2014). Workplace incivility also creates a heavy financial burden for health care organizations. Some estimates suggest that the annual cost of lost employee productivity due to workplace incivility may be as high as \$12,000 per nurse (Lewis & Malecha, 2011). In addition, the costs of incivility escalate when the expenses associated with supervising the employee, managing the situation, consulting with attorneys, and interviewing witnesses (i.e., doctors, nurses, patients, and others impacted by the offender or who witnessed the incivility) are included (Clark, 2013a; Pearson & Porath, 2009). Clearly, incivility in the workplace is a serious problem and must be addressed—especially since incivility by health care professionals can result in serious mistakes, preventable complications, and even death (Tarkan, 2008).

One evidence-based strategy to address incivility and lateral violence is through the use of cognitive rehearsal, a behavioral technique generally consisting of three parts:

- Participating in didactic instruction about incivility and lateral violence.
- Identifying and rehearsing specific phrases to address incivility and lateral violence.
- Practicing the phrases to become adept at using them.

DEFINING INCIVILITY, BULLYING, AND WORKPLACE MOBBING

There are several terms in the nursing literature used to describe undesirable and intimidating behaviors and interactions that occur between and among nurses and other health care workers. This section provides working definitions for three of the more common examples—incivility, bullying, and workplace mobbing. Historically, many nurse scholars have housed these terms all under the rubric of horizontal (also known as lateral) violence (Roberts, Demarco, & Griffin, 2009); however, although these terms are sometimes used interchangeably, each definition is distinctive and unique.

Incivility

Clark (2013a, 2013b) defines incivility as rude or disruptive behaviors that often result in psychological or physiological distress for the people involved (including targets, offenders, bystanders, peers, stakeholders, and organizations), and if left unaddressed, these behaviors may progress into threatening situations or even result in temporary or permanent illness or injury. Typically, incivility is generally considered to be a one-on-one experience and perceived to be less threatening than bullying or mobbing behavior. Some examples of uncivil behaviors include eye-rolling, making demeaning remarks,

excluding and marginalizing others, and issuing sarcastic remarks (Clark, 2013a).

Although considered to be a lesser form of intimidation, if perpetuated in a patterned way over time, incivility can have serious detrimental effects on individuals, teams, and organizations. In health care, the results of incivility can be devastating by negatively impacting team performance and the delivery of safe patient care, ultimately putting self and others at risk. How one perceives and responds to the uncivil encounter affects the level and intensity of the impact (Clark, 2013a). The same is true for bullying.

Bullying

In her influential work on bullying in nursing, Randle (2003) citing Adams (1992), defined bullying as the “persistent, demeaning and downgrading of humans through vicious words and cruel acts that gradually undermine confidence and self-esteem” (p. 399). In essence, bullying is considered to be an ongoing, systematic pattern of behavior designed to intimidate, degrade, and humiliate another. Some examples of bullying behaviors include threatening and abusive language, constant and unreasonable criticism, deliberately undermining another person, hostile verbal attacks, and rumor spreading. Lateral violence, also referred to as horizontal violence, is a form of bullying based on the theoretical construct of oppression theory and contextualized by viewing nursing as an oppressed group (Roberts et al., 2009).

Workplace Mobbing

In 1990, Leymann described “workplace mobbing” as employees “ganging up” (p. 119) on a target employee and subjecting him or her to psychological harassment that may result in severe psychological and occupational consequences for the victim. Simply stated, workplace mobbing is a type of bullying in which more than one person commits egregious acts to control, harm, and eliminate a targeted individual. In some cases, targets of mobbing may be excellent and exceptional workers. For example, Westhues (2004) suggested that mobbing behaviors among faculty in academic workplaces may be related to the envy of excellence and jealousy associated with the achievements of others. The authors further noted that some of the most common mobbing techniques are completely nonviolent, such as words spoken or written, while delivered politely with a smile.

Incivility, bullying, and workplace mobbing exact a heavy toll on individuals, teams, and organizations by negatively impacting employee retention, recruitment, and job satisfaction (Clark, 2013a; Spence-Laschinger et al., 2014). In addition, these behaviors can have devas-

tating and lasting effects on self-worth, self-confidence, clinical judgment, and ultimately patient safety. For example, when a nurse who is giving a hand-off report uses an abrupt or antagonistic communication style with an oncoming nurse, and the oncoming nurse feels intimidated or ill-equipped to deal with this type of communication, he or she may not ask for a full patient report, which in turn may negatively impact patient care. Workplace incivility within the nursing profession is of particular concern as the nursing shortage becomes more critical and the profession is called on to lead the advancement of the nation's health. Therefore, creating and sustaining civil workplaces is an imperative for the profession.

THEORETICAL BACKGROUND: OVERVIEW OF OPPRESSION THEORY

The conceptualization of the profession of nursing as an oppressed group is and has been held by many nursing scholars (Dunn, 2003; Roberts, 1983, 1997, 2000; Roberts et al., 2009; Skillings, 1992) and is theoretically grounded in the original work on oppressed group behavior (Fanon, 1963, 1967; Freire, 1971; Memmi, 1965, 1968). In Freire's (1971) sentinel work, *Pedagogy of the Oppressed*, he described the psychological and sociological behaviors that are often manifested by those who are oppressed and as such are marginalized and controlled by others perceived to have more power. The theory contends that nurses lack power and control in their workplaces as a result of health care moving into a physician-controlled hospital setting. Thus, the theory serves to connect nurses to other oppressed groups based on their similarly predictable interrelationship behaviors related to how they treat each other. The terminology used to describe the strife and communication style within oppressed groups often has been applied to those in the nursing profession. Oppressed group behavior has a negative impact on nurses in the workplace, and the act of not speaking up (known as silencing) is one of the most frequently described oppressed group behaviors in nursing (Roberts et al., 2009).

The terms *horizontal violence* and *lateral violence* evolved from oppression theory and refer to the behaviors often seen and described as bullying type behaviors that members of the oppressed group manifest toward each other as a result of being members of a powerless group. The descriptor language of lateral and horizontal refers to the relationship each of the members has to each other and in that context it is considered as all the same and linear.

Currently, the contemporary nursing scholars who study oppressed group behaviors in nursing (Hutchison,

Vickers, Jackson, & Wilkes, 2006; Lewis, 2006; Randle, 2003; Roberts, 1983, 1996, 2000; Roberts et al., 2009), particularly as it relates to these bullying type behaviors (lateral and horizontal violence), have suggested two perspectives to be considered in conceptualizing the nursing profession in this context. The first is to understand that to solely ascribe these behaviors as willful acts of nurses alone would be incorrect. The understanding of context is essential. Thus, a more collective understanding that these behaviors can be and often are an expression of the character of the workplace and its inherent perception and treatment of the nurses is indicated. Roberts et al. (2009) sought support and understanding for the necessity to view oppressed group behavior theory, as it is described, and recognition that it does not attribute blame to flawed nurses but rather attempts to explain the negative behaviors and uncivil environments manifested by an unequal power balance in the nurses' workplace.

The quest to equilibrate the power gradient in any work environment starts with the individual, and in this case, it begins with the individual nurse who plays an important role in establishing the tenor of the workplace. Nurses most vulnerable to uncivil work environments are most often of a particular cohort, such as new to nursing practice, new to a particular area of practice, transitioning to a new health care environment, and floating and per diem nurses (Griffin, 2014). Therefore, establishing respectful, professional communication in health care environments leads to better outcomes for patients and more civil, collegial nurses (Clark, 2013a; Simons & Mawn, 2010).

As a result, all nurses, especially those most vulnerable to incivility, must be equipped to effectively address uncivil behaviors as they occur. The simple act of speaking up is often an effective intervention. Through the use of cognitive rehearsal, nurses can learn rehearsed phrases designed to confront and stop bullying behaviors. The rehearsed and learned retort is matched in some fashion to the offense that has occurred. Griffin (2004) found that by rehearsing a preprogrammed retort to a colleague's uncivil affront or an individual uncomfortable situation, the level of both personal comfort and confidence in a cohort of new to practice nurses was raised. Smith (2011) also found the use of scripted language within many health care settings led to greater patient satisfaction because it allows nurses to use words and phrases already understood to express a specific meaning or to ask for additional information.

COGNITIVE REHEARSAL

In 2004, Griffin published the findings of her groundbreaking exploratory descriptive study using cognitive rehearsal as a tool against lateral violence for a cohort of

26 newly licensed nurses. During general orientation to the hospital, the newly licensed nurses learned the history and construction of lateral violence and its impact on patient care and nursing practice. Participants were given interactive instruction on cognitive rehearsal and practiced appropriate responses to frequent forms of lateral violence. The newly licensed nurses also received laminated cards that summarized accepted behavioral expectations for professionals and appropriate responses to the 10 most frequent forms of lateral violence. At the end of the 1-year study, 96.1% of newly licensed nurses stated that they had witnessed lateral violence on the units, and 46% reported being direct victims of lateral violence. Most important, the newly licensed nurses who used cognitive rehearsal to address lateral violence resulted in a complete stoppage of behaviors against newly licensed nurses.

Griffin (2004) concluded that the use of cognitive rehearsal as a tool for practicing intervention strategies in a safe and nonthreatening environment can be highly effective in preparing newly licensed nurses to address uncivil behaviors in the workplace. For example, a newly licensed nurse involved in the study was scheduled to work the evening shift during her first week of orientation and was somewhat unfamiliar with the unit and patient population. The nurse reported anecdotally:

I had four patients in three different rooms, but fortunately, they had the same attending physician so I felt pretty confident with my ability to provide quality care. However, just as the shift was beginning, the charge nurse changed my assignment and reassigned two patients with two different attending physicians. I had received only a minimal report, and when I got one of the patients up in a chair upon his [the patient's] request, the attending physician entered the room and screamed "everybody knows I need my patients in bed so I can complete my exam." Because of my CR [cognitive rehearsal] class, I responded "the individuals I learn the most from are clearer in their directions and feedback. Is there some way we can structure this type of learning?" It sounded contrite but it came out maybe not exactly as it was on my card, but it got out!

The use of cognitive rehearsal as an intervention strategy has been replicated in subsequent studies and found to be an effective way to prepare nurses to identify and address incidents of lateral violence (Embree, Bruner, & White, 2013; Stagg, Sheridan, Jones, & Speroni, 2011, 2013). In Embree et al. (2013), nurses employed in non-patient care roles, such as nursing leadership, physicians' offices, and hospital staff, received didactic content about lateral violence and cognitive rehearsal, and were provided laminated cue cards containing appropriate responses to common forms of lateral violence.

Although there was no statistically significant difference between pre- and postsurvey data, trends indicated a positive sense of empowerment and self-esteem; this was further supported by anecdotal data.

In their pilot study, Stagg et al. (2011) used a similar cognitive rehearsal method and reported a significant increase in nurses' knowledge of workplace bullying management, nurses' likelihood to report bullying behaviors, and nurses' preparedness to handle workplace bullying. In 2013, Stagg et al. replicated the study and found that among study participants, 50% witnessed bullying behaviors, 70% changed their own behaviors, and 40% reported a decrease in bullying behaviors. However, only 16% actually responded to bullying at the time the bullying occurred, which indicated the need to prevent and manage workplace bullying more effectively.

Smith (2011) also used scripts and role-playing for cognitive rehearsal and found that the technique can prepare staff and students to improve communication in critical encounters, especially when interpersonal conflict existed. In a two-part study conducted by Clark, Ahten, and Macy (2013, 2014), the researchers used live actors to simulate an uncivil nurse-to-nurse encounter using a problem-based learning (PBL) scenario in an academic setting. Nursing students enrolled in a senior leadership course participated in the first part of the study, which included preparatory readings and a 1-hour faculty-led didactic session on the topic of workplace incivility and the use of cognitive rehearsal as a strategy to counter incivility and bullying in the health care practice setting. The students observed the scenario, provided written feedback on its effectiveness, and participated in small group discussions to debrief the scenarios. This approach provided the students with effective strategies to manage conflicts in similar situations they may encounter as new nurses in the practice setting.

In a 10-month follow-up study, the students, now newly licensed, were asked to describe how they transferred the PBL knowledge presented in the classroom setting to their nursing practice; how their behavior had changed since participating in the PBL scenario; and what barriers and benefits they experienced to using the PBL scenario knowledge in the practice setting. The participants reported that the classroom-centered PBL scenario was an effective teaching strategy for preparing them to recognize and address nurse-to-nurse incivility in the workplace. Their comments mirrored Griffin's (2004) finding that having knowledge of incivility and bullying and using cognitive rehearsal for countering uncivil behaviors can empower nurses to confront instigators and episodes of incivility. Despite gaps in the

TABLE 1
COMMITMENT TO MY COWORKERS

As your coworker and with our shared organizational goal of excellent service to [our patients] and customers, I commit the following:

I will accept responsibility for establishing and maintaining healthy interpersonal relationships with you and every other member of this team.

I will talk to you promptly if I am having a problem with you. The only time I will discuss it with another person is when I need advice or help in deciding how to communicate with you appropriately.

I will establish and maintain a relationship of functional trust with you and every other member of this team. My relationship with each of you will be equally respectful, regardless of job titles or levels of educational preparation.

I will not engage in bickering, back-biting, and blaming (3Bs). I will practice caring, committing, and collaboration (3Cs) in my relationship with you and ask that you do the same with me.

I will not complain about another team member and ask you not to as well. If I hear you doing so, I will ask you to talk to that person.

I will accept you as you are today, forgiving past problems and ask you to do the same with me.

I will be committed to finding solutions to problems rather than complaining about them or blaming someone for them, and ask you to do the same.

I will affirm your contribution to the quality of our service.

I will remember that neither of us is perfect, and that human errors are opportunities not for shame or guilt, but for forgiveness and growth.

From "Commitment to My Co-Workers," by M. Manthey, 1988. Copyright 1988, 2014, by Creative Health Care Management (<http://www.chcm.com>). Reprinted with permission.

literature, cognitive rehearsal has been identified as a best practice to prevent and manage workplace bullying among staff nurses (Stagg & Sheridan, 2010).

PRIMARY PREVENTION AS A FRAMEWORK

Incivility is detrimental in any work setting, and organizations must take deliberate steps to prevent and eradicate the problem. Putting measures in place to prevent or preempt the problem of civility is recommended. To do this, leaders must openly and boldly address the problem of incivility and bullying; they must call it by name and encourage shared responsibility to effectively address the problem. The end goal is to create and sustain a safe, healthy, and thriving work environment where the organizational vision, mission, and values are shared, lived, and embedded in civility and respect (Clark, 2013a).

To begin, health care organizations must ensure that their foundational documents (i.e., vision, mission, philosophy, and shared values) are closely aligned with the concepts of civility and respect, and that the spirit and intent of these foundational documents are shared and embraced by employees throughout the organization. Next, making a commitment to coworkers to foster a healthy work environment can go a long way in fostering civility, especially when the commitment is focused on patient safety and quality patient care (Table 1).

After a commitment has been made, it is important to co-create and establish behavioral norms of decorum

that are essential to successful team functioning, quality patient care, and a safe work environment. Behavioral norms form the foundation for effective team functioning and stem from the organization's vision, mission, philosophy, and statement of shared values. Without functional norms, desired behavior is ill-defined, and thus, team members are left to make things up as they go along.

Unfortunately, there are times when prevention measures are unsuccessful. In such instances, intervention methods must be relied on to effectively address incivility and bullying behaviors. Cognitive rehearsal can be an effective intervention against incivility and bullying behaviors.

COGNITIVE REHEARSAL AS AN INTERVENTION

It is imperative to understand the nature of workplace incivility and lateral violence to prevent and effectively address the problem. Being treated in an uncivil manner changes an individual's natural neurobiological state, and the impact of this can be felt instantly. Some individuals flush, sweat, get angry or tear-up, or worse, they become silent. Griffin (2014) noted that some individuals ruminate internally about the exchange and wish later they had addressed the offender. These reactions call for an intervention because the longer the clock ticks after an uncivil assault, the less of an impact confrontation may have (Randall, 2003). Cognitive rehearsal is an evidence-

TABLE 2
COMMON UNCIVIL BEHAVIORS AMONG NURSES WITH ASSOCIATED COGNITIVE REHEARSAL RESPONSES^a

Uncivil Behavior	Verbal Response
Using nonverbal behaviors or innuendo (e.g., eye-rolling, making faces, deep sighing)	"I sense/see from your facial expression that there may be something you wish to say to me. It is OK to speak to me directly."
Name-calling, verbal affronts, demeaning comments, putdowns, sarcastic remarks	"I learn best from individuals who address me with respect and who value me as a member of the team. Is there a way we can structure this type of interaction?"
Using silent treatment or withholding important information	"It is my understanding that there was/is more information available regarding this situation. Please share any other important information since patient care depends on a full report."
Using anger, humiliation, and intimidation	"When the words that I hear make me fearful or shamed, I need to seek a respectful professional explanation. What was your intent?"
Spreading rumors, gossiping, failing to support, sabotaging a co-worker, or sharing information you were asked to keep private	"I don't feel right talking about him/her/situation when I wasn't there and don't know the facts. Perhaps the information was taken out of context. I suggest you check it out with him/her."
Making fun of another nurse's appearance, demeanor, or personality trait	"She/he is a valuable member of the team and deserves our support. How can we be more inclusive and work more efficiently as a team?"
Failing to support or encouraging others to turn against a coworker	"I am not feeling like a valued coworker. Can we approach this differently? What helped you to fit in here?"
Taking credit for others' work, ideas, or contributions	"I didn't expect your nonsupport. Behaving this way is unprofessional and makes me feel disrespected. How can we work together and support one another?"
Distracting and disrupting others during meetings	"Can I speak with you about your sense of urgency in our meetings? It distracts me and interrupts my thoughts."

^a Excerpts from Clark, 2013b; Dellasega, 2009; and Griffin, 2004.

based strategy to effectively communicate and deliver a message to uncivil or laterally violent colleagues that it is not okay for them to behave in an uncivil manner.

Addressing the uncivil encounter when it happens may have the greatest success in stopping the behavior. Randall (2003) noted that confronting bullies grabs their attention; however, many targets may lack the skill set or assertiveness to confront a bully and may need to learn to do so. Most individuals can recall a time or multiple times when they wish they had spoken up to someone or at the very least said, "I wish that I had the exact right words to say in that situation." Typically, these situations occur during times of stress when a creative or effective response is momentarily unavailable. According to Randall, the strategy for addressing the uncivil behavior should occur "in private, [with] no witnesses, and when the bully is unprepared" (p. 136).

Cognitive rehearsal is a technique often used in behavioral health for impulse control disorders that calls for the memorization (learned, although not necessarily "rote verbatim" memorization) of a thought or an expression designed to help an individual "stop an impulse," "cue a certain behavior," or "express a desire to

others" (Glod, 2008, pp. 58-59; Smith, 2011). The use of cognitive rehearsal in social situations has been proven to be an effective way for some individuals to control their environment.

For nurses, cognitive rehearsal is an effective intervention for addressing incivility and workplace bullying (Griffin, 2004). The cognitive rehearsal process typically consists of three parts:

- Participating in didactic instruction.
- Learning and rehearsing specific phrases to use during uncivil encounters.
- Participating in practice sessions to reinforce instruction and rehearsal.

Cognitive rehearsal can take on various forms. For example, the TeamSTEPPS approach (Agency for Healthcare Research and Quality, 2014) is a communication system designed for health care professionals and provides a powerful evidence-based framework to improve patient safety within health care organizations. This approach helps to improve communication and teamwork among health care professionals. CUS, an acronym for Concerned, Uncomfortable, and Safety, is one specific communication structure provided by TeamSTEPPS to

assist with conflict negotiation. When a health care professional uses CUS, it issues an alert that a patient safety problem has been identified. For example, a CUS framework may be used in the following way: “I am Concerned about Mr. Jones. I am Uncomfortable with his recent activity. I think we may have missed something, and I am worried about his Safety.”

A similar response may be used in the case of incivility. For example, if a nurse encounters an uncivil experience, he or she may respond in the following way: “I am Concerned about the tone of this interaction. I am Uncomfortable and beginning to feel stressed. I’m worried that my discomfort and stress may impact the Safety of our patients. Please address me in a respectful way.” **Table 2** lists some common uncivil behaviors among nurses and associated cognitive rehearsal responses.

DISCUSSION

Many of the articles reviewed for this retrospective article were a synthesis of three decades of research concerning incivility in nursing. It is evident that when nursing environments harbor uncivil or bullying behaviors, patients are put at risk, and nursing as a profession is disparaged and maligned. Although prevention is clearly the best approach toward minimizing or eliminating incivility in the nursing workplace, cognitive rehearsal is a valuable tool for effective conflict negotiation and a positive step toward resolving disagreements.

In her original work, situated in the context of oppression theory, Griffin (2004) raised awareness about the negative consequences of workplace incivility and lateral violence in nursing and concluded that cognitive rehearsal is an effective behavioral technique to address the problem. Since then, several researchers have used cognitive rehearsal in a variety of workplace and academic settings (Clark et al., 2014; Embree et al., 2013; Stagg et al., 2011, 2013) and found the use of cognitive rehearsal to be an effective intervention in addressing incivility and lateral violence. In some cases, the use of cognitive rehearsal resulted in a heightened sense of nurse empowerment and self-esteem, an increased awareness in nurses’ knowledge of workplace bullying and ability to address the offender (Stagg et al., 2011), and improved communication (Smith, 2011), and helped prepare new graduate nurses to effectively address incivility (Clark et al., 2014).

The essence of cognitive rehearsal as an intervention is rehearsing and practicing ways to deal with a situation between two individuals when incivility occurs. This is important because in addition to descriptive studies exploring incivility and bullying in nursing, nurses now are equipped with an evidence-based strategy to address some of the specific uncivil behaviors.

key points

Revisiting Incivility in Nursing

Griffin, M., Clark, C.M. (2014). **Revisiting Cognitive Rehearsal as an Intervention Against Incivility and Lateral Violence in Nursing: 10 Years Later.** *The Journal of Continuing Education in Nursing*, 45(12), 535-542.

- 1 This article scaffolds working definitions for three of the more common examples of undesirable behaviors and interactions that occur between and among nurses and other health care workers: incivility, bullying, and workplace mobbing.
- 2 A historical and updated review of the literature on the use of cognitive rehearsal as an effective, evidence-based intervention is provided.
- 3 Common language for addressing uncivil encounters is provided to empower nurses to effect change by focusing on the unifying and essential need to deliver safe, quality patient care.

How individual nurses treat each other and what a nursing practice environment looks and feels like is predicated on what behaviors are fostered by the nurses themselves. Continued research on the impact of incivility in different domains in nursing practice as well as in the academic environment produces and informs the profession. Therefore, the continuation of intervention studies using cognitive rehearsal is recommended. For example, one of the authors (C.M.C.) and her research partners will be conducting an intervention study using a laboratory-simulated experience to explore how emotional stress caused by an uncivil nurse-to-nurse encounter impacts a nurse’s work performance and patient safety. The researchers will measure the effects of stress on the participant (nurse) using biomarkers found in saliva, heart rate, blood pressure readings, and self-assessment scales to determine whether the prepared cognitive rehearsal response was effective in countering the stress effects of the uncivil encounter and was effective to the extent that work performance and patient safety were unaffected.

CONCLUSION

Cognitive rehearsal was revisited as a shield for incivility and lateral violence, and the use of cognitive rehearsal as a strategy for addressing incivility and bullying behaviors in nursing continues to be a valuable tool. Being well-prepared, speaking with confidence, and using respectful expressions to address incivility can empower nurses to break the silence of incivility and oppression.

The intent of the original study was to improve nurse communication in health care settings and to ensure a safer environment for patients.

REFERENCES

- Adams, A. (1992). *Bullying at work—How to confront and overcome it*. London, England: Virago Press.
- Agency for Healthcare Research and Quality. (2014). *TeamSTEPPS: National implementation*. Retrieved from <http://teamstepps.ahrq.gov>
- Clark, C.M. (2013a). *Creating and sustaining civility in nursing education*. Indianapolis, IN: Sigma Theta Tau International.
- Clark, C.M. (2013b). National study on faculty-to-faculty incivility: Strategies to foster collegiality and civility. *Nurse Educator*, 38, 98-102. doi:10.1097/NNE.0b013e31828dc1b2
- Clark, C.M., Ahten, S.M., & Macy, R. (2013). Using problem-based learning scenarios to prepare nursing students to address incivility. *Clinical Simulation in Nursing*, 9, e75-e83. doi:10.1016/j.ecns.2011.10.003
- Clark, C.M., Ahten, S.M., & Macy, R. (2014). Nursing graduates' ability to address incivility: Kirkpatrick's level-3 evaluation. *Clinical Simulation in Nursing*, 10, 425-431.
- Dellasega, C.A. (2009). Bullying among nurses. *American Journal of Nursing*, 109, 52-58.
- Dunn, H. (2003). Horizontal violence among nurses in the operating room. *Association of Operating Room Nurses Journal*, 78, 977-988.
- Embree, J.L., Bruner, D.A., & White, A. (2013). Raising the level of awareness of nurse-to-nurse lateral violence in a critical access hospital. *Nursing Research and Practice*, 2013, 1-7. doi:10.1155/2013/207306
- Fanon, F. (1963). *The wretched of the earth*. New York, NY: Grove Press.
- Fanon, F. (1967). *Black skin, white masks*. New York, NY: Grove Press.
- Freire, P. (1971). *Pedagogy of the oppressed*. Harmondsworth, England: Penguin.
- Glod, C.A. (1998). *Contemporary psychiatric-mental health nursing: The brain behavior connection*. Philadelphia, PA: F.A. Davis.
- Griffin, M. (2004). Teaching cognitive rehearsal as a shield for lateral violence: An intervention for newly licensed nurses. *The Journal of Continuing Education in Nursing*, 35, 257-263.
- Griffin, M. (2014). *A modicum of lateral violence education leads to nurse self-accountability*. Manuscript submitted for publication.
- Hutchinson, M., Vickers, M., Jackson, D., & Wilkes, L. (2006). Workplace bullying in nursing: Towards a more critical organisational perspective. *Nursing Inquiry*, 13, 118-126.
- Lewis, M. (2006). Nurse bullying: Organizational considerations in the maintenance and perpetration of health care bullying cultures. *Journal of Nursing Management*, 14, 52-58.
- Lewis, P.S., & Malecha, A. (2011). The impact of workplace incivility on the work environment, manager skill, and productivity. *The Journal of Nursing Administration*, 41, 41-47. doi:10.1097/NNA.0b013e3182002a4c
- Leymann, H. (1990). Mobbing and psychological terror at workplaces. *Violence and Victims*, 5, 119-126.
- Manthey, M. (1988). *Commitment to my co-workers*. Minneapolis, MN: Creative Health Care Management.
- Memmi, A. (1965). *The colonizer and the colonized*. Boston, MA: Beacon Press.
- Memmi, A. (1968). *Dominated man: Notes towards a portrait*. New York, NY: Prentice Hall.
- Pearson, C., & Porath, C. (2009). *The cost of bad behavior: How incivility is damaging your business and what to do about it*. New York, NY: Penguin.
- Randall, P. (2003). *Adult bullying: Perpetrators and victims*. New York, NY: Brunner-Routledge.
- Randle, J. (2003). Bullying in the nursing profession. *Journal of Advanced Nursing*, 43, 395-401.
- Roberts, S.J. (1983). Oppressed group behavior: Implications for nursing. *Advances in Nursing Science*, 5(4), 21-30.
- Roberts, S.J. (1996). Breaking the cycle of oppression: Lessons for nurse practitioners? *Journal of the American Academy of Nurse Practitioners*, 8, 209-214.
- Roberts, S.J. (1997). Nurse executives in the 1990s: Empowered or oppressed? *Nursing Administration Quarterly*, 22, 64-71.
- Roberts, S.J. (2000). Development of a positive professional identity: Liberating oneself from the oppressor within. *Advances in Nursing Science*, 22(4), 71-82.
- Roberts, S.J., Demarco, R., & Griffin, M. (2009). The effect of oppressed group behaviours on the culture of the nursing workplace: A review of the evidence and interventions for change. *Journal of Nursing Management*, 17, 288-293.
- Simons, S.R., & Mawn, B. (2010). Bullying in the workplace—A qualitative study of newly licensed registered nurses. *AAOHN Journal*, 58, 305-311.
- Skilling, L. (1992). Perceptions and feelings of nurses about horizontal violence as an expression of oppressed group behavior. *NLN Publications*, 14-2504, 167-185.
- Smith, C.M. (2011). Scripts: A tool for cognitive rehearsal. *The Journal of Continuing Education in Nursing*, 42, 535-536. doi:10.3928/00220124-20111118-03
- Spence-Laschinger, H.K., Wong, C.A., Cummings, G.G., & Grau, A.L. (2014). Resonant leadership and workplace empowerment: The value of positive organizational cultures in reducing workplace incivility. *Nursing Economics*, 32(1), 5-15, 44.
- Stagg, S.J., & Sheridan, D. (2010). Effectiveness of bullying and violence prevention programs: A systematic review. *AAOHN Journal*, 58, 419-424. doi:10.3928/08910162-20100916-02
- Stagg, S.J., Sheridan, D., Jones, R.A., & Speroni, K.G. (2011). Evaluation of a workplace bullying cognitive rehearsal program in a hospital setting. *The Journal of Continuing Education in Nursing*, 42, 395-401. doi:10.3928/00220124-20110823-45
- Stagg, S.J., Sheridan, D.J., Jones, R.A., & Speroni, K.G. (2013). Workplace bullying: The effectiveness of a workplace program. *Workplace Health & Safety*, 61, 333-338. doi:10.3928/21650799-20130716-03
- Tarkan, L. (2008, December 1). Arrogant, abusive and disruptive—And a doctor. *The New York Times*. Retrieved from <http://www.nytimes.com/2008/12/02/health/02rage.html>
- Westhues, K. (2004). *The envy of excellence: Administrative mobbing of high-achieving professors*. Lewiston, NY: Edwin Mellen Press.
- Workplace Bullying Institute. (2014). *2014 WBI U.S. workplace bullying survey*. Retrieved from <http://workplacebullying.org/multi/pdf/WBI-2014-US-Survey.pdf>

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