UNIVERSIDAD DE MURCIA

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TESIS DOCTORAL

Workplace violence, burnout and health of nursing professionals in Hospital Setting

Violencia laboral, burnout y salud de los profesionales de enfermería en el ámbito hospitalario

D. Maria João Vidal Alves

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UNIVERSIDAD DE MURCIA

DECLARACIÓN DE AUTORÍA Y ORIGINALIDAD DE LA TESIS PRESENTADA EN MODALIDAD DE COMPENDIO O ARTÍCULOS PARA OBTENER EL TÍTULO DE DOCTOR

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Violencia laboral, burnout y salud de los profesionales de enfermería en el ámbito hospitalario

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Índex

RESUMEN

La violencia es una amenaza para el bienestar en general y es reconocido internacionalmente que debe ser erradicada como cualquier otra enfermedad, especialmente por su potencial disruptivo al nivel individual, de las organizaciones y de las comunidades. La definición más ampliamente utilizada remite para el uso (o la amenaza) de violencia o ejercicio de poder, de forma intencional, contra alguien o un grupo de personas, y que causa daño en la persona o personas víctimas.

La violencia en el mundo del trabajo es ampliamente designada como violencia laboral y suele ser multifactorial. Se encuadra en la violencia comunitaria y puede ocurrir entre personas no relacionadas entre sí (un robo violento en una organización o centro) (tipo 1), entre usuarios y trabajadores de una organización que interactúan, como ocurre en la atención al cliente (por ejemplo, servicio de seguridad, proveedores de salud) (tipo 2), y entre compañeros de trabajo de rangos similares o superiores, con una relación directa (tipo 3). Todos esos tipos de violencia debilitan los sistemas de salud por su impacto sobre los profesionales, perjudicando la atención de los usuarios de servicios de salud. El personal de enfermería está, segundo los estudios especializados, particularmente expuesto a violencia laboral por su carácter de contacto directo, de prestar cuidados a personas en estado de vulnerabilidad y bajo grande presión y exigencia. Como el fenómeno ocurre exactamente y cuales los puntos clave en que intervenir es lo que falta conocer.

Las organizaciones internacionales subrayan la necesidad de gestión de los factores de riesgo, de clarificación de los mecanismos de funcionamiento y consecuencias, así

como la promoción de ambientes de trabajo saludables. Sin embargo, los mecanismos del impacto de la violencia, dependiendo del tipo de violencia ejercida, sus formas y las personas objetivo, no están claros. Este trabajo de investigación tiene por objetivo caracterizar el fenómeno de violencia lateral en uno de los grupos profesionales más impactados (enfermería), la dimensión de impacto dependiendo de la exposición, características individuales, y los trayectos de este impacto según los diferentes tipos de exposición. El enfoque de este trabajo es en los tres tipos de violencia lateral, de tipo personal, laboral y social, y en la tercera parte del trabajo se examina la violencia de usuarios de tipo físico y no físico, delante de las variables de estudio concernientes a salud, *burnout* y satisfacción laboral.

Los resultados revelan una exposición muy elevada de los profesionales de enfermería a la violencia ejercida por compañeros de trabajo, especialmente del tipo personal, como sean los rumores o ataques personales. Estos datos corroboran el fenómeno descrito en la literatura como hostilidad y falta de apoyo, siendo común contra los enfermeros varones, y contra los menos experimentados, pero no necesariamente los más jóvenes. De hecho, las enfermeras con más de 50 años de edad perciben mucho menos violencia lateral, de los tres tipos. En violencia lateral, como en otros tipos de violencia, más que la asimetría de poder, es la percepción de poder que permite que la violencia ocurra y sea perpetuada.

Sin embargo, se ha verificado que hay factores de riesgo que aumentan la probabilidad de violencia lateral como, por ejemplo, trabajar por turnos, o ejercer su trabajo en departamentos de mayor riesgo como el de urgencias o de consultas externas.

El impacto negativo es observable en la satisfacción con el trabajo, tanto por falta de motivación interna, como percepción de ser valorado en su trabajo. La salud física y

psicológica son impactadas por la violencia lateral, con incidencia de síntomas de ansiedad y depresión presentes, y es una fuerte predictora de burnout.

El análisis de conglomerados encontró una satisfacción laboral significativamente menor y un impacto mucho más severo en la salud en caso de una mayor exposición a la violencia lateral. Se destacan las víctimas mujeres, más jóvenes, y con menos experiencia. El grupo 1 evidencia una baja exposición a los tres tipos de violencia lateral. Se trata de un perfil con satisfacción moderada-alta, una variación leve de la salud mental (subclínica) y una alteración moderada-alta de las variables relacionadas con el burnout. Los efectos de experimentar violencia lateral pueden ser mitigados mediante apoyo social y la resiliencia individual. Por otro lado, el segundo perfil, el grupo 2, que comprende individuos con una exposición mucho más elevada a los tres tipos de violencia lateral, muestra una satisfacción laboral mucho menor. De hecho, este perfil exhibe un impacto más severo en la salud (aún a nivel subclínico) y una puntuación más alta, particularmente, en los ítems relacionados con el agotamiento emocional.

La comparación de estos perfiles permite observar que todas las variables tuvieron magnitudes de efecto relevantes, excepto la eficacia profesional. El mayor efecto se observó en el agotamiento emocional y la disfunción social, seguido del cinismo, la ansiedad y el insomnio. Curiosamente, a pesar de que el grupo 2 presenta puntuaciones más altas que el grupo 1, la única variable que muestra una variación de gravedad definida es el agotamiento emocional.

Se sabe que el estrés toxico motiva la disrupción del equilibrio homeostático por agotar los recursos normales del sistema nervioso y produce daños a medio y largo plazo a diversos niveles. Los niveles de estrés soportados por víctimas de violencia lateral,

repetida y por tiempo prolongado, suele ser un estrés toxico. Los impactos en la salud fueron analizados en este trabajo de investigación con recurso a la creación de modelos de ecuaciones estructurales.

Este impacto es sufrido por tenerse, a veces de forma continuada, una valoración negativa de su trabajo, de sus competencias y todo lo relacionado con él, desde el salario, los turnos, los horarios de trabajo o la carga de trabajo. Nuestros resultados sugieren que las enfermeras y enfermeros que perciben violencia de sus compañeros, se sienten más agotadas emocionalmente y desarrollan más sintomatología ansiosa-depresiva y somática, pero responden internalizándose, autodesensibilizándose o cayendo en el letargo (cinismo), lo que afecta sus habilidades de interacción social (disfunción social).

El papel mediador de la resiliencia frente a la violencia laboral sugiere lo siguiente: cuanto más resilientes son las víctimas, más soportan, a menudo enmascarando importantes signos de alerta, que constituyen los ingredientes básicos para el agotamiento. Pero es admisible anticipar que los profesionales que perciben violencia durante sus horas de trabajo por parte de sus compañeros de trabajo, y que exhiben sentimientos de desapego y agotamiento, además de dudar de sus capacidades y admitir consecuencias para su salud, rara vez se sentirán felices en su lugar de trabajo. Nuestros resultados demuestran que esa experiencia de violencia repetida y prolongada por parte compañeros de trabajo es un fuerte predictor de burnout. Se destaca el agotamiento emocional como el efecto destructivo más prevalente y con el potencial de mediar trastornos de ansiedad, depresivos y de somatización altamente incapacitantes. Se observó, al mismo tiempo, que la violencia, sea de tipo personal, social o laboral, impacta negativamente la satisfacción con el trabajo en las personas afectadas.

En general, nuestros hallazgos apoyan que los enfermeros y enfermeras que sufren violencia lateral tienden a experimentar menor satisfacción intrínseca, lo que implica una falta de respuesta a la necesidad del trabajador de tener sensaciones positivas, motivadoras y lograr su realización personal. Tal como lo vemos, la baja satisfacción intrínseca implica una percepción por parte de los profesionales de una baja atribución de responsabilidad, de pocas o ninguna oportunidad de toma de decisiones, y de tener sus habilidades ignoradas o subdesarrolladas. Por otro lado, la satisfacción extrínseca, entendida con respecto a las variables organizacionales, también se ve afectada por la violencia lateral.

El objetivo de calcular los modelos fue buscar, utilizando la violencia laboral como predictor de la sintomatología y las variables de burnout como mediadores, una explicación más amplia. Se obtuvieron coeficientes de regresión con y sin modelo de mediación, estimaciones directas y estandarizadas y se utilizó el análisis *bootstrap* para calcular los efectos directos de la mediación. Nuestros resultados apoyan el modelo hipotético que la exposición a violencia lateral lleva a que las enfermeras terminen percibiendo una salud mucho peor cuando está mediada por el burnout, especialmente por el agotamiento emocional. Esto agrega evidencia a los hallazgos que relacionan más violencia lateral con más burnout, sin ignorar el impacto directo de la violencia en la salud, tanto física como mental.

Junto con las fuertes correlaciones positivas observadas entre los tres subtipos de violencia lateral y los dos subtipos de violencia del usuario y la disminución de la calidad de los indicadores de salud, subrayamos la importancia del tiempo durante el cual se soporta esta violencia. Tales hallazgos invitan a la reflexión sobre el agotamiento, como

una respuesta de estrés psicológico a condiciones de trabajo exigentes, que surge gradualmente, generalmente empezando con síntomas de agotamiento emocional, y una sensación de vacío como resultado de altos niveles de estrés tóxico. El agotamiento emocional es una característica central del burnout y, en nuestros resultados, se encuentra en el origen de resultados especialmente adversos de los subtipos de violencia de usuario y lateral de naturaleza más sutil o refinada: violencia de usuarios no física y violencia lateral personal, respectivamente.

Las percepciones de las enfermeras sobre la violencia de los usuarios pueden ser abrumadores y explicar los niveles tóxicos de estrés relacionados con el trato con pacientes o familiares violentos, que establecen las bases para una mala salud mental y física. Los modelos probados que se centran en los diferentes subtipos de violencia muestran fuertes relaciones entre la violencia percibida por parte de los usuarios y la salud, especialmente con el papel mediador del agotamiento emocional. Particularmente, en el tipo de violencia no física, con la despersonalización y el agotamiento emocional como mediadores, nuestro modelo sugiere efectos indirectos de la violencia verbal de usuarios (no física) en la salud general a través del burnout, debido al efecto acumulativo del estrés, que se suma a otros estudios.

Desde comentarios despreciativos hasta amenazas a la vida, las enfermeras y enfermeros enfrentan agresiones diarias no físicas que concurren con síntomas somáticos, ansiedad, disfunción social y depresión. Esto es peor si no son apoyadas o motivadas. El modelo pone la violencia física por parte de los usuarios como un fuerte predictor de agotamiento emocional y despersonalización, enfatizando la necesidad de prevenirla, ya

que es una vía conocida hacia el burnout a pesar de su impacto en la salud general a un nivel menos significativo.

Nuestros modelos explicativos de la violencia lateral también subrayan que el tipo personal tiene un efecto negativo directo en la salud de las víctimas, independientemente de los mediadores. Pero la despersonalización y particularmente el agotamiento emocional, predicen los resultados de mala salud independientemente de la vía directa entre percibir los ataques personales de compañeros y los problemas de salud. Así que, se pude decir que, recibir comentarios personales de hostilidad verbal, comúnmente presente en la literatura descritos como incivilidad, se ha relacionado con altos niveles de burnout. Pero, de manera más expresiva, el modelo demuestra el papel mediador de estos ataques sociales a la salud de las enfermeras y enfermeros, además del impacto directo del violencia lateral de tipo social en la salud, referido consistentemente como exclusión social, tratamiento del silencio, hablar en la parte posterior y derogación personal.

Nuestro modelo de violencia lateral relacionado con el trabajo agrega evidencia a su relación directa con la salud y el papel modulador altamente significativo del agotamiento emocional. La sensibilización de los profesionales es fundamental y la evidencia enfatiza que las víctimas a menudo desconocen la naturaleza abusiva de estos comportamientos. Al mismo tiempo, es posible que los perpetradores ignoren el impacto potencialmente destructivo de sus acciones o siquiera que esas acciones constituyan un acto violento, hasta que sea demasiado tarde.

Por fin, los resultados no apoyan que la violencia de compañeros de trabajo sea más impactante, duradera y, en general, perjudicial para las víctimas que la violencia por parte

de usuarios o familiares (externa). De hecho, el modelo explicativo no representa mayores efectos de la violencia lateral directamente en la salud o a través del burnout.

Las conclusiones del presente estudio podrán establecer una contribución importante a los programas de prevención e intervención que promuevan el conocimiento y el desarrollo de estrategias sobre el tema de la violencia lateral entre profesionales, organizaciones y la comunidad, con el fin de optimizar la salud ocupacional en una de las áreas profesionales más desafiantes y fundamentales a la sociedad.

Palabras clave: violencia lateral, violencia usuarios, violencia laboral, urgencias, violencia sanitaria.

ABSTRACT

Violence threatens well-being in general and is internationally reckoned as a hazard to be eradicated like any other disease for being disruptive to workers, organizations, and communities. In the healthcare context, specifically, it undermines the very foundations of health systems and impacts critically workers and patient care. Yet, the mechanisms through which this impact occurs, depending on the types of violence, its targets, and its shapes, are still unclear.

The current thesis aims to characterize lateral violence in the most impacted health professional group, nurses, the impacts observed depending on exposure and personal features, and the pathways of such an impact considering different types of exposure and types of violence.

Results point to a high exposure of nurses to violence from coworkers, especially of the personal type, such as gossiping and person-directed attacks, confirming the phenomenon depicted in literature as part of the sink or swim paradigm in nursing, being common in against male nurses, and those less experienced. A negative impact is found on psychological and physical health, and cluster analysis found significantly lower intrinsic job satisfaction and a more severe impact on health among those with greater exposure to lateral violence. Our results further support that reiterated and prolonged experiences of both user and coworker violence are strong predictors of burnout, with emotional exhaustion rising as the most prevalent deleterious outcome, and with a mediating role to highly impairing anxious, depressive, or somatization disorders.

Hopefully, such conclusions pose the theoretical backbone of intervention and prevention programs that raise awareness and protect professionals, towards the improvement of occupational health in one of the most crucial and challenging settings.

Keywords: lateral violence, user violence, workplace violence, hospital, health violence

RESUMO

A violência é uma ameaça ao bem-estar em geral e é por isso internacionalmente reconhecido que deve ser erradicada tal como qualquer outra doença, pelo seu potencial disruptivo para pessoas, organizações e comunidades. No contexto da saúde em específico, a violência mina a pela base os sistemas de saúde e tem um impacto enorme nos profissionais e no cuidado aos pacientes e utilizadores dos cuidados de saúde. Contudo, os mecanismos de ação deste impacto, em função do tipo de violência exercidos, das suas formas e das pessoas-alvo, não são claros. O presente trabalho visa caracterizar o fenómeno da violência lateral num dos grupos profissionais mais afetados (enfermagem), os impactos observados em função da exposição e das características individuais, e as trajetórias deste impacto considerando os diferentes tipos de exposição e de violência.

Os resultados apontam para uma elevadíssima exposição de enfermeiros e enfermeiras à violência exercida por colegas de trabalho, especialmente do tipo pessoal, como sejam os rumores ou ataques pessoais. Estes dados confirmam o fenómeno que vem sendo descrito na literatura como parte do paradigma "sink or swim" (afundar ou nadar) na enfermagem, sendo comum contra enfermeiros do sexo masculino, e contra aqueles com menos experiência.

O impacto negativo é observável na saúde física e psicológica, e a análise de clusters detetou uma satisfação laboral significativamente mais baixa e um impacto muito mais grave na saúde em caso de maior exposição a violência lateral. Os nossos resultados sustentam que experienciar violência por parte de utentes ou colegas de trabalho reiteradas e prolongadas no tempo é um forte preditor de burnout, salientando-se a

exaustão emocional como o efeito destrutivo mais prevalente e com potencial de mediação para perturbações ansiosas, depressivas e de somatização altamente incapacitantes.

As conclusões do presente estudo podem constituir um importante contributo para programas de prevenção e intervenção que promovam conhecimento e desenvolvimento de estratégias sobre o tema da violência lateral junto de profissionais, organizações e comunidade, no sentido da otimização da saúde ocupacional de uma das áreas profissionais mais desafiadas e profundamente fundamentais à sociedade.

Palavras-chave: violência lateral, violência utentes, violência laboral, hospital, saúde

1. GENERAL INTRODUCTION

1.1 Violence. An analysis of the phenomenon.

Violence is, at least in general, condemned by civilized societies as a human-rights violation. Yet, interpersonal relations involve interaction and this may result in conflict or in some sort of violence, in a more or less overt manner.

1.1.2 What is violence and what is not

Johan Galtung, a pioneer of peace research, said that a definition of violence should be sufficiently wide to address all its existing forms but specific enough to allow a concrete course of action against it (Galtung, 1964, 2018).

Violence and peace, are seen as antipodes. Peace, as the absence of violence, reflects a sense of commonality, and violence is tacitly settled as a disruption of commonality (Galtung, 2018). Yet, harmful social orders may coexist with such a concept of peace (without disruption). Inaction towards a curable disease or conformity in the face of social inequities results in the loss of the more vulnerable, which is accepted (although mourned) in an environment of conformity seen as peaceful. In such a case, one can not say that no violence existed. So, peace and violence are not mutually exclusive (Galtung, 2018).

Violence has been devised in terms of its (interpersonal) influence (Galtung, 1965), considering that there is a subject, an object, and an action. A distinction is made between physical and psychological violence, whether there is an object that is hurt, an agent, or an intention, and whether violence is manifest or latent.

1.1.3 Violence conceptualization and definitions

The more commonly used definition of violence is traced back to 1996, by a World Health Organization (WHO) working group, as "*The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either result in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation*." (Krug et al., 2002; WHO, 1996). This definition encompasses all types and vectors of violence, and omission/neglect (figure 1).

The WHO's report on Violence and Health refers to subtypes of violence that are intertwined, and share a common ground of risk factors, such as substance use, poverty, and social inequities (Krug et al., 2002; Matzopoulos et al., 2008). Most violence happens in low-income countries (2.5 times higher rate) (Krug et al., 2002), since poverty poses a serious risk of structural violence (Rylko-Bauer & Farmer, 2016).

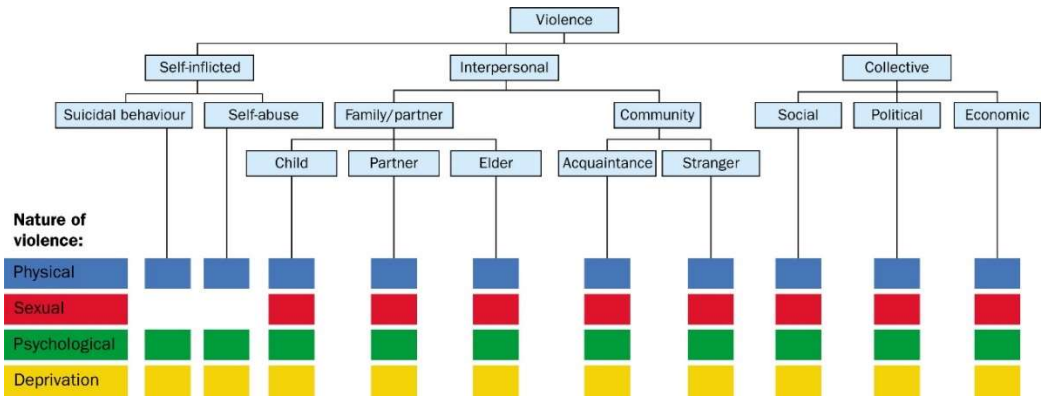

Figure 1 - Types of violence (Krug et al., 2002)

Physical violence consists in hurting or restraining somatically, which can ultimately end in killing (Galtung, 2018). Psychological violence refers to non-somatic acts such as injuring by using lies, threats, or manipulation (Cremin & Guilherme, 2016; Galtung, 2018; National Academies of Sciences & Medicine, 2018). Sexual violence consists of sexual acts, attempts, or other, directed at another person's sexuality by force or coercion, regardless of the relationship or setting (Campbell et al., 2019; Organization, 2003). Neglect is a failure to respond to the person's needs (Krug et al., 2002; Magalhães, 2020), excluding intentional withholding of care, which is a deprivation abuse (Golden et al., 2003).

1.1.4 The whos, the whats, and the whys in violence

The target of violence transcends the human or biological dimension of the object of violence, incorporating the power of threat, factual or not, or material destruction that embodies the threat (Galtung, 1964, 2018). The agent (of violence) may be a group or society (figure 2).

Social inequities, or stigmatization, perceived as a form of violence, often cannot be attributed to a person-agent (Galtung, 2018). In such cases, the social structure endorses violence and unequal access to human rights (Ho, 2007; Rylko-Bauer & Farmer, 2016).

However, victims do not always acknowledge victimization, especially if subliminally encouraged to self-blame, favoring violence normalization (Gramazio et al., 2021; Thapar-Björkert & Morgan, 2010). And the agents, are sometimes unidentifiable or a result of the social structure (Galtung & Fischer, 2013b). Additionally, intention to harm, reiterated and power-based, produces the notion of bullying, used for school

violence (Cuadrado-Gordillo, 2012; Einarsen et al., 2020; Juvonen et al., 2003) that also suits workplaces (Hogh et al., 2011; Leong & Crossman, 2016; Namie, 2003).

Intentional violence reflects both the acceptance of the result of violence by its agent (Cuadrado-Gordillo, 2012; Einarsen et al., 2020) and his attitudes toward its use (Pina et al., 2021).

Violence is not always overt. Latent violence, although invisible, creates confusion, damaging consciousness (Galtung, 2018). Yet, structural violence, often of such kind, falls into this nebulous that leaves perpetrators unknown (De Maio & Ansell, 2018).

The danger of health structural violence normalization is due to its insidious nature, and omnipresence (De Maio & Ansell, 2018; Farmer, 2003), undetachable from the social and cultural aspects influencing perception (Kivivuori, 2014).

According to the seminal work of Bandura and his social learning theory, people learn how to behave by watching others (Bandura, 1962), so, violence is based on conditioned behaviors, by role-modeling and imitation, and bolstered in a group-level phenomenon of victims, perpetrators, and bystanders (Escartín et al., 2021).

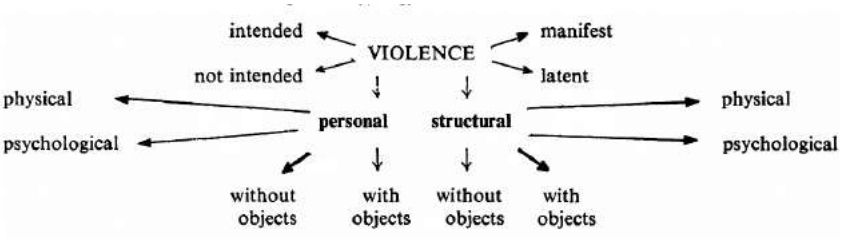

Figure 2 - Typology of Violence (Galtung, 1964, 2018)

a) Victims

Emilio C. Viano (2000), a pioneer in the field of victimology, conceptualized four levels based on how violence is perceived by victims: (1) First level, when the harmed person does not self-perceive as a victim (e.g. legitimizing violence); (2) Second level, when the victim finds violence unfair but feels helpless, fears retaliation, and perceives little support; (3) Third level, when victim actively seeks help; and (4) Fourth level when victim status was acknowledged and justice is sought.

Victims in the first and second levels are of greater concern. They endure violence if they do not realize the risks, for learned helplessness, and make detection and suspicion very challenging (Magalhães, 2020).

The increasing emphasis on victim-centered justice led to growing interest in risk management, yet, the risk factors of becoming a victim are deemed similar to those of being an aggressor (Dillenburger, 2008).

b) Aggressors: Violence is often not an end but a means and often emerges during social thrives (Piquero et al., 2021; Whitehead, 2007). As a learned behavior, it is based on prior attempts that succeeded or not (Bandura, 2006). Building on that, it is reinforced, by the modulating role of beliefs, resembling a contagious disease (Huesmann, 2018). Perpetrators tend to carefully select targets with limited resources (Salmivalli & Isaacs, 2005), balancing between the social reward of peers and loss of affection (Veenstra et al., 2010). Violence becomes a self-empowering tool (Pina et al., 2021) under the blessing of peers who reinforce the perpetrators' sense of power and status (Pina et al., 2021; Salmivalli, 2014).

c) Bystanders: addressing victims and aggressors alone, may lead to a partial analysis (Wiens & Dempsey, 2009). The definition of bystander refers to someone who is present but does not take part ("Cambridge Dictionary," 2021). Bystanders pose both as a reward and an obstacle to violence (Salmivalli, 2014). If supportive of violence, they increase the bully's sense of impunity (Salmivalli, 2014). Yet, they are increasingly seen less as a problem and more as a solution (Pouwelse et al., 2021). The bystander effect of Latané and Darley (1968), tested in school bullying, (Stueve et al., 2006; Twemlow & Sacco, 2013), is relevant to workplaces where perceived severity influences helping behaviors (Hellemans et al., 2017), stressing the value of awareness. Studies argue that bystanders may be constructive or not, and have active or passive roles (Jönsson & Muhonen, 2022; Namie, 2003; Ng et al., 2022; Paull et al., 2012). Their prosocial roles depend on intrapsychic features (self-determination) that impact attitudes, but they often fear for their image and retaliation (Tsang et al., 2011).

d) Groupthink: Drawing upon the essay of Gustave Le Bon, and mental unity as a motor of collective actions, typically intolerant and impulsive (Le Bon, 2009), violence is conveyed. This brings us to obedience. Milgram (1963) studied how far people would go when obeying orders involving harm by delivering 300-volt shocks to another human being when ordered by a superiorly validated authority figure, and all participants did (Milgram, 1963, cit. in Miller, 2004). The author theorized that people have two states of behavior: an autonomous, by acting and taking responsibility, and an agentic state, diverting blame to who gave the order (Milgram, 1974). Phillip Zimbardo's work shows that humans are shaped by systemic and situational forces illustrating how people, under pressure, act in

ways never before expected (Zimbardo, 2011). Many human rights violations were seen as crimes of obedience (Kelman, 2005), pined to a "groupthink" trend based on authorization, routinization, and dehumanization (Post & Panis, 2011).

1.2 Violence at work

Violence is indisputably a menace to health and many countries steadily subscribed to WHO's refrain that it must be eradicated like any other disease (Gordon, 1949; Krug et al., 2002). WPV is disruptive to workers, organizations, and communities (ILO, 2018).

1.2.1 Definitions of workplace violence and related concepts

Workplace violence (WPV) is identified as *intentional work-related abuse, assault, and threats toward professionals, in their workplace, including physical and psychological violence* (Chappell & Di Martino, 2006; Lippel, 2016). The International Labor Organization (ILO), defines "violence and harassment" at work as *a set of unacceptable behaviors, unique or repeated, that cause physical, psychological, sexual, or economic harm, including gender-based violence and harassment* (ILO, 2019), hostile to persons or groups (Chappell & Di Martino, 2006; Koritsas et al., 2010; Wiskow, 2003).

In this context, intention and repeated harassment are identified as mobbing (Einarsen et al., 2020; Zapf et al., 2020). The term *Mobbing* derives from the Scandinavian term for bullying (in Swedish, *mobbning*) (Heintz, 2004; Olweus, 2009), and was initially used in school settings to depict group engagement (Salmivalli, 2010). It is a multifactorial phenomenon that has been related to sex differences (of aggressor and target), status (Veenstra et al., 2010), and aggressor's perception, whose appraisal of the victim is

influential (Pina et al., 2021; Veenstra et al., 2010) since they choose victims who are less expected to defend themselves or to be defended (Veenstra et al., 2010).

WPV is included in the interpersonal type of community violence (OSHA, 2022), and classified according to those involved and their relationship:

- Type I Violence: when no relationship exists between individuals or organizations, as happens in bank or shop robberies.
- Type II Violence: when the aggressor and the organization or workers interact as occurs in client attention and care (e.g. security service, health providers);
- Type III Violence: when the aggressor and organization/workers share space and happen among coworkers with similar or higher ranks, with a direct relationship.

1.2.2 International recommendations on WPV

Many countries forbid WPV under different legal scopes and terminologies (ILO, 2018). Convention number 190 (on Violence and Harassment) stressed that WPV is "incompatible with the promotion of sustainable enterprises and impacts negatively on the organization of work, workplace relations, and worker engagement" (ILO, 2019).

Still, the most recent survey published by ILO, from the 2021 Lloyd's Register Foundation World Risk Poll, warns that statistics on WPV and harassment are sporadic and scarce.

1.2.3. Legal frameworks: a critical view

Across countries, different postures are found. Most non-EU developing countries lack regulation on WPV. There is a reference to disregard for promoting an anti-violence culture in workplaces (Chernyaeva, 2014), where court decisions reflect this gap.

The European Parliament Directive on *measures to prevent and combat mobbing and sexual harassment in the workplace* (EU, 2018) acknowledges that legislation and best practice standards at national levels promote psychosocial risk management. This must be fueled by common strategies to prevent work-related stress (Leka & Jain, 2014).

In Portugal, the Labor Code and a specific law (*Lei n.º 7/2019*, annex to *Lei n.º 35/2014*) aimed at preventing harassment in both public and private workplaces. In Spain, *Ley 31/1995* addresses violations and risks such as moral harassment, and legal updates were created to specify when organizations must take action (DGT, 2020; MTI, 2009).

1.3 Workplace violence in healthcare

The severity of WPV is seen as "an international emergency that undermines the very foundations of health systems and impacts critically on patient's health" (WMA, 2020). The current thesis addresses WPV in the nursing profession, in public hospitals.

1.3.1. Types of workplace violence in healthcare

The phenomenon should be analyzed under the different scopes used in the most relevant literature: user violence (type 2) and coworker violence (type 3).

User violence has a high prevalence (Llor-Esteban et al., 2017; López-García et al., 2018; Pina, Peñalver-Monteagudo, et al., 2022; Ruiz-Hernández et al., 2019). It consists

in physical and non-physical attacks that target professionals, and concur to decrease their psychological well-being and satisfaction in the job (Galián-Muñoz et al., 2016; López-García et al., 2018)

Coworker violence may be (1) vertical, if between a superior and an employee, and can be top-down or down-up (Waschgler, Ruiz-Hernández, et al., 2013), being the first more prevalent (Norton et al., 2017; Zapf et al., 2020); or (2) lateral, consisting of harassing behaviors between coworkers with equivalent status (Magnavita & Heponiemi, 2011; Waschgler, Ruiz-Hernández, et al., 2013). Lateral violence can be displayed from person-directed attacks (personal lateral violence) to social isolation (social lateral violence) and work-related harassment (workplace-related lateral violence) (Einarsen et al., 2020). The first consists of verbal hostility, gossiping, persistent criticism, practical jokes, attacks on private life, intimidation, humiliation, acts of contempt, emotional abuse, and social exclusion (Einarsen et al., 2020; Waschgler, Ruiz-Hernández, et al., 2013; Zapf et al., 2020). The second includes assigning unreasonable deadlines, unmanageable workloads or no tasks at all (or meaningless ones) manipulating information, and censoring the target (Einarsen et al., 2020; Waschgler, Ruiz-Hernández, et al., 2013; Zapf et al., 2020). The third consist of being ignored, undervalued, and impeded from getting training or research (Waschgler, Ruiz-Hernández, et al., 2013).

1.3.2 Prevalence of workplace violence in healthcare

The rate of WPV has been reported lower than 55.6% of employees (Kremic et al., 2017) suggesting dark figures in the phenomenon, not represented in official statistics

(Kodellas et al., 2012). International statistics point to high prevalence in the healthcare context (Eurofound, 2022).

A recent ILO report reveals that, of nearly 75,000 workers, in 121 countries surveyed in 2021, more than 22% suffered at least one type of violence or harassment at work (ILO, 2022). Of these, 60% endured it multiple times, and one-third experienced more than one type (psychological, physical, and sexual). Sexual violence and harassment reached 6.3%, being more reported by women (8.2%) than men (5%).

Most studies point to substantial user violence rates in hospital emergency departments (ED) and mental health departments (MHD) (Chappell & Di Martino, 2006; Liu et al., 2019; Pallarés et al., 2021; Ruiz-Hernández et al., 2019).

In a recent study, EDs in Spain displayed: 100% of professionals were exposed to at least one violent act in the last year; eight out of ten, were victims of non-physical violence; and three out of ten, physical violence. Non-physical type in EDs impacted auxiliary staff, followed by doctors, nurses, security staff, and administrative staff (Pallarés et al., 2021).

In a systematic review of 253 studies, with 331,544 professionals, 61.9% reported exposure to any type of WPV from users, 42.5% non-physical, and 24.4% to physical (Vento et al., 2020). A recent review finds nurses at higher risk of WPV (59.2%) followed by medical professionals (56.8%) (Liu et al., 2019), which is supported by Spanish data that identify nurses as especially exposed to nonphysical (71%) and physical violence (19.9%) from users (Galián-Muñoz et al., 2014).

MHDs also reveal a high prevalence (92.1%), where non-physical is more prevalent (90.7%) than the physical type (53.6%), and depend on the time of stay of patients (patients who stayed less time were more hostile), and nurses and auxiliary, the more targeted (Ruiz-Hernández et al., 2019; Serrano Vicente et al., 2020).

1.3.3 WPV in healthcare during COVID-19 pandemic

The lesson learned from the covid-19 pandemic, with its traumatic upsurge declared by WHO in march 2020, in a cinematic scale that emptied cities can not be disregarded. During the pandemic, WPV against healthcare professionals reached a new level. From social stigmatization (e.g. for their proximity to infected patients and fear of transmission of the virus) (Schubert et al., 2021), to being physically assaulted at work, besides the overwhelming work overload and higher work demands, cases rose worldwide (McKay et al., 2020; World Medical Association, 2020). More than 600 violent incidents and harassment affected health professionals due to the Covid-19 outbreak (Devi, 2020).

A recent metanalysis of 13 observational studies (17.207 participants) presents a high total prevalence of violence (47%) during the covid-19, of more non-physical type (44%) and medical professionals impacted by user violence (68%) (Ramzi et al., 2022). Stigmatization alone, related to COVID-19, has motivated high rates of depression and anxiety among the targeted professionals (Schubert et al., 2021).

It could be expected that a buffering effect of professional cohesion might occur. Still, studies found high levels of coworker violence during the pandemic (Bakalis et al., 2022; Özkan Şat et al., 2021). In samples of nurses, mobbing has been identified by most, highly influencing turnover pondering (Özkan Şat et al., 2021), and nurses with less power and

shorter professional experience were more affected by mobbing behaviors (Bakalis et al., 2022).

1.3.4 Highlights of WPV research

The present highlights are here mentioned based on their relevance to the current work, not lessening the importance of other matters. It will, thus, succinctly refer to relevant knowledge produced, global consequences, and important tools, to cut short.

Violence's negative costs include both direct, such as those arising from absenteeism, turnover, work accidents, ill health, and death, as well as indirect costs, such as decreased effectiveness and quality, and reduced competitiveness (Di Martino, 2002). Both short and long-term psychosocial consequences are caused by WPV, considering its stressful traumatic nature and continued occurrence (Mento et al., 2020). Fear, anger, anxiety, guilt, and helplessness are mentioned by several studies, and depression, post-traumatic stress, lower life quality, and shorter life expectancy are common (d'Ettorre et al., 2018).

Numerous studies in Spain have, in the latest years, provided important conclusions, as well as useful insight. The validation of the Hospital Aggressive Behavior Scale for user violence (HABS-U) by Waschler, Ruiz-Hernández, et al. (2013) - later adapted specifically for Mental Health (HABS-MH-U) by Ruiz-Hernández et al. (2019), - and for coworker violence (HABS-CS) by Waschler, Ruiz-Hernández, et al. (2013) is a remarkable milestone. They provide valuable tools to address the main vectors of violence in the workplace.

The impact of WPV is observable in several aspects of nursing professional's lives such as job satisfaction, by lowering it considerably, in the absence of support networks (del Carmen Pérez-Fuentes, Gázquez, et al., 2020; Galián-Muñoz et al., 2016; Li et al., 2019). Also in high levels of burnout, with pervasive effects on health (Friganović et al., 2019; Hsiao et al., 2021; Khamisa et al., 2013; López-López et al., 2019).

1.4. Healthcare violence models

To make WPV in healthcare a comprehensible phenomenon and a plausible object of research, different explaining models are drawn to embrace its multifactorial nature.

1.4.1. The interactive ecological model

WHO's ecological model proposes a multifactorial perspective on WPV, encompassing biological, social, cultural, economic, and political interrelated factors (WHO, 2022). Risk factors of victimization and behaviors are put in four levels:

a. First level: risk factors of biological nature or related personal history and demographics (educational background and age), psychopathology, violence antecedents, and history of substance abuse.
b. Second level: contextual factors that impact both victims and perpetrators, such as family, friends, and intimate partners.
c. Third level: community-level factors where personal and social relations take place, including neighborhoods, schools, workplaces, etc.

d. Fourth level: addresses the societal structure. The likelihood and risk of WPV rely on culturally-based attitudes and customary beliefs, and gender stereotypes, inequity, as well as acceptance of corporal punishment, matter.

According to this model, levels often overlap and impact each other depending on shifts or reinforcement (figure 3). Someone who endorses violence may be more impactful if the environment supports this belief, increasing the odds of violent behavior (Krug et al., 2002).

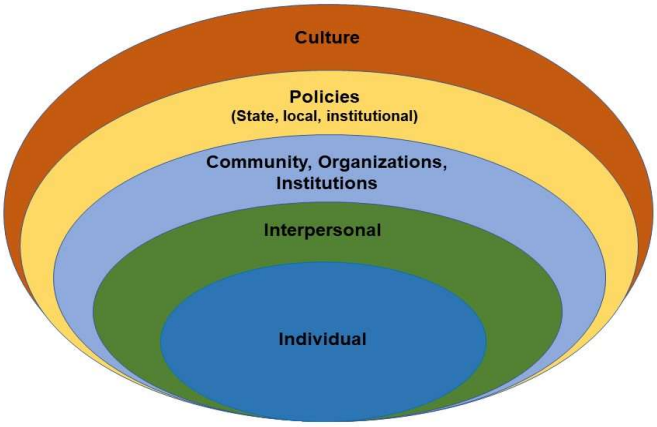

Fig. 3. WHOs ecological model (2002) Adapted from McLeroy et al. (1988) by Maria Vidal Alves

1.4.2. Chapell and Di Martino model

A relevant model for this thesis, for encompassing the workplace, was proposed by Chappell and Di Martino in 1998 and later adapted to healthcare (Chappell & Di Martino, 1998; Chappell & Di Martino, 2006). The authors defend the multifaceted and interactive nature of WPV and advocate for the high risk in healthcare (Chappell & Di Martino, 2006). There is the risk of WPV acceptance as normative at work (Llor-Esteban et al., 2017).

Interaction modulates violence at the contextual, individual, labor, and societal levels (Chappell & Di Martino, 2006). Contextual factors refer to those determined by globalization, technology, increased vulnerability, and job insecurity. Among individual factors, given features predispose to violence, such as being young, male, with a history of violence and substance abuse, as well as personality and temperament issues, poor skills, and dissonance between expectations and reality. Such features have a bidirectional vectorization, both in the case of victims and offenders (Chappell & Di Martino, 2006).

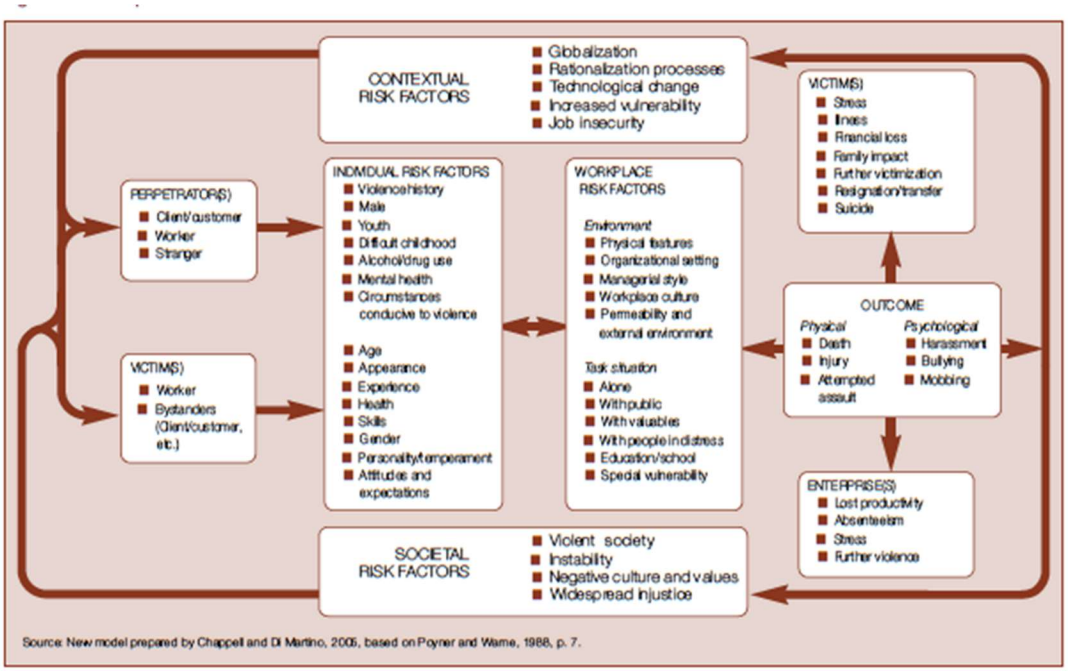

Figure 4. WPV model, adapted from Chappell y Di Martino (2006). Allowed use by authors.

In this model, the work environment itself poses risks, ranging from contextual (e.g. organizational style, work culture) to task-related issues (e.g. working with the public, stressful environments). The model points to the influential role of the workplace's social surroundings if considered stressful for its instability, violence, proneness to negative

values, and of overall internalized injustice sense (Chappell & Di Martino, 2006). Its adaptation to healthcare is depicted in figure 5.

Offenders may be internal (systemic or work team-related) and external (patients, or family members). The main risk factors of healthcare are rooted in its care-based work, high workloads, lack of resources, and working with vulnerable individuals (and family members) due to their illness, etc.

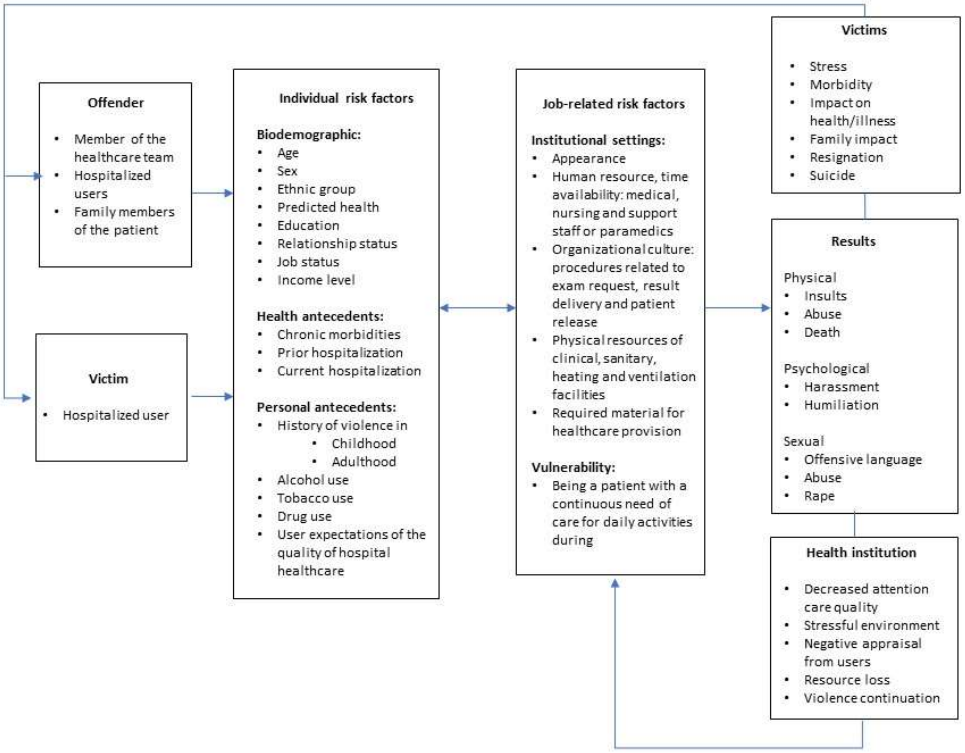

Figure 5. Interactive WPV model in health, adapted by Casas & Klijn (2011). Translation by Vidal-Alves.

1.4.3. Predisposing factors

Risk and vulnerability factors contribute to a higher likelihood of victimization (Zapf et al., 2020) and can have an environmental, personal, societal, or cultural nature (Chappell & Di Martino, 2006). Organizational acknowledgment of these risk factors,

their nature, and functioning allows for the identification of possible causes and the development of effective preventive programs (García-Pérez et al., 2021; Liu et al., 2019).

Both concerning user violence and coworker violence, vulnerability issues that increase the likelihood of being victimized were identified, e.g. racial/ethnic (Dehghan-Chaloshtari & Ghodousi, 2020; Sabri et al., 2015), hospital departments (Bambi et al., 2014; Liu et al., 2019) and being a nurse (Cebrino & Portero de la Cruz, 2020; Hahn et al., 2013; Liu et al., 2019), which is the population of interest of the present thesis.

1.5. User violence

Risk factors of user violence may be listed as (a) worker-related; (b) offender-related; (c) work-related; and (d) societal factors (Llor-Esteban et al., 2017; López-García et al., 2018; Raveel & Schoenmakers, 2019).

Worker-related factors concern age, educational level, relationship status, sex, and time length at the current job or job position (Liu et al., 2019). Those with more time at the job (6 to 16 years) have been suggested as more at risk of being victimized (Liu et al., 2019; Maran et al., 2019; Serrano Vicente et al., 2020), increased for non-married workers (Liu et al., 2019).

Concerning the sex of the worker, the consulted literature is not consensual. Despite studies pointing to a higher risk of WPV in male professionals (Maran et al., 2019), others suggest a higher number of episodes in women (Serrano Vicente et al., 2020). A recent systematic review, though, presents a different conclusion by ruling out such differences, biased by a higher number of female participants in some studies (Liu et al., 2019).

Female workers are more likely to be sexually harassed and male workers are more vulnerable to physical attacks (Liu et al., 2019).

Offenders are patients, relatives, or close persons, and are mostly male (Serrano Vicente et al., 2020). One offender-related factor is the state of vulnerability. The common reason for seeking medical attention is illness or pain which lowers tolerance (Arnetz et al., 2015; Chappell & Di Martino, 2006).

A recent qualitative study addressed perceived causes and, according to nurses, the patient's disease or vulnerability triggers relatives' hostility. Patients get frustrated with treatments, long waiting times, perceived neglec, or lack accurate communication (Bhattacharjee, 2021; Kaya et al., 2016). Nurses perceive anger management problems, as "overreacting", and female nurses are seen as more "weak and vulnerable", besides being doubted in their abilities (Yesilbas & Baykal, 2021).

Work-related circumstances entail features predisposing users to violence such as unmet expectations of users and relatives and ineffective hospital organization (Najafi et al., 2018) but also work shifts, which decreases nurses' resilience (Dehghan-Chaloshtari & Ghodousi, 2020). Working in MHD and EDs relates to higher exposure to WPV (Llor-Esteban et al., 2017) and nurses' proximity to patients has been identified as a cause of higher exposure, compared to other professionals (Waschgler, Ruiz-Hernández, et al., 2013), especially when there is need of restraint or transition (Arnetz et al., 2015).

Societal factors such as crowded environments, long waiting lines, lack of security, workload, lack of staff, etc., are mentioned by studies as the explosive mixture that motivates WPV occurrence (Raveel & Schoenmakers, 2019; Ruiz-Hernández et al., 2019). Risk rises in excessive work schedules (more than 40h/week) (Liu et al., 2019).

Nonphysical violence is higher in urban settings, and physical violence in hospitals and primary care (Liu et al., 2019; Serrano Vicente et al., 2020). Prior experiences and community violence impact the perpetration of WPV in healthcare (Bhattacharjee, 2021), particularly in ED, usually crowded and characterized by acute cases (pain, fear), self-perception of vulnerability, and communication difficulties (Bhattacharjee, 2021). Professionals without WPV preventive training are more vulnerable (Hahn et al., 2013)

1.6. Coworker violence

In the literature on coworker WPV in nursing, the terms found are, interchangeably, lateral/horizontal violence, bullying, and incivility but lateral violence were privileged. Parting from nursing studies, there is a long-legged "thick skin" narrative, from academic education to professional training (Carter et al., 2013; Griffin, 2004; Rosi et al., 2020; Wolf et al., 2018). It is what the "tough love lesson" refers to, referring to an arduous learning process during the early years of new graduates (Leong & Crossman, 2016; Rosi et al., 2020).

1.6.1. Offender (coworker) risk and protection factors

The acceptance of violence at work as normative, and work overload or reduced staff, lay the foundations for lateral violence (Nowrouzi-Kia et al., 2019; Vento et al., 2020). Among nursing personnel, most perpetrators are nurses, with prior bullying-related behaviors (Skarbek et al., 2015; Wolf et al., 2018).

Psychological studies theorize that aggression is a result of factors that influence psychological states that lead to aggression (proximal factors) and, distal factors, of developmental and environmental nature, impacting personality and cognition

(Bhattacharjee, 2021; DeWall & Anderson, 2011). So, aggression results from thoughts that influence appraisal and determine decision-making about aggressive or non-aggressive responses (Allen et al., 2018).

Adverse environments in nursing teams are usually related to power, lack of leadership skills (Shorey & Wong, 2021), and unsupportive behavior of nurses (colleagues, trainees, subordinates). Power is sought by instilling fear, whether to protect their position, assert their importance in the organization, or just improve their self-perception (Condie, 2016; Grace, 2016).

A leading role figure who is visible in the field and inhibits incivility and harassment behaviors is protective of violent occurrences (Shorey & Wong, 2021) providing a caring role and positive environment (Anthony & Brett, 2020; Peng et al., 2022). Nurse leaders also may be key in the advocacy of robust policies at the organizational level, and in fostering a well-balanced work environment within the team (Anthony & Brett, 2020).

1.6.2 Conflict sources: from bias to pride and prejudice

It is widely published in nursing journals and most health-related publications, that there is a culture of "nurses eating their young" (Aebersold & Schoville, 2020; Gillespie et al., 2017; Meissner, 1986; Sauer, 2012). Studies point to generational differences (Stevanin et al., 2018) and the inexperience of younger nurses as triggers of incivility from older nurses (Leiter et al., 2010).

New graduates see more experienced nurses as an elite who fears innovation (Rosi et al., 2020). Also, nurses in management positions are exposed to violence vertically, both

top-down (from superiors) and down-up (subordinates), criticized or having their skills questioned (Tuna & Kahraman, 2019).

1.7 Consequences of WPV against nurses

Magnavita (2014) described WPV and occupational stress as a "chicken and egg" situation. According to his conclusions, job stress predicts non-physical violence without proper support, while violence is *per se* a severe cause of stress.

The negative consequences o WPV are detected in workers, organizations, and patients (Shorey & Wong, 2021) and transcend the workplace and workers, with an impact on families (Mache et al., 2015; Rodríguez-Muñoz et al., 2017).

Violence has a highly negative impact whether exerted by someone external to the organization (user, family member) (Liu et al., 2019; Llor-Esteban et al., 2017; Pallarés et al., 2021; Ruíz-Hernández et al., 2016) or by colleagues (Boudrias et al., 2021; Hogh et al., 2011; Najafi et al., 2018; Shorey & Wong, 2021). They include physical and psychological disorders (Chappell & Di Martino, 2006; Hassankhani et al., 2018; Lever et al., 2019), emotional disruption and burnout (Shorey & Wong, 2021) as well as decreased job satisfaction (Grace, 2016) and worsened quality of patient care (Grace, 2016; Rosi et al., 2020; Shorey & Wong, 2021).

1.7.1 Health consequences and Burnout

Coworker violence has a stronger impact than user violence (Pien et al., 2019) and is correlated with poor health and high rates of sick leave (Choi & Lee, 2017; Lever et al., 2019). It is consistently and bi-directionally linked to depressive, anxiety, and post-

traumatic indicators (Verkuil et al., 2015), as well as suicide ideation (Lever et al., 2019). It has further been associated with hypothalamic–pituitary–adrenocortical (HPA)-axis disruptions (Galletta et al., 2019; Rossouw, 2018) and signs of oxidative stress, a common ground of morbidity (Di Rosa et al., 2009).

According to Christina Maslach, an American professor of Psychology, there are three dimensions involved in burnout (Maslach & Leiter, 2006; Maslach et al., 2001) that occur as a response to work-related stress: exhaustion, cynicism, emotional detachment, and infectiveness.

a. **Exhaustion**: stress-based, it is an individual sense of being overwhelmed and lacking resources both physically and psychologically

b. **Cynicism/Depersonalization**: interpersonal, it is depicted by the callous, detached response to stimuli, in an attempt to buffer the exhaustion strain.

c. **Personal inefficacy/accomplishment**: this is the self-evaluation component and reflects a low sense of competence and achievement.

Burnout is a result of psychological wearing down and a response to pervasive and prolonged exposure to interpersonal stress, common in care (Maslach & Leiter, 2006). An important psychometric tool is the Maslach Burnout Inventory (MBI), designed to measure burnout (Maslach et al., 1997; Maslach & Leiter, 2006; Maslach & Leiter, 2017). Lever et al (2019) found studies using the variables devised by Maslach (Maslach & Leiter, 2006) that strongly correlated workplace bullying to emotional exhaustion.

Other consequences of burnout that is mentioned in the literature refer to allostasis, referring to the term coined by McEwen and Stellar “allostatic load” (McEwen & Stellar, 1993), describing a mechanism through which the body seeks homeostatic balance, by

allocating metabolic energy to face stressful demands and stimulating pathophysiological responses upon the nervous system hyperarousal (Juster et al., 2010). Consequences affect brain functions, cause inflammation, immunosuppression, cardiovascular illness, and, in the long run, premature death (Bayes et al., 2021).

Studies also show that the experience of lateral violence is a predictor of conflict at home, with the influence of a burnout dimension: psychological detachment (Rodríguez-Muñoz et al., 2017).

Workers under burnout report a state of emotional fatigue, often manifested by exhaustion, apathy, and loss of interest in the job (Seguel & Valenzuela, 2014; Weinberg & Creed, 2000), typical in caregiving (Pérez-Fuentes, Gázquez, Ruiz, & Molero, 2017).

According to a recent study, burnout syndrome has a high prevalence in Spain (Juliá-Sanchis et al., 2019) and has been related to the continuous close interaction observed in healthcare, particularly in the nursing profession (del Carmen Pérez-Fuentes, Jurado, et al., 2020; Muñoz et al., 2018).

1.7.2 Job satisfaction

Following Locke's definition of job satisfaction as a positive emotional state related to the subjective perception of work experiences, Adams & Bond put it as "the degree of positive affect towards a job or its components" (Adams & Bond, 2000). To achieve a sense of fulfillment and well-being, more than one isolated positive experience is required and needs to be repeated (Csikszentmihalyi & Seligman, 2000) but the balance between individual and collective well-being weights on organizational decision-making, as do economic concerns.

The measurement of this dimension commonly addresses an extrinsic viewpoint (physical work conditions, colleagues) and an intrinsic perspective (perceived recognition for work, responsibility, and promotion). High levels of WPV have been associated with significantly lower job satisfaction in nurses (Li et al., 2019; Muñoz et al., 2018), although buffered by social support (Gázquez Linares et al., 2021).

Coworker violence increases stress, and lowers job satisfaction, creating unsafe environments for patients (Oh et al., 2016a). Also the vertical violence reports (deprivation from career opportunities, being disregarded) (del Carmen Pérez-Fuentes, Gázquez, et al., 2020; Hartin et al., 2020), and attacks to reputation (e.g. telling patients that the nurse treating them is incompetent) (Shorey & Wong, 2021; Thrasher, 2020) damage job satisfaction (Chang & Cho, 2016).

Despite all the challenges faced by nursing professionals, different studies present it as something that can be shielded by empowering leadership (Boamah, 2019) and organizations that foster job satisfaction concerns and high-quality patient care (Laschinger & Fida, 2015; Leggat et al., 2010).

1.8 Preventive measures against WPV in healthcare

1.8.1 Conceptual approach

Shorey and Wolf (2021) portrayed workplace bullying in nursing emerged through a metanalysis of 27 studies in four countries, and streamline it on how violence is exerted, its drivers, the impact, and responses. Violence ensues via (1) exclusion and abuse, (2)

excessive scrutiny, (3) intimidation, and (4) damage to career and reputation. Theorized causes of occurrence and endurance of the phenomenon surpass the interindividual level. Individually, it is ruled by power and control which is feverously kept after conquered, and nurses are depicted as prone to knock their rivals down to feel well (Grace, 2016). On the other hand, absent and uninvolved leaders are held liable for letting violence spread like a disease (Hanks, 2017; Hartin et al., 2020).

Nurses' work context is overall depicted as toxic for its stressful and highly demanding characteristics, which are the volatile mix favorable to workplace coworker violence (Rosi et al., 2020; Shorey & Wong, 2021).

1.8.2 Existing models

The model adopted by the WHO, to begin with, addresses the multifaceted nature of violence by using an ecological approach. This is a preventive approach to violence based on individual and interpersonal relations, community-based strategies, and societal (Krug et al., 2002).

The theorization of Chappell and Di Martino (2006) is one of the most widely used to address violence in the world of work and focuses on preventing violence setting by taking action on three main fronts (figure 6):

(1) Primary prevention: organizational action-taking to prevent violence;

(2) Secondary prevention: ensure immediate action after the conflict takes place, such as medical treatment, and inquiry;

(3) Tertiary prevention: actions that prevent violence in the long run, such as victims' rehabilitation, reintegration, and trauma-informed actions.

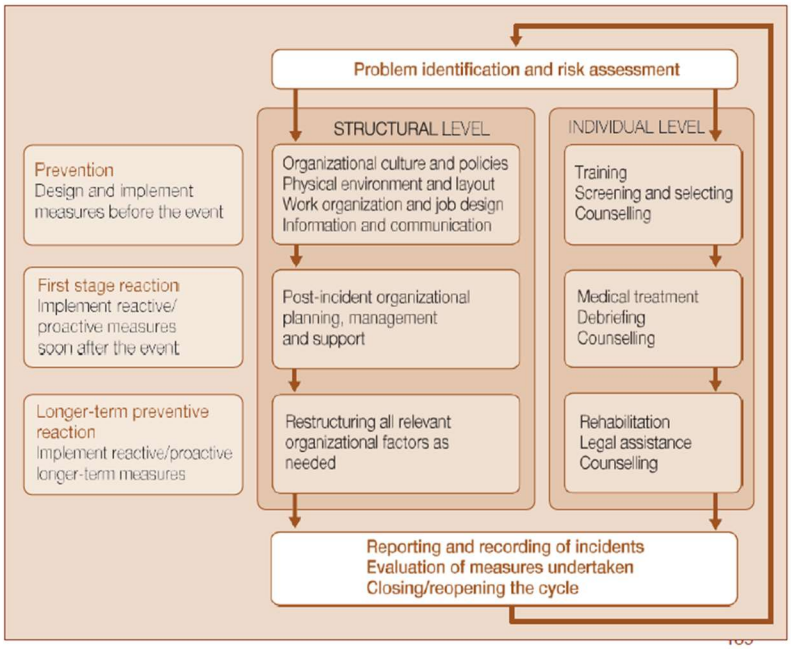

Figure 6. Chappell & Di Martino's prevention model, from Violence at Work (p.189) ILO (2006).

The model considers preventive interventions such as (1) prioritizing organizational interventions to ensure qualified personnel, encourage positive attitudes, insure proper information to all stakeholders (managers, workers, and community), improve risk-preventive work conditions, avoiding excessive workload by conveying clear job demands; (2) tackling environmental aspects posing as external stressors (noise, workplace design); (3) addressing worker's individual skills, by providing training and assistance after violent events take place.

Thus, promoting a humane work culture, based on equality, dignity, and tolerance, by having leaders engaged in prevention, promoting open discussion and a positive

environment, besides valuing workers' contributions is a crucial place to start. The studies included in the present thesis aim to respond to a set of needs identified in the consulted literature.

2. General objetives

2.1. Main Objectives

2.1.1. Explore personal and work-related variables asociated to lateral violence in nurses, that may be tacked in a preventive approach and

2.1.2. To identify key areas of action (training and policymaking) in intervention programs in workplaces, based on its potential in reducing violence in healthcare contexts.

2.2. Specific Objectives

2.2.1. Explore the main hazzards in nursing profession related to lateral violence, based on the latest and most relevant studies, carried in the last decade, to determine the basic variables involved in this type of violence specifically.

2.2.2. Determine the profiles of nursing professionals according to the levels of exposure to diferent types of lateral violence and the observed impact on health and job satisfaction, burnout dimensions and both physical and psychological health.

2.2.3. To clear the role played by burnout in workplace violence and point out main strategic targets for prevention and intervention in organizational settings, in order to prevent it as well as medium and long-term effects on health.

3. Published articles

3.1 Study 1 – Tough love lessons: Lateral Violence among hospital nurses

Vidal-Alves, M. J., Pina, D., Puente-López, E., Luna-Maldonado, A., Luna Ruiz-Cabello, A., Magalhães, T., Pina-López, Y., Ruiz-Hernandez, J. A. & Jarreta, B. M. (2021). Tough love lessons: Lateral violence among hospital nurses. International Journal of Environmental Research and Public Health, 18(17), 9183.

This study was published in the *International Journal of Environmental Research and Public Health*, in 2021. The last indicator of the JCR impact factor is 4.799 (Q2 in the field of Public, Environmental and Occupational Health) in 2021. The authors are the following: doi: 10.3390/ijerph18179183

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3.2 Study 2 - Profiles of lateral violence in nursing personnel of the Spanish public health system

Pina, D., Vidal-Alves, M., Puente-López, E., Luna-Maldonado, A., Luna Ruiz-Cabello, A., Magalhães, T., Llor-Esteban, B., Ruiz-Hernandez, J. A. & Martínez-Jarreta, B. (2022). Profiles of lateral violence in nursing personnel of the Spanish public health system. PLoS one, 17(5), e0268636. doi: 10.1371/journal.pone.0268636

This study was published in the *PloS ONE*, in 2022. The last indicator of the JCR impact factor is 4.069 (Q1 in multidisciplinary sciences) in 2021. The authors are the following:

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3.3 Study 3 - (Un) broken: lateral violence among hospital nurses, user violence, burnout, and general health: a structural equation modelling analysis

Vidal-Alves, M. J., Pina, D., Ruiz-Hernández, J. A., Puente-López, E., Paniagua, D., & Martínez-Jarreta, B. (2022). (Un) broken: lateral violence among hospital nurses, user violence, burnout, and general health: a structural equation modelling analysis. Frontiers in medicine, 9:1045574. Doi: 10.3389/fmed.2022.1045574.

This study was published in the *Frontiers in Medicine*, in 2022. The last indicator of the JCR impact factor is 5.493 (Q1, in Medicine, General & Internal) in 2021. The authors are the following:

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4. Global discussion

Workplaces can be a place of self-achievement and happiness-seeking since it presents challenges and requires goal-setting which creates opportunities for gratification (Csikszentmihalyi, 1990). Challenges draw people from their comfort zones and allow them to enter a flow state that is more than seeking enjoyment (to which we are genetically driven). It is a path to excelling oneself, by testing abilities and finding new ones using self-competition or other, generating an optimal experience (Csikszentmihalyi, 1990; Csikszentmihalyi & Seligman, 2000). Nonetheless, the same setting that is stimulating and rewarding can also be an extremely stressful environment, because it exceeds personal coping strategies and causes harm. Balance is lost.

Violence is the prime example of a menace to individuals' well-being and happiness seeking. As such, it contributes highly to lowering their level of needs satisfaction below what is potentially possible (Galtung & Fischer, 2013b). This often takes its toll on health and leads to reduced resilience (Cordero & Mateos-Romero, 2021; Ford & Ivancic, 2020; García-Izquierdo et al., 2019; Lee et al., 2019).

Following the lessons learned from the social learning theory, people learn how to behave by watching others (Bandura, 1962), and violence is no exception, acquired by conditioning, role-modeling, and imitation, and bolstered by those around us (Escartín et al., 2021). It is often intentional and, as such, it reflects the agent's favorable attitudes towards its use (López et al., 2021) and the agent's acceptance of the result of violence (Cuadrado-Gordillo, 2012; Einarsen et al., 2020). As such, it is considered an action to be prevented and punished by law (Portuguese Penal Code [*Código Penal Português*]; Spanish Penal Code [*Codigo Penal*]).

Some settings, such as hospitals, are highly challenging workplaces that combine high work demands and violence/incivility (Bakalis et al., 2022; Bhattacharjee, 2021; Cecelia L. Crawford et al., 2019; d'Ettorre et al., 2018; Dellasega, 2009; Fink-Samnick, 2016; García-Pérez et al., 2021; Lamothe & Guay, 2017; Lever et al., 2019; Li et al., 2020; Liu et al., 2019; López-García et al., 2018; Magnavita, 2014).

Sometimes, verbal aggression and disregard became something "as natural as the air around us", as Paul Farmer said, concerning inequalities in health (De Maio & Ansell, 2018; Farmer, 2003). The dangers of normalizing structural violence, even by mere inaction in the face of its insidious nature and ubiquity, result in violence normalization and costs on life quality (Galtung & Fischer, 2013b).

Differentiating between direct violence and indirect violence, for example, provides a better insight into the phenomenon. The first embodies physical aggression, often the source of fatal outcomes and massacres across History (Galtung & Fischer, 2013b); while the latter is expressed in indirect structural and culturally-based violence, rooted in the foundations of societies. Such violence underlies phenomena that range from *apartheid*, through which the suppression of human rights of a group of human beings was accepted/tolerated, to the gender-based violence and inequity that persists in culturally-validated stereotypes (Cremin & Guilherme, 2016).

Workplaces have a purpose that is usually measured in goals and efficacy and working in a team is necessary and requires conflict resolution and a peaceful environment. But we said earlier that peace may be obtained at the expense of personal sacrifices, especially if accomplished through avoidance of direct violence, yet devoid of resolution (negative peace) (Galtung & Fischer, 2013a).

Positive peace, on the other hand, resorts to promoting circumstances that discourage or remove violence but this requires dialogue, cooperation, and co-creation (Cremin & Guilherme, 2016; Galtung & Fischer, 2013a) involving all stakeholders (e.g. organizations, workers).

As Galtung put it, violence involves an agent and a recipient (2018). Despite the attentional bias of crime studies in the past, the emphasis on victim-centered justice emerged in the last century and led to growing interest in finding the nature of victimization and the likelihood of becoming a victim.

Victimization was connected to those most vulnerable as more prone to becoming victims or developing sequels (Schott, 2013) including samples of nurses (Krut et al., 2021). For example, self-perceived vulnerability may carry inside fear of being harmed (*injurability*) or at risk (Schott, 2013), since the fear of crime historically relates to vulnerability (Guedes et al., 2012; Killias & Clerici, 2000). Is this the case in healthcare workplaces?

Some types of violence (non-physical) and harassment at work are said to be often gender-based, embodying both the hostile working environment and "conducts based on sex affecting the dignity (…) unwelcome, unreasonable, and offensive to the recipient; and a person's rejection (…) is used explicitly or implicitly as a basis for a decision which affects that person's job" (*quid pro quo* sexual harassment) (ILO, 2018). A Portuguese study with a sample of nurses found that aggressors were mostly female (51.69%) or both female and male (32.67%) (da Silva João & Saldanha Portelada, 2019).

Drawing upon such notions, we hypothesized that the lateral violence perceived by hospital nurses is related to variables such as sex, age, area of work, job tenure, and length of time on the job which are expected to impact perceptions, as observed in the literature

on user violence. Also, the consequences most commonly found in the literature (burnout, low job satisfaction, and health problems) would vary according to the perception of lateral violence.

Our first study argues for a considerably high exposure of nurses to violence from coworkers and inappropriate behaviors in their workplace (Einarsen et al., 2009; Estryn-Behar et al., 2008; Hamblin et al., 2015; Norton et al., 2017; Spector et al., 2014). It also found support for its highly negative impact on psychological health (Bambi et al., 2019; Waschgler, Ruiz-Hernández, et al., 2013), leading nurses to consider leaving the job (Bambi et al., 2019; Stanley et al., 2007). As a result, pondering the adverse impact of this phenomenon on patient care and attention if they stay on the job, is inevitable (Johnson, 2009).

We found male nurses with greater rates of personal lateral violence (such as having rumors spread about them). Prior studies had similar findings (Guay et al., 2014; López-López et al., 2019; Wright & Khatri, 2015). The influence of cultural aspects may be accountable (e.g. women being seen as more vulnerable and frail) (Sakellaropoulos et al., 2011; Spector et al., 2014). Yet, no sex differences were found in social and work-related attacks, nearer to other studies that find no significant sex differences in lateral/horizontal violence (Purpora et al., 2012).

Besides the physical, psychological, and sexual manifestations of workplace violence toward a person or group of people (Chappell & Di Martino, 2006; Koritsas et al., 2010; Wiskow, 2003), the intentionality is referred to when there is a pattern of harassment, known as mobbing (Einarsen et al., 2020; Zapf et al., 2020). The term derives from the Scandinavian word for bullying (in Swedish, *mobbning*) (Heintz, 2004; Olweus, 2009) as

"a group of children ganging up on the same victim, harassing and tormenting him/her repeatedly" (Olweus, 2009; Salmivalli, 2010).

This is a multifactorial phenomenon (Veenstra et al., 2010) that is helpful to lateral violence studies. Studies suggest that the aggressor's appraisal of specific characteristics of the victim determines violence' exertion, whether according to findings concerning psychopathic criminals (Book et al., 2013) or school violence studies (López et al., 2021; Veenstra et al., 2010). In the latter, aggressors tend to choose their victims depending on the likelihood of losing the affection of others, preferring victims who are less expected to be able to defend themselves or be defended (Veenstra et al., 2010) among other aspects broadly explained in specialized research (López et al., 2021; Ruiz-Hernández et al., 2020). Although outlying the purposes of the current assignment, such inputs are of considerable interest.

Previous research on workplace violence suggests that perpetrators target those who are newer to the job for being less experienced and less likely to defend themselves (Bambi et al., 2019; Berry et al., 2016). Our study found a higher prevalence of personal lateral violence in professionals with an inferior time in the job yet not necessarily the youngest. Personal-based violence such as gossiping, boycotting, and tough love is commonly perceived by young nurses as part of a permissive culture of vertical and/or lateral violence (Berry et al., 2016), but it also targets nurses who are not necessarily young, but are younger than their leaders (Berry et al., 2012).

The youngest nurses in our sample were not those who perceived more workplace violence in general, challenging studies that indicate a higher risk in younger people (Ariza-Sosa et al., 2015). This is suggestive that lateral violence is more a matter of

power, in which victims seem to have less of it, more than age. This is to say that it may be true that sometimes power may come with age, but there are other features to be accounted for.

For example, one of the seven parameters of Ege (Ege, 2010) to identify mobbing situations, refers that victims are unable to defend themselves due to power asymmetry, whether lateral/horizontally (when the victim and aggressor hold similar positions in the job, but the first perceives the second as stronger), vertically (when the mobber and the victim have different positions), or even strategically (when the aggressor, which higher position, uses mobbing to make the victim leave the job or department).

In fact, nurses were found to get mobbed mostly of the descending type in a Portuguese study, mostly from head nurses (42.44%) and doctors (29.03%) and those less identified as aggressors where medical aid and administrative personnel (da Silva João & Saldanha Portelada, 2019), suggesting that higher power is more frequently found in aggressors.

Besides, lateral violence in healthcare is a nurse-to-nurse phenomenon that is sheltered by institutionalized tolerance (Wilson, 2016). It is anchored to the belief that hierarchy requires a certain amount of toughness and domination to succeed (Bloom, 2019; Wilson, 2016) as is observable in lateral violence legitimizing cultures (Fink-Samnick, 2016). This is frequent in Latin European countries, keeping a relationship with low personal distance (Karatuna et al., 2020), but with clear power differences (Norton et al., 2017).

This though-love guided nurse-to-nurse knowledge-sharing puts trainees and newly hired nurses with experience, regardless of age, in a vulnerable position (Dellasega,

2009). Striking as it may seem, only one out of five nurses is aware of the abusive behaviors that they are being targeted at within their workplace (da Silva João & Saldanha Portelada, 2019).

Interestingly, our data finds nurses aged more than 50 years less likely to perceive aggressions such as withholding information, disregarding, or being forced to work below individual competence, although other studies identified it in nurses with a longer average time in the profession (20 years) (Etienne, 2014). They are mostly reported as frequent in nurse leaders and staff toward new nurses (Berry et al., 2012) while the risk of lateral violence is reported to decrease as nurses' length of service and age increase (Karatuna et al., 2020).

The present work found perceived co-worker violence to be higher among nurses who work shifts. This is corroborated by previous studies that conclude a higher risk of vertical and lateral violence in shift-working nurses, compared to fixed-schedule workers (Dewitty et al., 2009; Norton et al., 2017). It also finds social lateral violence factors to have a higher prevalence in external consultations and outpatient units although without significant differences. There are references in the literature pointing to higher rates of lateral violence in Emergency Services (Oh et al., 2016b; Spector et al., 2014).

The more violence nurses perceived, considering all forms of lateral violence analyzed in the present study (personal-, social-, and work-related), the less extrinsic and intrinsic satisfaction they felt in their jobs. Besides, the likelihood of developing burnout symptoms was significantly increased in such cases, placing considerable danger to nurses' health, as is observed in user violence studies (Galián-Muñoz et al., 2014; Galián-Muñoz et al., 2016; Llor-Esteban et al., 2017).

The present data further places lateral violence as a predictive factor for burnout ($\beta = 0.37$ $p < 0.001$) with a relevant negative correlation with job efficiency ($r = -0\ 322$, $p < 0.01$), similar to prior studies (Bambi et al., 2018).

Considering that violence is deleterious to any person's well-being, it represents a significant additional stressor to nurses who are working in a challenging setting *per se*. This is especially true when it is prolonged in time when, in the long run, it becomes toxic and health-disruptive, impairing self-regulating body functions and psychological health (ILO/WHO, 2014).

An ER-based study found a total of 91.7% of respondents revealing that lateral violence was decreasing their job satisfaction, putting in question the loss of a considering high percentage of nurse workforce (53.3% pondering transfer or turnover) (Swafford, 2014) or absenteeism (1.5 times higher in comparison to non-victimized peers) (Bambi et al., 2018).

After random block sampling, prompting a total sample of 925 nurses from 13 public hospitals in southeast Spain, our cluster analysis was aimed at evincing characteristics of nursing professionals depending on the lateral violence perceived. Mostly young of age but also in the profession or current job for less time, reinforcing the previous readings, and largely female, the analysis performed on our sample allows us to draw a negative correlation between personal, social, and work-related violence and both extrinsic and intrinsic satisfaction.

Several studies have depicted the relationship between violence and burnout in healthcare (Chirico, Ferrari, et al., 2021; Gascón et al., 2013; Marôco et al., 2016) Estryn-Behar, 2008 #745; Wu, 2020 #422}and other professions (Chirico, Capitanelli, et al.,

2021; Oliveira & Queirós, 2012). Depending on a lower or higher perception of these three forms of lateral violence by nurses, an overall significant correlation is found to burnout symptoms, more substantial in the case of a higher perception. Burnout syndrome has a high prevalence in Spain (Juliá-Sanchis et al., 2019) and has been related to the continuous close interaction observed in healthcare, particularly in the nursing profession (del Carmen Pérez-Fuentes, Jurado, et al., 2020; Muñoz et al., 2018)

Troublesome health problems (anxiety, insomnia, social dysfunction, somatic symptoms, and depressive symptoms) are identified in the studied sample of nurses who were exposed to lateral violence, and those with higher scores of perceived lateral violence have the worst health outcomes. Yet the results suggest that health is impacted by lateral violence *per se,* regardless of its frequency of intensity, supporting prior studies (De Puy et al., 2014; Hassankhani et al., 2018; Najafi et al., 2018), often taking the form of an overall inflammation state (Bayes et al., 2021). Such outcomes include hypothalamic–pituitary–adrenocortical (HPA)-axis disruptions (Galletta et al., 2019; Rossouw, 2018) and signs of oxidative stress that are a common ground of several morbidities (Di Rosa et al., 2009). The HPA axis refers to the hormonal interactions leading to cortisol production and its dysregulation is known to underlie conditions such as depression, anxiety, sleep disorders, burnout, obesity, diabetes, and hypertension (Bellingrath et al., 2008). However, there are studies about WPV that find no association between cortisol and long sick leaves from work (Grynderup et al., 2017; Gullander et al., 2015).

Another overwhelmingly disruptive consequence mentioned in literature is allostasis, referring to the term coined by McEwen and Stellar "allostatic load" (McEwen & Stellar, 1993). It is a mechanism through which the body maintains homeostatic balance, by allocating metabolic energy to face stressful demands (Juster et al., 2010). Lupien et al (2006) presented allostasis as the price paid for the nervous system hyperactivation, meaning that the same structures allowing adjustment to stress and protecting it in the short-range are, at the same time, prone to be counterproductive if hyperaroused by stimulating pathophysiological responses (Juster et al., 2010).

Studies also show that the experience of lateral violence is a predictor of conflict at home, with the influence of a burnout dimension: psychological detachment (Rodríguez-Muñoz et al., 2017). Workers under burnout report a generalized state of emotional fatigue, which is often manifested by a feeling of exhaustion, apathy, and loss of interest in the job (Seguel & Valenzuela, 2014; Weinberg & Creed, 2000), as also occurs in other fields, such as caregiving (Pérez-Fuentes, Gázquez, Ruiz, & Molero, 2017).

It is extremely admissible to anticipate that nurses who perceive violence during their working hours from coworkers, and who exhibit detachment and exhaustion feelings, besides doubting their abilities and admitting consequences to their health, will seldom feel happy at their place of work. The sense of continuous positive experience, related to the flow state that derives in happiness at work (Csikszentmihalyi & Seligman, 2000) and of positive affect (Adams & Bond, 2000) is, in these cases, completely obstructed. In general, our findings support that nurses who suffer lateral violence tend to experience lower intrinsic satisfaction, implying a lack of response to the worker's need for positive sensations and self-accomplishment (Decker et al., 2009).

As we see it, low intrinsic satisfaction entails a perception by professionals of a low responsibility attribution, of little or no decision-making opportunities, and of having their skills disregarded or not appropriately used, developed, or duly valued, leading to a widely observed lowered sense of accomplishment in the workplace (Chang et al., 2019; Decker et al., 2009; Kalleberg, 1977).

On the other hand, extrinsic satisfaction understood concerning organizational variables is also impacted. This impact leads the professional to have a negative appraisal of his/her job and all that is related to it, from company policies, salary, and shifts, to work schedules or workload (Zheng et al., 2017). The association between these variables in the current study has also confirmed the findings of other ER-based studies (Swafford, 2014) with most respondents stating that lateral violence decreases their job satisfaction, and considering transference to another unit, hospital, or turnover, a reading that is common to other approaches (Berry et al., 2016).

This suggests that nurses targeted by violence from their peers, feel more exhausted emotionally and develop more anxious-depressive and somatic symptomatology, but respond by internalizing, self-desensitizing, or slipping into lethargy (cynicism), which affects their social interaction abilities (social dysfunction) (Gil-Monte, 2002; Seguel & Valenzuela, 2014).

Krut et al (Krut et al., 2021), in their thematic analysis, demonstrate LV as destructive to mental health and as a leading cause for new nurses abandoning their profession. The emerging subthemes were the perception of a vicious cycle of violence, of older nurses eating their young, along with the shame, isolation, and vulnerability of victims. This is supportive of lateral violence predicting significant health deterioration, besides lowering

job satisfaction, which overall is a common framework that leads nurses to leave their jobs (Berry et al., 2016; Krut et al., 2021; Stanley et al., 2007; Wilson, 2016), although not totally clearing the role of burnout in such reckoning. There is consensus, though, that such a reality promotes harmful conditions to the quality of patient care in case these nurses decide to stay on the job, without a proper resolution of this problem (Johnson & Benham-Hutchins, 2020; Johnson, 2009; Krut et al., 2021).

Summarizing data resulting from our cluster analysis, which is coherent with priorly performed correlational analysis, cluster 1 evinces a low exposure to all three types of lateral violence. It is a profile with moderate-high satisfaction, a mild mental health variation (subclinical), and a moderate-high alteration of variables related to burnout. The effects of experiencing lateral violence may be mitigated by social support and resilience (Lee et al., 2019). The mediating role of resilience when facing harassment in the workplace promotes the following: the more resilient victims are, the more they endure, (García-Izquierdo et al., 2019) often masking important alert signs, which constitutes the basic ingredients to bake burnout.

On the other hand, the second profile, cluster 2, comprising individuals with much higher exposure to all three types of lateral violence, displays much lesser job satisfaction. In fact, this profile exhibits a more severe impact on health (still at a subclinical level) and a higher score on burnout-related variables, particularly on emotional exhaustion-related items.

Comparing these profiles allows noticing that all variables had relevant effect magnitudes, except for professional efficacy. The highest effect was observed in emotional exhaustion and social dysfunction, followed by cynicism, anxiety, and

insomnia. Interestingly, even though cluster 2 presents higher scores than cluster 1, the only variable that displays a definite severity variation is emotional exhaustion. This variable changes from moderate-high in cluster 1 to high in cluster 2 which suggests a gradually increasing tendency of the negative consequences on nurses who suffer lateral violence continuously. This was suggested by previous research about the relationship between workplace bullying behaviors and professional well-being, burnout, and turnover intent in nurses, pointing to a significant relationship between the first variable and all subdomains of burnout, especially emotional exhaustion (Kim et al., 2019).

Emotional exhaustion was named by Leiter and Maslach (2003) as "the core burnout domain directly affected by workplace bullying". Wolf et al. (2017) achieved identical results in a qualitative study in which emergency nursing personnel, by classifying lateral violence as the source of emotional and mental exhaustion, in a cyclic progression of fatigue and bullying, and so on. Causes are traced back to the phenomenon described as "competitive nursing", based on the idea that competitive effort and excessive workload are seen by nurses as what makes them more valuable and well-considered in decision-making moments (Wolf et al., 2017).

What seems striking is that incivility and bullying among nurses spread as a rite of passage during nurses' training and first years of practice (Cecelia L Crawford et al., 2019). The toxic culture of "nurses eating their young" is particularly present during the first year of nursing practice and has proven to be harmful to nurses' mental health (Krut et al., 2021). Many authors suggest that this outcome is preventable by using simulation and role-plays tackling WPV behaviors and consequences, during academic training (Aebersold & Schoville, 2020; Schoville & Aebersold, 2020).

Considering the hazards of workplace violence to health professionals and services, organizational policies became mandatory in developed countries to prevent it and its consequences on psychological health (Leka & Jain, 2014; Potter et al., 2019). Preventive programs and health-promoting benchmarking may prevent workplace violence from happening or at least detect its occurrence in an early stage (Chirico, 2015; Potter et al., 2019).

Albeit these results are revealing of the challenges posed by lateral violence to nurses and healthcare, we must point out that since it was not possible to obtain the participation of 100% of the nurses of all participant centers, the obtained results require prudent interpretation. We found it necessary to reduce the extent of the evaluation to properly analyze the phenomenon and chose to exclude variables that would probably have allowed further knowledge, such as user violence, for example. Also, considering that this study is based on data collected before the COVID-19 pandemic, some aspects may have changed in the meanwhile in the Spanish public health system.

Drawing upon the previous approach, a cross-sectional design with a double descriptive-associative strategy was used to allow another look over the 950-nurse sample. Physical and non-physical violence from users toward professionals was measured using Health Aggressive Behavior Scale – Users (HABS-U), while personal, social, and occupational violence among co-workers, by using the Health Aggressive Behavior Scale – Co-workers and Superiors (HABS-CS). A burnout scale, Maslach Burnout Inventory – General Survey (MBI-GS), was used to assess professional exhaustion, efficacy, and cynicism, while dimensions of depression, anxiety, somatization, and social dysfunction, were evaluated by using the General Health

Questionaire (GHQ-28). The goal to calculate the models was sought by using workplace violence as a predictor of symptomatology and using the burnout variables as mediators. Regression coefficients with and without mediation model, direct and standardized estimates were obtained and bootstrap analysis was used to calculate direct mediation effects.

Our results provide support to the hypothesized model, meaning that exposure to WPVH leads to nurses ending up perceiving much poorer health when it is mediated by burnout, especially by emotional exhaustion. This adds evidence to findings that relate more WPV to more burnout (Bernaldo-De-Quirós et al., 2015), without disregarding the direct impact of violence on health. Alongside the strong positive correlations observed between all three subtypes of lateral violence and both subtypes of user violence and decreased quality of health indicators, we underline the importance of the time during which this violence is endured.

Such findings invite reflection on burnout, as a psychological stress response to demanding work conditions, that arises gradually, usually beginning with symptoms of emotional exhaustion (Maslach & Schaufeli, 2018), and a feeling of emptiness and exhaustion resulting from high toxic stress levels (Maslach & Schaufeli, 2018). Emotional exhaustion is a central feature of burnout and, in our results, is found in the roots of especially adverse outcomes of the subtypes of both user and coworker violence that of a more subtle or refined nature: non-physical UV and personal lateral violence, respectively. Such evidence supports the powerful negative effect of latent forms of aggression, seldom noticed by the victim or bystanders (Einarsen et al., 2020).

Preventing WPVH is a step to improve the work environment (Wu et al., 2020) and a key element to improve nurses' health and prevent decreased well-being and work quality (Hsiao et al., 2021). Moreover, it significantly predicts poor health perception, via the indirect relationship between user violence and nurses' general perceived health, with emotional exhaustion and cynicism as mediators. The latter are dangerous products of WPVH, since, for not being easily identified, they allow the hazard to persist and insidiously destroy the victim's ability to function in a medium and long-term (Boudrias et al., 2021; Laschinger & Grau, 2012; Pina, Llor-Zaragoza, et al., 2022).

Verbal and psychological abuse is actually the most frequently observed in health institutions (Mento et al., 2020), a latent form of violence (Galtung, 2018) based on person-directed abuse. It consists of using manipulation, misleading, or lying to disrupt the victim (Sloan et al., 2010; Sweet, 2019) and, as described by Griffin (Griffin, 2004), in "non-verbal innuendo (raising eyebrows, making a face)" and "verbal affront (covering up, snide remarks, lack of openness, and abrupt responses)."

Nurses who depersonalize and become cynical as a response to work-related stress, which is the interpersonal dimension of burnout (Hogh et al., 2011), are often merely responding to an overload of emotional exhaustion and loss of idealism, and end up shifting from giving their very best to give the bare minimum (Maslach & Leiter, 2006).

What also should raise the most absolute concern, for a variety of reasons, is that what begins as a strategy of self-protection may crystalize and derive in severe dehumanization (Fontesse et al., 2021; Maslach & Leiter, 2006; Maslach & Schaufeli, 2018; Vaes & Muratore, 2013). The observed dynamics of WPVH are here consistent with previous

studies, correlating depersonalization positively to user and lateral violence (Khamisa et al., 2013; López-López et al., 2019).

In order to prevent common consequences such as nurses turnover (Hsiao et al., 2021; Kim et al., 2019), and decision-making impairment, which are detrimental to patient care (Volz et al., 2017), our findings urge action to prevent violence from occurring, namely by improving work relations (Wu et al., 2020).

Nurses' accounts of user violence can be overwhelming and explain the toxic levels of stress related to dealing with violent patients or relatives, which set the grounds for ill mental and physical health (Hassankhani et al., 2018). Tested models focusing on the different subtypes of violence show strong relationships between perceived violence from users and health, especially with the mediating role of Emotional Exhaustion. Particularly, in the non-physical type of violence, with depersonalization and Emotional Exhaustion as mediators, our SEM suggests indirect effects of verbal (non-physical) UV on ill general health outcomes through burnout, due to the cumulative effect of stress, adding on to other studies (Galián-Muñoz et al., 2016; Llor-Esteban et al., 2017; Ruíz-Hernández et al., 2016; Waschgler, Ruiz-Hernández, et al., 2013) besides the burden of Emotional Exhaustion on professionals' wellbeing (Pina, Llor-Zaragoza, et al., 2022) and professional efficacy (Llor-Esteban et al., 2017).

From deprecating comments to life threats, nurses face daily non-physical aggressions that concur with somatic symptoms, anxiety, social dysfunction, and depression (Llor-Esteban et al., 2017). This is worse if nurses are not supported or motivated (Galián-Muñoz et al., 2016).

Physical violence in hospitals particularly impacts male nurses, and is recurrently employed by patients' relatives, more when the patient is seen as vulnerable by the aggressor (Dafny & Beccaria, 2020). The high prevalence of user Physical violence in our data is similar to other studies (Liu et al., 2019) harming general health (Lanctôt & Guay, 2014; Mento et al., 2020; Schablon et al., 2018) with or without burnout as mediators, but stronger when both are used as other authors sustained (Salvagioni et al., 2017) while mediating depression symptoms (Laschinger & Grau, 2012).

The model puts physical violence by users as a strong predictor of Emotional Exhaustion and Depersonalization, stressing the need of preventing it for it is a known pathway to burnout (Gascón et al., 2013), notwithstanding its impact on general health at a less significant level (Volz et al., 2017).

Our Lateral violence explaining models also underline Personal type as holding a direct negative effect on victims' health regardless of mediators. But depersonalization and particularly Emotional Exhaustion, predict ill health outcomes regardless of the direct pathway between perceiving personal attacks from other nurses and health problems. Being a direct target of personal remarks and verbal hostility, commonly present in the literature as incivility, has been related to high levels of burnout (Bambi et al., 2018) particularly emotional exhaustion (Spence Laschinger et al., 2009).

Also, our SEM particularly indicates that Emotional Exhaustion is strongly predicted by social lateral violence and its typical harassing behaviors, ganging up against, plus intimidating and isolating strategies. The social type of lateral violence lies in the obstacles posed to the victim, in ostracizing agendas, and humiliation (Cacioppo & Patrick, 2008; Pina, Vidal-Alves, et al., 2022). But, more expressively, the model

demonstrates the mediating role of these social attacks on nurses' General Health, apart from the direct impact of Social LV on health, consistently referred to as social exclusion, silence treatment, speaking in the back, and personal derogation (Bambi et al., 2014; Bambi et al., 2019; Johnson, 2011; Rosi et al., 2020; Waschgler, Ruiz-Hernández, et al., 2013).

Contrary to our expectations and to prior studies (Pien et al., 2019), our results do not support that violence from coworkers is more impactful, long-lasting, and overall deleterious to nurses than violence from users (external). Our SEM does not depict higher effects of LV directly on health or through burnout pathways.

As said before, nurses are victims, but also perpetrators (Bambi et al., 2019), and many exhibit favorable attitudes toward this sort of violence (Babiarczyk et al., 2020; Bambi et al., 2019; Einarsen et al., 2009; Estryn-Behar et al., 2008). Undermining colleagues to get ahead and gain recognition in the workplace, regardless of ethical concerns is frequent (Dafny & Beccaria, 2020; Myers et al., 2016). This work-related LV is aimed at exerting power and destroying the self-esteem of those with less power (Myers et al., 2016; Roberts, 2015; Rosi et al., 2020).

Our Work-related LV model adds evidence to its direct relation to Health and the highly significant modulating role of Emotional Exhaustion. Raising awareness of professionals is fundamental when evidence stresses that victims are often unaware of the abusive nature of these behaviors. Also, perpetrators may ignore the destructive impact of their actions until it is too late.

The Oppressed Group theorization puts the strain on the perpetrator's insecurity as a risk factor (Roberts, 2015), employed in the rite of passage of nursing work pathways (Rosi et al., 2020). It is legitimized as a tough-love approach conveyed to every new nurse, to prepare them for the future (Leong & Crossman, 2016; Vidal-Alves et al., 2021).

Finally, as the first sign of burnout (and the primal effect of violence) emotional exhaustion requires immediate action from organizations and policy-makers (Leong & Crossman, 2016; Rosi et al., 2020), but appropriate prevention actions must tackle attitudes toward nursing education (Fink-Samnick, 2016; Gillespie et al., 2017; Gutiérrez-Puertas et al., 2020), bystander education (Hellemans et al., 2017; Jönsson & Muhonen, 2022; Ng et al., 2022; Padgett & Notar, 2013; Paull et al., 2012), and start in higher degree institutions both to prevent violence, detect early signs (during internships, for example) and promote a healthy workplace environment.

Studies have found higher resilience in victims who do not perceive external support (e.g. from their organization) or perceive an external endorsement of the violence that affects them (Ford & Ivancic, 2020). But resilience, if understood as a positive adaptation, or an ability to stay mentally stable despite experiencing substantial trauma or adversity (Herrman et al., 2011; Rutter, 1993), leads to the endurance of violence for long periods, since it does not raise alarming features in the affected professional, or because the affected professional has the ability to mask it. This may be an explanation for how nurses endure violence to an extent that allows burnout to install and impact health more severely.

Reframing back to the stimulating nature of the world of work, one can say that it is fundamental to a person's growth (Csikszentmihalyi, 1990). This growth is here outlined as moderately goal-guided and moved by motivation and will toward attainable goals. This personal growth is within reach if the person is allowed to overcome challenges, which promotes a feeling of being more capable and skilled. It further allows differentiation, a process towards the uniqueness of the self, but it also allows integration, which means the union with other people, with different views from that of the self. Combining both is essential in the world of work, leading to success. Someone who differentiates may grow, yet get mired in loneliness or egotism. On the other hand, someone who depends only on being integrated will lack autonomy or personal individuality. Investing psychic energy in both might increase a professional's well-being and satisfaction.

Curiously, the pioneer studies about flow experiences (Csikszentmihalyi, 1990; Csikszentmihalyi, 2000), define it as "*a subjective psychological state that people report when they are completely involved in something to the point of forgetting time and their surrounding except the activity itself*". They were found to be reported more often when working, although individuals report they feel more motivated toward leisure than at work, this occurred because they feel more motivated in flow than in apathy (Csikszentmihalyi, 2000). This flow experience relates to features such as motivation, peak performance, peak experience, and enjoyment (Abuhamdeh, 2020; Csikszentmihalyi, 2013). Workplaces may be places of enjoyment for being a challenging activity that requires skills, and a pathway to happiness (Csikszentmihalyi, 2013), provided that disruptions such as workplace violence are deterred.

Several programs stand for prevention models. Some stress the power of legislation and sanctions to deter violence and to force organizations to take action against it (Chirico et al., 2019; Chirico, Nucera, et al., 2021). Other focus on intervention by suggesting protocols for action after violence took place, facilitating revelation by those targeted (d'Ettorre et al., 2018). They further recommend fostering positive relationships with healthcare users and encouraging training in areas such as self-safety, emotion validation, empathy, or interpersonal communication (d'Ettorre et al., 2018; Pina, Peñalver-Monteagudo, et al., 2022) or promoting accurate reporting of each violent incident and organizational full commitment to WPV prevention programs that involve and account for the needs of nurses along the way (d'Ettorre et al., 2018; Raveel & Schoenmakers, 2019).

The exercise of power is often the root of a negative environment in nursing teams, combined with a lack of leadership skills (Shorey & Wong, 2021). Some authors underline that nurses not only are unsupportive toward one another (colleagues, trainees, subordinates), but also actively use power and instill fear in order to protect their position, assert their importance in the organization, or just improve their self-perception (Condie, 2016; Grace, 2016). Someone who endorses violence may be more impactful if his/her environment also supports this belief, by increasing the probability of adopting violent behaviors, differently from the outcome of living in a non-violent setting, where a peaceful resolution of conflict might be more likely (Krug et al., 2002).

The feeling of being in a war zone is encouraged by leaders who are absent from the field, and turn a blind eye to the hostility and violent behaviors taking place. On the flip side of the coin, a leading role figure who is visible in the field and inhibits incivility and

harassment behaviors is protective of violent occurrences (Shorey & Wong, 2021). This is especially critical for those new to the job who seek to establish good work relationships (Hanks, 2017) but are often unaware of the existence of coworker violence and will require support upon facing such a harsh reality (Rosi et al., 2020). Furthermore, considering that the role of leadership in nursing teams has been presented as a protective factor by providing a caring role and positive environment (Anthony & Brett, 2020; Peng et al., 2022) this appears as a significant strategic area to invest in to prevent lateral violence.

Some strategies, namely those involving the role of bystanders, seem promising. Bystanders are colleagues who are in a strategic position to witness WPV, including the most insidious incivilities. If they tolerate or ignore violence, this gives bullies a sense of impunity (Salmivalli, 2014), but, if they do not, they are increasingly viewed less as a problem and more as part of the solution (Pouwelse et al., 2021). Their inaction may be due to low perceived severity, which is paramount in determining helping behaviors, but also due to not feeling equipped to assist harassed colleagues (Hellemans et al., 2017).

As many ethnographic studies have shown, sometimes a culture of fear, violence, and helplessness exists because no alternatives are foreseen. From the selfishness of historically impoverished civilizations, and enjoyment of explicit violence in warrior tribes to ignoring what a smile or a laugh mean due to internalized fears, this lack of better perspectives leads entire groups to remain fearful, unhappy, and under psychic entropy, although alternatives exist (Abuhamdeh, 2020; Csikszentmihalyi, 1990; Csikszentmihalyi, 2013).

Ultimately, we meant to bring to light a phenomenon that seems, although extremely hazardous, to have remained under the veil of tolerance and normalization, leaving so many nurses without their smiles. Empowerment comes from knowledge and it is hoped that this work has been a valuable contribution to such an honorable goal.

Knowing nurses from a more in-depth perspective (such as clinical psychology, as patients) reinforced to me the idea that most of them, if not all, are so incredibly brave and self-demanding on a daily basis that this study and all that is still to be done become more and more crucial as I think of it. People who dedicate their lives to saving the lives of others, reducing their pain, healing their wounds, and who work under the high strain of time and knowledge demands that such tasks include, deserve both academia and science close attention in the pursuit of positive work relations, personal achievement, patient-care best quality, and both personal and collective happiness, in the long-run.

Life, health, and personal integrity are constitutional rights and the results of this study are a reminder that they are not being guaranteed and safeguarded in the world of work, and in healthcare settings in particular. Nurses, like most health professionals, dedicate their lives to the health, well-being, and care of others. This does not need to take place at the expense of their own health and well-being, no matter how demanding the task. On the contrary, their work may be an important source of motivation and stimulus as well as an opportunity for personal growth. We hope to have provided a solid contribution to improve the quality of the work environment, violence prevention, and health promotion of nurses and leave here a sincere tribute to all.

6. General conclusions

Based on the obtained results, the following general conclusions may be drawn:

- Lateral violence among nurses is prevalent and impactful. Different features may be found between its common expressions: personal, social, or work-related.

- Our results stress about Personal Lateral Violence that: it is more evinced by male nurses, by nurses with short to medium length of time on the job, yet not necessarily the youngest of age, and not necessarily new to the job. Our explaining model of Personal lateral violence evinces strong impact on Emotional Exhaustion and Cynicism. Nurses' health is weakened by Personal Lateral Violence, which produces more anxiety and somatic symptoms. Both intrinsic and extrinsic job satisfaction are significantly negatively impacted by personal lateral violence. Personal lateral violence highly predicts both Emotional Exhaustion and Depersonalization in nurses and emerged as a significant predictor of deteriorated health, directly, and through burnout pathways, especially emotional exhaustion.

- Social Lateral Violence was perceived regardless of sex, of the hospital's magnitude but differently inside hospitals, being more prevalent in outpatient and external consultation units. It is more identified by nurses aged 30 to 50, with 6 to 11 years in the profession and 11-15 years in the current job position. Our explaining model demonstrated the high impact of Social Lateral Violence on social dysfunction, a dimension of burnout. Social lateral violence predicts both nurses' emotional exhaustion and depersonalization similarly; our explaining model depicts how emotional exhaustion can be predictive of deleterious effects on health.

- Work-related Lateral Violence was perceived regardless of sex, age, and hospital size, yet more prevalent in outpatient and external consultation units. It impacts negatively both job satisfaction, but particularly intrinsic satisfaction. Our Work-related lateral violence model supports a highly negative effect on health and a highly significant modulating role of Emotional Exhaustion between Work-related lateral violence and poorer health (somatization, anxiety, insomnia, depression).

- Our cluster analysis, based on dividing nurses according to their lower or higher exposure to Lateral Violence revealed that: the high-exposure group was associated to significantly more emotional exhaustion and depersonalization symptoms and identify more somatization, anxiety, insomnia, and depression symptoms, with the higher effect observed on social dysfunction. The comparison between profiles indicates that professionals with higher exposure to lateral violence feel lesser job satisfaction and more deleterious effects on their psychological and physical health.

- According to our explaining model, user violence is as impactful, long-lasting, and lethal as lateral violence, directly or through burnout pathways. Emotional exhaustion rose as an extremely expressive pathway between user violence and health problems. Verbal user violence predicted emotional exhaustion and depersonalization more significantly than physical user violence and both foretold a negative impact on health, more outstandingly so with emotional exhaustion as a mediator.

- In conclusion, a personal reflection. Knowing nurses more in-depth disclosed that most are so tough and self-demanding that they will endure any adversity, despite their suffering, but risk exhaustion and detachment due to that. They dedicate their lives to saving others, reduce their pain, working under high strain and work demands. Academia

and science owes them the pursuit for positive work relations, personal achievement, and personal and collective happiness, in the long-run. Life and health are constitutional rights and the professionals that safeguard them are not a guarantee (as Covid evinced recently) and must be protected. I leave here my sincere tribute to all nurses around the world.

Limitations

Although honest responses were encouraged by guaranteeing the anonymity of participants, a bias may persist, especially when sensitive is collected. Also, the study refers to a specific region, not acounting for differences from other populations nationally and internationally. It is to mention that it was not possible to have the questionnaire filled by 100% of nurses at the participanting centers. Besides, data was collected before the COVID-19 pandemic, and that much has changed in the meanwhile due to the various changes occurred in public health systems, not only in Spain but in many other countries.

Moreover, vertical violence, wether active or passive, was not assessed, since it was not considered the prime purpose of this thesis but is a very important aspect to be tackled.

A qualitative approach would also have provided valuable insight of the phenomenon. We hope to carry out such an analysis in the future, in Spain and Portugal.

Avenues for future research

It might prove beneficial to test the effectiveness of preventive policies included in university curricula, about occupational hazzards, human relations, as well as violence, and its consequences. Tackling attitudes toward use of “tough love”, mobbing, condescending behaviors, and challenging their validity in nursing education.

In healthcare workplaces, awareness strategies may also be tested for their ability to challenge professionals beliefs about what is acceptable behavior toward others, the consequences of violence on individual and collective health and theory of change. Combined with victims and bystanders' empowerment, about user and lateral violence, such strategies may be game changers in attitude change programs. This requires full organizational engagement, to frustrate violent competition and reinforce cohesion. Efficacy of support responses to help-seekers may be studied since there is evidence that bystanders will manifest more antisocial behavior and less prosocial behavior toward a targeted colleague if they anticipate stigma by association, while the opposite is also true.

Nurse leaders should be tested as key elements in organizational prevention programs, by engaging in advocacy and design of robust policies at the organizational level, through focus groups that foster a well-balanced work environment within the team.

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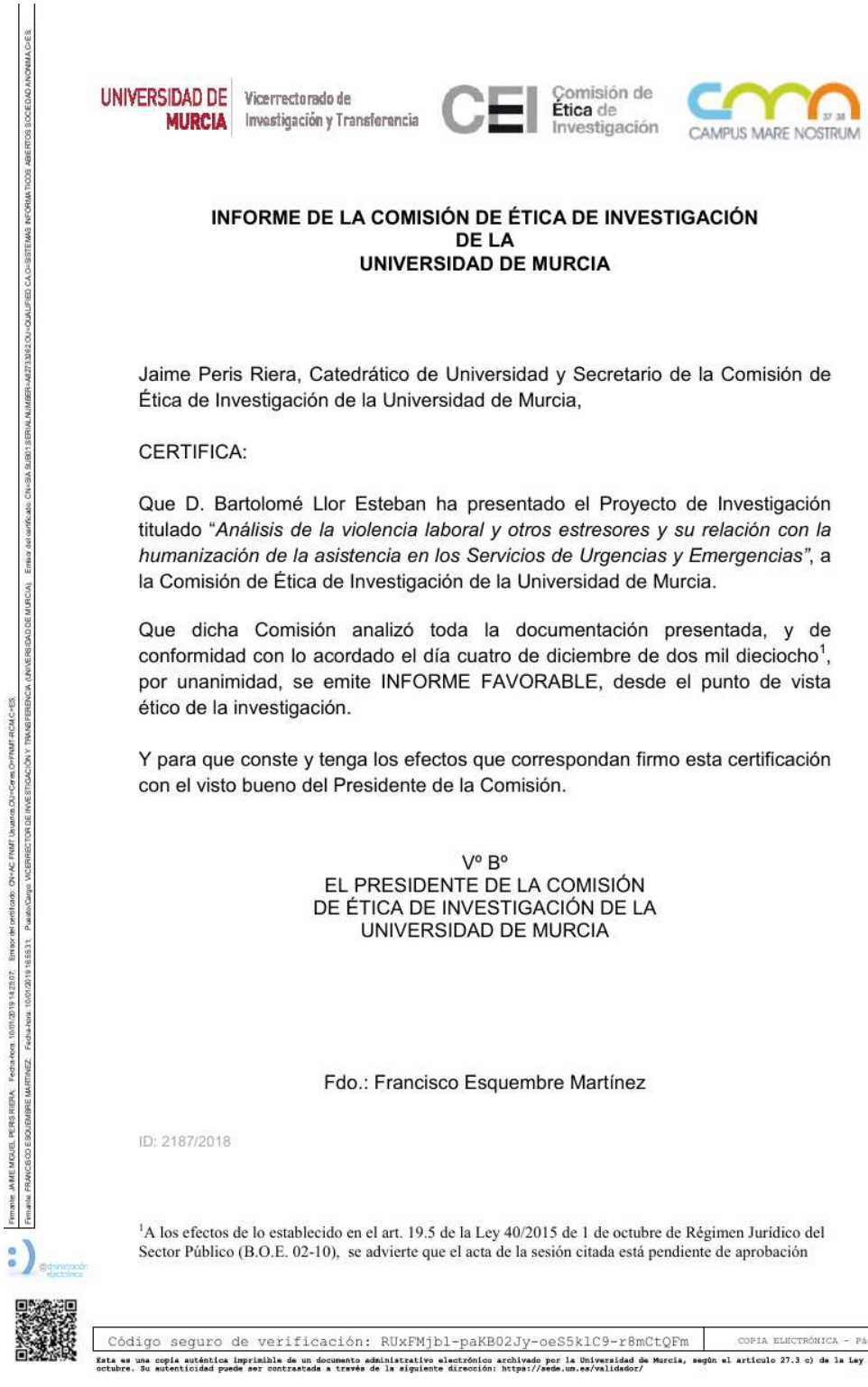
ANNEXXES

8. Annexes

ANNEX 1: Approval by Ethics Committee of University of Murcia (data collection Portugal)



UNIVERSIDAD DE MURCIA Vicerrectorado de Investigación y Transferencia — CEI Comisión de Ética de Investigación — CAMPUS MARE NOSTRUM

INFORME DE LA COMISIÓN DE ÉTICA DE INVESTIGACIÓN DE LA UNIVERSIDAD DE MURCIA

Jaime Peris Riera, Catedrático de Universidad y Secretario de la Comisión de Ética de Investigación de la Universidad de Murcia,

CERTIFICA:

Que D. Bartolomé Llor Esteban ha presentado el Proyecto de Investigación titulado "*Análisis de la violencia laboral y otros estresores y su relación con la humanización de la asistencia en los Servicios de Urgencias y Emergencias"*, a la Comisión de Ética de Investigación de la Universidad de Murcia.

Que dicha Comisión analizó toda la documentación presentada, y de conformidad con lo acordado el día cuatro de diciembre de dos mil dieciocho[1], por unanimidad, se emite INFORME FAVORABLE, desde el punto de vista ético de la investigación.

Y para que conste y tenga los efectos que correspondan firmo esta certificación con el visto bueno del Presidente de la Comisión.

Vº Bº
EL PRESIDENTE DE LA COMISIÓN
DE ÉTICA DE INVESTIGACIÓN DE LA
UNIVERSIDAD DE MURCIA

Fdo.: Francisco Esquembre Martínez

ID: 2187/2018

[1]A los efectos de lo establecido en el art. 19.5 de la Ley 40/2015 de 1 de octubre de Régimen Jurídico del Sector Público (B.O.E. 02-10), se advierte que el acta de la sesión citada está pendiente de aprobación

Código seguro de verificación: RUxFMjb1-paKB02Jy-oeS5klC9-r8mCtQFm — COPIA ELECTRÓNICA - Página 1 de 1

Esta es una copia auténtica imprimible de un documento administrativo electrónico archivado por la Universidad de Murcia, según el artículo 27.3 c) de la Ley 39/2015, de 2 de octubre. Su autenticidad puede ser contrastada a través de la siguiente dirección: https://sede.um.es/validador/

ANNEX 2: Approval of Research plan adjustment by the Academic Committee of the Forensic Sciences Ph.D. Program (excerpt)

7. Como asuntos de trámite:

    - Se aprueba la Modificación del Plan de Investigación de Dña. María Joao Vidal Alves, y el nuevo título de su tesis doctoral: "*Workplace violence, burnout and health of nursing professionals in hospital setting*" en inglés, y "Violencia laboral, burnout y salud de los profesionales de enfermería en el ámbito hospitalario", en español.

    - Se aprueba la solicitud de Prórroga de 1 año en el Programa presentada por Dña. Montserrat López Melero
    - Se aprueba la solicitud de Prórroga de 2 años a tiempo parcial presentada por D. Félix Grilo Bartolomé

8. No hay ruegos y preguntas

Sin más asuntos que tratar finaliza la reunión a las 13:00 horas

Vº Bº LA COORDINADORA

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ANNEX 3: Approval of the research methodologies by the Ethics Committee of the University of Murcia (data collection in Murcia, Spain)

UNIVERSIDAD DE MURCIA | Vicerrectorado de Investigación e Internacionalización

CAMPUS MARE NOSTRUM

COMISIÓN DE ÉTICA DE INVESTIGACIÓN

INFORME DE LA COMISIÓN DE ÉTICA DE INVESTIGACIÓN DE LA UNIVERSIDAD DE MURCIA

Jaime Peris Riera, Catedrático de Universidad y Secretario de la Comisión de Ética de Investigación de la Universidad de Murcia

CERTIFICA:

Que D. José Antonio Ruiz Hernández ha presentado el proyecto titulado *"Violencia laboral en profesionales de Atención Primaria"* a la Comisión de Ética de Investigación de la Universidad de Murcia, cofinanciado con fondos propios de la Universidad de Murcia y con la ayuda recibida por Dª. Cecilia López García en la Convocatoria de 2012 de Ayudas a Proyectos de Investigación del Colegio Oficial de Enfermería de la Región de Murcia

Que dicha Comisión analizó toda la documentación presentada, y de conformidad con lo acordado el día 11 de marzo de 2013[1], por unanimidad se emite informe FAVORABLE desde el punto de vista ético de al investigación.

Y para que conste y tenga los efectos que correspondan, firmo esta certificación, con el visto bueno del Presidente de la Comisión, en Murcia 11 de marzo de 2013.

Vº Bº
EL PRESIDENTE DE LA COMISIÓN
DE ÉTICA DE INVESTIGACIÓN
DE LA UNIVERSIDAD DE MURCIA

Fdo.: Gaspar Ros Berruezo

[1] A los efectos de lo establecido en el art. 27.5 de la Ley 30/1992 de 26 de noviembre de Régimen Jurídico de las Administraciones Públicas y del P.A.C. (B.O.E. 27-11), se advierte que el acta de la sesión citada está pendiente de aprobación

ANNEX 4: Approval of the *Servicio Murciano de Salud* for the research

Servicio Murciano de Salud

Área I Murcia Oeste Arrixaca

Fecha: Murcia a 30 de mayo de 2013

De: D. José Vicente Albaladejo Andreu
Director Gerente Hospital Clínico Universitario Virgen de la Arrixaca, Área I Murcia Oeste

N/Ref. JVAA/LH

Universidad de Murcia

D. José Antonio Ruiz Hernández
D. Bartolomé Llor Estebán
Directores Grupos de Investigación
Psicología Social y Salud Laboral.
Universidad de Murcia
Campus Universitario de Espinardo
30100. Espinardo

Estimados Directores:

En contestación a su solicitud de autorización para la recogida de datos a través de encuesta y mediante muestro aleatorio entre los profesionales sanitarios de los Centros de Salud de Alcantarilla-Sangonera, Alhama, La Alberca, Murcia-San Andres, Mula El Palmar y Espinardo, para el Proyecto de Investigacion **" Violencia Laboral entre los profesionales de Atencion Primaria"** suscrito por D. Jose Antonio Ruiz Hernández y D. Bartolomé Llor Esteban, Investigadores Principales y Directores de los Grupos de Investigación "Psicologia Social" y "Salud Laboral" de la Universidad de Murcia. le comunico que no existe inconveniente por parte de esta Gerencia en la realización del citado estudio.

Le recordamos que deberá hacernos llegar una copia del estudio una vez concluido, a la Gerencia de este Hospital ya que resulta de gran interés para nosotros.

La persona con la que deberá contactar en el Hospital es D. Luis Martos García, Supervisor de la Unidad de Docencia y Formación Continuada de Enfermería (teléfono 968 369 680), así como con D. Pablo Vigueras Paredes, Jefe de Servicio de Asesoría Jurídica, para la firma del documento de confidencialidad en el teléfono 968 369 666.

Un cordial saludo,

Consejería de Sanidad y Política Social. Servicio Murciano de Salud. Región de Murcia. Área de Salud I. Dirección Gerencia

José Vicente Albaladejo Andreu
Director Gerente Área I Murcia Oeste
Hospital Clínico Universitario Virgen de la Arrixaca

ANNEX 5: Approval and disclosure by the research committee of *Servicio Murciano de Salud*

Servicio Murciano de Salud

ÁREA DE SALUD VII MURCIA ESTE
HOSPITAL GENERAL UNIVERSITARIO REINA SOFÍA

INFORME DE LA COMISIÓN DE INVESTIGACIÓN

Francisco Miguel González Valverde, presidente de la Comisión de Investigación del Hospital General Universitario Reina Sofía, Área de Salud VII, Murcia Este.

CERTIFICA

Que en la sesión celebrada el día 12 de julio de 2013 se ha examinado la propuesta para que se lleve a cabo en esta Área de Salud el proyecto: ***Violencia Laboral en Profesionales de Atención Primaria***, que tendrá como responsable a D. José Antonio Ruiz Hernández, profesor de la Facultad de Psicología de la Universidad de Murcia, y se considera que:

- Conoce el protocolo de actuación
- Se cumplen los requisitos necesarios de idoneidad en relación con los objetivos del estudio.
- El estudio no ocasiona ninguna interferencia en el seguimiento habitual de os pacientes incluidos en el mismo.
- Las participaciones de los investigadores en este estudio no interferirán, en ningún caso, con sus labores asistenciales.
- La capacidad del grupo de investigación y los medios disponibles son apropiados para llevar a cabo el estudio, habiéndose comprometido los investigadores a llevarlo a cabo de acuerdo con su contenido.
- No están previstas compensaciones económicas.

Por lo que está Comisión de Investigación **acepta que dicho estudio sea realizado** en el ámbito del Área de Salud VII, Murcia Este, del Servicio Murciano de Salud.

Murcia, 12 de julio de 2013

El Secretario de la Comisión de Investigación

Enrique Bernal Morell

Hospital Reina Sofía COMISIÓN DE INVESTIGACIÓN

ANNEX 6: Approval for *Tesis por compendio* by the *Comisión Académica de Doctorado*

UNIVERSIDAD DE
MURCIA

Dª. MARIA JOÃO VIDAL ALVES

Vista la solicitud presentada el día 13 de julio de 2023, por **Dª. MARIA JOÃO VIDAL ALVES**, con NIU U0170002D sobre autorización para presentación de tesis doctoral como compendio de publicaciones con carácter previo a la tramitación de la misma en la Universidad de Murcia, le comunico que la Comisión de General de Doctorado, vistos:

- el informe previo de la Comisión Académica del Programa de Doctorado en Ciencias Forenses.
- el visto bueno de la Escuela Internacional de Doctorado.

resolvió, en su sesión de 19 de julio de 2023, **ACCEDER** a lo solicitado por la interesada pudiendo, por tanto, presentar su tesis doctoral en la modalidad de compendio de publicaciones con los siguientes artículos, siempre que aporte, con antelación a la presentación de la tesis doctoral, originales de los documentos que contienen firma manuscrita:

1. "Tough Love Lessons: Lateral Violence among Hospital Nurses".
2. "Profiles of lateral violence in nursing personnel of the Spanish public health system".
3. "(Un)Broken: Lateral violence among hospital nurses, user violence, burnout, and general health: A structural equation modeling analysis".

La presente resolución no pone fin a la vía administrativa. Frente a ella, de conformidad con lo previsto en el capítulo II del título V de la Ley 39/2015, de 1 de octubre, del Procedimiento Administrativo Común de las Administraciones Públicas y en el artículo 21 de los Estatutos de la Universidad de Murcia, aprobados por Decreto 85/2004, de 27 de agosto, los interesados pueden interponer recurso de alzada ante el Rector de la Universidad de Murcia, en el plazo de un mes, contado desde el día siguiente al de la notificación o publicación, sin perjuicio de que puedan intentar cualquier otro recurso que a su derecho convenga.

Lo que en cumplimiento del artículo 40.1 de la vigente Ley 39/2015, de 1 de octubre del Procedimiento Administrativo Común de las Administraciones Públicas, se notifica a **Dª. MARIA JOÃO VIDAL ALVES.**

La Vicerrectora de Estudios, y
Presidenta de la Comisión General de Doctorado
Sonia Madrid Cánovas

Documento firmado con certificado electrónico reconocido