Factors Facilitating Destructive Behaviors in Nurses Towards Other Healthcare Workers in Iranian Healthcare Organizations: a Qualitative Study

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Research

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Abstract

Introduction:

Destructive behavior is considered a chronic, deep-rooted problem in the profession of nursing. Academic articles addressing the issue have existed in literature for the past three decades. Destructive behavior costs healthcare institutions in terms of funds, and it has unpleasant impacts such as escalating absenteeism, reduced productivity, and reduced quality of care for the patients. Finding ways to eliminate such behavior requires a perception and full recognition of the factors that cause and promote it. Since destructive behavior is a complex, multi-dimensional concept that is dependent on context and the culture of the particular organization or society, this research concentrates on the factors shaping such behavior and promoting it in Iranian healthcare institutions.

Material and Methods:

The present study makes use of the conventional content analysis method to explore the views and experiences of nurses and other healthcare workers by interviewing 30 individuals and one focus group and recording 120 hours of observation in 6 hospitals around the capital city of Tehran comprising 2 private facilities and 4 state hospitals. The interviews were all recorded, transcribed and analyzed.

Results:

Through data analysis 26 subcategories and 5 main categories of underlying causes, namely, inappropriate organizational mindset, ineffectual management, complex conditions of work in the nursing occupation, unprofessional standards of education and training for nurses, and personal contributions were identified.

Conclusion:

The present study demonstrates that the main factors promoting destructive behavior in Iranian healthcare organizations are the organizations themselves. To solve the problem of destructive behaviors organizational problems such as ineffectual management, shortage of facilities and infrastructures, a chronic human resource shortage, institutionalized injustice stemming from a state of physicians’ oligarchy, favoritism as a cultural trait, and systematic bullying must first be tackled.

Introduction:

Destructive behavior is a fairly new term introduced by the Joint Accreditation Commission to describe a wide range of negative behaviors. The Joint Commission defines destructive behaviors as “verbal and physical aggression or threatening behavior, as well as such passive actions as refusing to perform assigned duties or quietly exhibiting a non-cooperative attitude throughout routine activities (1). Behaviors such as yelling, criticizing, rumor-mongering, inciting self-imposed isolation, exposing to public humiliation, creating an atmosphere of fear and intimidation, delegating work in an unjust manner, and
many others count as destructive behaviors (2). It appears that the incidence of destructive behaviors has shown no sign of abating despite efforts made to stem such behavior. As studies show, 79% of hospital nurses consider themselves victims of these behaviors. In a study Griffin¹ (2004) has demonstrated that 96.1% of newly educated nurses witness destructive behaviors in the first year of their employment while 46% of them are themselves subjected to such behaviors. Griffin states that 60% of nurses who are new to the profession leave their position within the first six months citing destructive behaviors as the reason (3). This is while the Joint Accreditation Commission in 2008 considered destructive behavior as a widespread problem and put a code of behavior in place to address the issue and to confront and put a stop to belligerency towards coworkers in healthcare environments (2). The International Council for Nurses (ICN)², too, gave weight to the issue when in 2014 it hosted a conference about violence at healthcare facilities (4). On the other hand, the negative impact of such behavior on workers, the organization, and the patients has been reported in nursing sources for the past 30 years. It seems, considering the nature of the profession of nursing and the character of its mission, that health workers ought to observe the ethical principle of “do not harm”, whereas the occurrence of destructive behavior among the nursing staff is just the type of behavior that causes harm. The reasons why destructive behaviors occur among nurses are complex and various theories have been put forward to try to explain the phenomenon. For instance, there has been an abundant use of concepts related to oppressed-group behavior and the theory of oppression in nursing sources, and yet, some researchers have voiced concern over the use of this theory in relation to nursing. To give an example, certain research has pointed out that linking destructive behaviors to the oppressed-group model fails to draw a clear picture of the intent of the perpetrators of such behaviors or to shed light on the role played by the organization (5). Sources have also demonstrated that the potential for destructive behaviors exists equally in all work environments, but that the reasons why they emerge or the factors that shape and solidify the destructive behavior are different in different organizations (6, 7). A survey of available literature leads to the conclusion that although the importance of the issue and its undesirable effects has made it deserving of mention in sources both old and new, most available studies, in particular those conducted in Iran, have only skimmed the surface, deploying descriptive methods or opinion polls to cover the subject matter (8-10). Therefore, with the need for more qualitative research to be done in this area to try to understand the nature of the destructive behavior and the factors that foster and promote it in the Iranian cultural and religious context, the authors intend to base their research in the experience of nurses and other healthcare workers and their point of view in the context of culture, society, and religion in Iranian medical care organizations.

Material And Methods:

To analyze the experiences and viewpoints of the participants the conventional content analysis method was applied.

Participants and Locations: The study population was chosen from clinical workers at six hospitals – four state-run, two private - in the city of Tehran. In view of the complexity of the concept involved, the
researchers tried to make a selection of a variety of participants in different occupations such as nurses, physicians, midwives, laboratory workers, radiologists, and orderlies representing differences in gender, age group, marital status, work background, duty shift, and the especially assigned ward or department (Table No. 1). The sampling process involved the researchers’ going into the field and explaining the study’s objective to the participants, thus choosing among them on the basis of the inclusion criteria in the study via a purposive sampling process. The study lasted from 2014 until 2016, when saturation of data was achieved.

Data Collection: Methods used in data collection included individual interviews, group discussion, and observation. Individual semi-structured interviews constituted the main method of data collection. Prior to the session proper, a brief 10-minute introductory meeting was conducted with each participant to explain the objective of the study and obtain permission. If a candidate showed interest, the time and the venue, preferably a secluded, quiet place, were then fixed with their approval. At the interview, the interviewer always began with a few neutral questions, while no effort was spared by them to gain the trust of the interviewee. The session typically began with a general question such as “how do you interact with coworkers in the medical team during a normal shift?” Each interview lasted between 15 and 90 minutes, averaging 45 minutes. Four individuals who were interviewed only allowed notes to be taken by the researchers, ruling out audio recordings. There was also one group discussion session with seven participants, six of whom had already been interviewed in private. The group meeting lasted 120 minutes. Its objective was to reach a consensus on the findings already obtained as to the main factors and promoters of destructive behaviors during observations and at individual interviews, and to possibly have those findings reconfirmed. The objective at this stage of the study was in fact to enhance the precision and credibility of the data obtained and not to collect more new data. Another method of collection of data in this study was observation, which consisted in the researcher initially observing the ward and the staff to familiarize themselves with the environment followed by participatory observation. Participatory observation entailed learning through becoming involved in the daily routine of the working lives of the participants in their natural environment (11). The researcher verbally asked the person in charge of the ward and the staff for permission to watch how they behaved towards each other. Permission was given, again verbally, and the people involved all gave their consent to being observed provided their identities remained confidential. In order to avoid the possibility of the Hawthorne effect settling in, the observations were conducted intermittently over a long period of 120 hours overall, during the morning, afternoon and night shifts, in busy emergency and General ICU wards. The focus was on both verbal and non-verbal interactions of nurses, the nurses’ manner of encountering others in person or on the phone, and correspondence of verbal to non-verbal behaviors. The recorded observations complemented the information obtained during interviews. Saturation of viewpoints was taken as the measure for determining the viewpoint sample size and the end point to sampling. In this study the saturation of viewpoints was the point at which no new concept and/or new dimension or quality could be added to that already obtained for each category.

Data Analysis: Analysis requires that the researcher be immersed in information. This is achieved at first through listening carefully to the descriptions supplied by the participants, and then, by reading and
reading again the same transcriptions. It is only by immersing themselves in the data, that the researcher is enabled to pick out the key words and the true implications of what has been said. To do so, first the voice recordings are transcribed and the descriptions read through several times in order that a general sense of the meanings that are scattered throughout the text is gained. Next, the researcher rereads the text more carefully, poring over every line and every word, picking out the main phrases and concepts concealed in each line or paragraph, and assigning a code to each main phrase. Then the codes are compared and classified in accordance with their conceptual similarities and differences. These classifications and the main concepts obtained are further compared to arrive at the main themes. In the present study the MAXQDA-10 software was deployed for classification of data.

Scientific Precision and Robustness of Data: To gauge the accuracy and robustness of the data the Guba and Lincoln set of four criteria was applied. To increase the credibility of the data, the researcher attempted to forge a close and amicable relationship with each participant and to create the kind of atmosphere that ensured the interviews given were heartfelt and freely voiced. Also, involvement in the project over a long period of time (2 years) and engrossment in the data obtained in the course of the study helped increase the credibility of the data. In this research various methods of data collection including individual and group interviews and observation were applied. Furthermore, the researcher tried to introduce as much variety into the samples as possible. Thus in addition to nurses as the main participants, individuals from other occupations such as physicians, orderlies, laboratory workers and radiologists were enlisted. The participants were selected from different hospitals and different work shifts and represented a broad selection from the point of view of age, gender, professional background, type of ward in which they served, level and field of education, and marital status to increase the credibility of the research conducted. Finally, data analysis was carried out simultaneous with data collection. The researcher documented all the steps and processes of the research from start to finish in order that the foreign jury would be able to assess the work on the basis of the documentation. To ensure a measure of solidity and reliability, the researcher tried to document all the stages of the research including collection of data, analysis of data, coding and classification, and the creation of the categories, to enable other researchers to review the text. Moreover, through presenting a thorough and precise description of the phenomenon under inquiry, the context of the research and impediments and limitations to it, and also by probing to find out whether professionals generally and the participants in the present research in particular could recognize themselves in the developed narrative and in the findings of the study, the researcher attempted to enhance the transferability of the study.

Ethical Considerations

Having received a letter of introduction through the research directorate at the Baqiyatallah University of Medical Sciences along with other necessary permits issued by the dean's office and the offices of the nursing staff, the researcher entered the location of the research to familiarize the participants with the aim and process of the research and to obtain their informed verbal and written consent to participation in the research by giving interviews and being observed. Measures were put in place to ensure that the
identity of each participant remained confidential. The researcher provided the participants with contact information and was ready at all times to answer their queries about the research.

Results:

Through analysis of the data it emerged that factors that initiated and promoted destructive behaviors in clinical staff were many and diverse, and that they could be classified under five main themes.

Inappropriate Organizational Mindset

The experiences related by the participants led to the finding that “inappropriate organizational mindset” was conducive to destructive behaviors among clinical workers. A subcategory and secondary concept informed by this theme was “the workers’ distorted conception of organizational justice”. Other factors were underlying the “inappropriate organizational mindset” were found to be a “culture of bullying”, “unwarranted expectations on the part of the organization in the absence of the necessary infrastructure”, “an atmosphere of disenchantment across the board” and “the effect of the organization being a teaching and training institution”.

The healthcare workers’ distorted conception of organizational justice: This included and was rooted in three sub-categories, namely, “procedural injustice”, “interactive injustice” and “distributive injustice”. Issues such as “an inefficient supervisory system”, “different supervisory systems for physicians and nurses”, “unjust judgments and rulings”, “injustices in assessment”, “an ineffectual system of rewards and punishments”, “ineffective performance assessment”, and “ignoring individual merits” all contributed to the feeling among the health workers that “procedural injustice” was prevalent. Furthermore, the workers felt and could perceive of injustice at the interactive level. They viewed all instances of “managers holding on to their position through established cliques” and “unjust apportioning of duties” as imparting a feeling of “interactive injustice” to the workforce. Other manifestations of “interactive injustice”, in their view, were “unjust and ineffectual organizational support” for staff, “favoritism across the board”, and “a general preference given to physicians”.

The major signs of a prevailing “distributive injustice” mentioned by the participants were “injustice in the payment of bonuses”, “uneven distribution of resources”, “preferential payment of compensation”, “compensation being disproportionate to the job description and conditions of work”, “delayed payment”, “lack of shared financial benefit and hence shared interest in admitting and treating patients”, and “cuts made in the compensation and benefits on a host of pretexts”.

The culture of bullying: Another category that fell under the “inappropriate organizational mindset” theme was the “culture of bullying”, which lent itself to “a high incidence of destructive behaviors”. In the shadow of such a cultural impropriety, healthcare workers experienced “resistance to positive change”, the common practice of “yelling at people to get results”, “a prevalence of undue exercise of power and a tendency to subject those of a lower rank to bullying”, “a culture of giving precedence to the interests of the organization”, “a culture of inadequate appreciation”, and “a culture of preferential treatment of the
physicians”. The situation worsens because of “the organization adjusting to the culture of angry outbursts”, “staff following the example of fellow workers and those of long standing within the organization”, “the ‘contagiousness’ of destructive behaviors and their transmission as a culture to new staff”. In the words of one of the participants, “in the emergency unit, where what we are doing is in full view, the head nurse, say, is seen and heard snapping at us in a disrespectful tone to attend to the patient; then the same stress is transmitted to the patient, and you end up with a situation where the patient is ready to use an aggressive tone with us ...” – Participant No. 6, male, a nursing postgraduate student.

Unwarranted expectations on the part of the organization in the absence of an infrastructure: A major concept within the concept of “inappropriate organizational mindset” turned out to be “unwarranted expectations by the organization in the absence of an infrastructure”. This concept incorporated certain issues at the level of the organization that included “shortage of hospital equipment and supplies”, “shortage of welfare facilities”, “insufficient positions provided within the organizational chart”, “disproportionate expectations in view of the services that can actually be offered”, “exercise of clinical governance in the absence of an infrastructure”, “dispensing edicts while ignoring the limited resources available”, “outdated rules and standards”, and “bureaucracy and a hierarchical system”, all of which and many others besides created “an atmosphere of disgruntlement across the board”. The disgruntlement spread to areas such as “salary and benefits”, “the atmosphere dominating across the organization”, “pressure of work”, “facilities provided”, and “a shortage of manpower”. Added to all those were the impact of the hospital being a “teaching hospital”. One participant in the focus group expressed it thus:

“All other hospitals have already set up credibility and clinical governance frameworks and have made provisions to ensure the criteria are met. It’s sad that many of our doctors know nothing about those provisions or the new way of thinking behind them. For instance, one of the things that build credibility is the stipulation that the attending physician must daily visit the patient. Yet we have an attending doctor that doesn’t once show up during the week. Another standard is short duration of hospitalization. To achieve that you need the right infrastructure, such as a system whereby visits are done on a regular basis, supplies are adequate and the standard of the work done by the workforce is high. The standards we are working with in my estimation go back to twenty or thirty years ago.”

**Ineffectual Management**

Another contributing factor in destructive behaviors creeping into the work environment was “ineffectual management”. According to the participants, “the governance of incompetent managers over medical care institutions”, “ineffective planning”, “ineffective organization”, “ineffective human resource provision” and “ineffective control” all bred destructive behaviors among the workforce to one degree or another. “Governance of incompetent managers over the organization” and manifestations thereof such as “poor knowledge and poor managerial skills among the management”, “managers selected on grounds other than competence and capability”, “ignorance of the managers of the circumstances of their staff”, “adoption of ineffective managerial approaches”, “an autocratic style of management”, “mismanagement of time and over-scheduling by managers”, “abuse of authority”, and “neglecting the interests and
requests of the staff” all impacted the work done by the nursing staff. The situation was exacerbated by the “role model and mentoring provided by ineffectual managers” and the “lack of leadership qualities”. Yet another issue arising from “ineffectual management” was “ineffective planning” by the management that faced the staff with “defective organizational instructions”, the problem of “assignment of responsibility to inexperienced health workers”, and “poor placement of members of the workforce”.

In addition, “ineffectual management” led to an overall “ineffectual organization”. This ineffectuality manifested itself through “double assignment of borderline duties and the ensuing interference”, “insufficient familiarity with the duties”, “ignoring the job descriptions”, “ambiguity in the roles and positions”, and, in general, a whole subcategory of “role overlap and failure to comply exactly with the job descriptions”.

“Ineffectual management” had resulted in “provision of ineffectual manpower” manifested in “a severe shortage of human resources”, “inappropriate selection and screening of job applicants”, “deployment of inefficient members of staff across the organization”, “frequent replacement of staff members and deployment of interns or volunteers”, “failure to attract well-trained, competent individuals to the organization”. Ultimately, “ineffective control”, demonstrated through “widespread failure to comply with the rules”, was yet another problem that emerged as a result of “ineffectual management”. Participant No. 7 described it thus: “The head nurses believe they can never be wrong, and they speak from a position of always being right.” Participant No. 21 had this to say: “It is important that the head nurse’s expectations of the nursing staff be expressed in clear terms, otherwise how is the head nurse to know for sure that what is on her mind is precisely what the staff is going to carry out? Members of staff have been known to become frustrated and to complain that ‘after one year of working here, it is still not clear what the head nurse expects of us, so that if I work fast, I’m accused of doing sloppy work, but then if I slow down, the head nurse will complain about me taking my time, which is why one year into the job I still don’t know what this particular head nurse means by “being good at one’s job”! She has simply continually failed to make her ideas clear to us, a failure that happens far too often in our profession.’”

**Complex conditions in the nursing occupation:** Incorporated in the concept of “complex conditions in nursing” are “the organization taking nurses’ contribution for granted”, “overwork”, “frequent and long working shifts”, “the stressful and tense nature of nursing”, and “the impact of the specialist work and general duties carried out by the nursing staff that results in frequent interactions on the quality of those interactions”, any of which could cultivate destructive behavior by a nurse towards other health workers. The subject of “work overpressure” cropped up many times as the participants spoke out in tones betraying great dissatisfaction. Additionally, financial burdens that drove nurses to accept “frequent and long shifts” and “stress and tension” that is inherent to the nursing profession caused pressure and exhaustion and an inadvertent tendency to behave in a destructive way. The head nurse at an emergency unit cited the example of a nurse calling and demanding “to be relieved or else the whole unit is going to come crashing down on the rest of the workforce, I promise you! I am at the end of my tether, with all the beds full and 10 extra beds placed in the middle of the ward and only 5 nurses to attend to all the patients who are bound to start complaining.” Participant No. 29 had this to say: “nurses can’t make ends
meet solely by doing one single shift. So they take on two shifts; night shifts and regular back-to-back shifts wear them out and create tension, depression and burnout, which, together, tend to lower a nurse's threshold.”

**Unprofessional standards of training and education for nurses:** Substandard training and education for nurses was found to contribute to the development of “distorted interactions” among nurses. “Poor quality of education provided to nursing students and poor quality of continuous education at the hospital” as well as “nurses’ want of proper skills theoretically or in practice” fall under this main category. Nurses themselves as well as participants from other occupations frequently expressed concern over unskillful nurses who invited the scorn and verbal abuse of outsiders. Their shortcomings in this area followed the shortcomings of faculties of nursing and those of hospitals. Participant No. 11 asked, “Where have we gone wrong that a specially trained ICU nurse is so clueless about how to pull out a chest tube without causing emphysema in the patient, which the surgeon has to call on the patient in the middle of the night and blame us for letting a novice handle that patient? Evidently we are still dealing with an issue when it comes to professional training.”

**Personal contributions:** In the present research the concept of “personal contribution” was found to represent fertile ground for the germination of destructive behaviors. Secondary concepts such as “personality traits”, “over-familiarity with coworkers”, “an experience of previous destructive behaviors”, “impact of personality on the type of behavior”, “negative qualities related to personality”, “frustrated needs”, “family issues”, “the role of gender”, and “religious convictions” made up the main concept of “personal contributions” as a category. Participant No. 25: “Different nurses behave differently. Sometimes a nurse is just right for the job because her attitude and her words can have a calming effect. A call from somebody with a problem may irritate me personally. Yet another nurse may respond to the same call with a calm and reassuring tone that will appease the caller and remove antagonism. It is true, though, that occasionally someone is ready to hold some issue against me, which drives me mad because actually the person themselves were to blame and not I, and yet he or she could be blind to the fact and ready to point a finger and demand rectification.”

**Discussion:**

Data analysis in the present research led to a number of contributory factors in destructive behaviors. The study by Walrath *et al.* (2010) categorizes factors involved in provocation and onset of destructive behaviors under three major themes, namely, “intrapersonal”, “interpersonal”, and “organizational”. (12) By comparison, our main categories include, in addition, work overpressure and the cultural element, with the difference that in the present study the subcategories gathered under the concept of culture have been chosen differently, where key concepts such as a state of physician oligarchy and favoritism, excluded from the Walrath study, have been included. This difference may well be an indication of different cultures prevailing at medical care organizations in different countries.
Hutchinson et al. (2010), in their study titled “a combination of individual factors, group work and organizational work: testing a multi-dimensional model of destructive behaviors in nursing work environments”, present a model that takes “unofficial organizational alliances” as the most important organizational factor in the formation of destructive behaviors. (13)

As in the Hutchinson study, in the present study, too, organizational factors were reported as key in the development of destructive behavioral patterns. Important factors such as “inappropriate organizational mindset” and “ineffectual management” include key concepts such as organizational injustice, physician oligarchy, and the culture of favoritism, which in the Hutchinson study are given the collective term “unofficial organizational alliances”. Our study’s findings show that another important organizational factor in the formation of destructive behaviors among nurses is a distorted perception of organizational justice. Numerous experimental and descriptive studies and observations have shown a relation between organizational injustice as perceived by the healthcare workforce and the incidence of destructive behavior (14–16). The culture of an organization has a significant bearing on behavior. In organizations in which the general atmosphere and the culture allow disrespect and open hostility, the staff is more inclined to behave destructively and display aggression (17, 18).

According to several studies nursing students and nurses who are new to the work environment adjust to a culture of disrespect and destructive behaviors, accept the norm, and even begin to display such behavior themselves (19). Another factor is a disorderly work environment governed by conflicting rules, policies and procedures and made toxic by extreme rivalry (20–21). Also, there is a conviction that destructive behaviors tend to surface in those healthcare organizations that put greater emphasis on obedience (18). Style of management and leadership, too, can impact behavior. An autocratic style of management, the open leadership style, and unsuitable and uneven punitive measures are conducive to a rise in the incidence of destructive behaviors (22, 23). On the contrary, where the management intervenes on behalf of the victim and attempts to resolve the issue, later situations tend less frequently to deteriorate into those where destructive behaviors occur than when the management has not been supportive (20). Also, nurses subjected to destructive behaviors have reported generally experiencing less depression and burnout or wishing to leave their job if the management has played a supportive role compared to victims who have enjoyed no support from the management (24). Sources demonstrate quite conclusively how organizational factors can play a role in the formation of destructive behaviors among the workforce, a position which corroborates our findings. There appears to be less information available on the connection between healthcare workers’ individual requirements and destructive behavior. Hoel and Cooper (2000) state that destructive behavior is related to heavy workload and discontent experienced as a result of defective interaction in the workplace. They have found that overemphasis on customer satisfaction can translate into the staff facing a huge workload and unreal or unnecessary demands by the clientele, while the fundamental needs of the staff are given secondary priority. Evidence of this hypothesis includes the authors’ findings following an opinion poll that point to destructive behavior by customers intensifying in the service sector (25).
Our findings, similarly, showed that the customer-oriented attitude evolving in medical care organizations and a growing emphasis on customer satisfaction and the Charter of Patients’ Rights had been accompanied by growing demands and expectations on the part of the patients. This was while the provision of the necessary infrastructure including a sufficiently large pool of human resources had not been given much consideration. Therefore, negligence at management level to look into the state of the infrastructure and oversight as to the plight of nurses who were required to follow the principle of customer-centricity caused overwork and tension and brought about growing discontent among the workforce and a corresponding increase in the incidence of destructive behaviors. Vartia (2001) found that several aspects of the work environment such as complex and difficult duties constituted an explanatory factor in instances of victimization as a result of destructive behaviors (26). An important secondary concept under “personal contributions” is “personality traits” and “impact of personality on behavior”. Our findings showed that nurses with destructive behaviors could be divided into two groups one of which consisted of individuals who were characteristically nervous, tense and prone to aggressive outbursts and who, to one degree or another, always behaved destructively towards everyone around them, while the other group was made up of individuals who were more likely to behave destructively only when conditions were hard, such as when they were stressed because of heavy workload. In the literature, destructive behaviors have been shown to be too complex to be explained solely in terms of the personality of the perpetrator or of the victim (27). However, at the level of the individual the characteristics of both the perpetrator and the victim have a bearing on the phenomenon (28). A study conducted in Ireland demonstrates that the victims of destructive behaviors have particularly nervous, repressed, timid and conscientious dispositions (29). Mathieson and Einarsen (2005) draw on the results of their study to state that among the three groups involved in destructive behaviors which consist of the perpetrators, the victims, and victims who are provocateurs, those in the last group tend to have had more experience of destructive behavior during childhood and at workplace (30). Another personal factor that has been cited in this report is the “role of gender”. Huge (2009) states that men and women are most probably equally reported to have been targeted as victims of destructive behaviors (31).

Milczarek (2010) has demonstrated that the gender of both the victims and the perpetrators of destructive behaviors play an important part in the emergence of such behavior. As far as healthcare environments are concerned, men seem to be targeted more than women (32). Our findings show that in their interactions men behave more equably in the face of problems and tend to overlook details. At the same time, conflicts and unhealthy interactions drive men more than women towards aggressive behavior; indeed, physical violence occurs more often among men than it does among women.

In the sources on consumption of medication, alcohol abuse and impaired psychological health have been suggested as increasing the risk of occurrence of destructive behaviors. The key point highlighted in the literature is that even though certain individual factors increase the risk, it is very likely that destructive behaviors only emerge when the culture and norms within an organization allow them to (32). In the present study additional factors including problems at home and frustrated desires and needs have been recognized as risk factors while religious convictions have been found to have a reducing and preventative effect. Adherence to religious tenets and observance of the codes of behavior prescribed by
religious edicts led to far more effective communication among the personnel. The special regard for human dignity in Islamic teachings and the emphasis placed in the religion on humanism caused the more religious employees to treat others with respect and to try to strike up better communication and display a more dignified behavior. Other studies have considered certain cultural factors, specifically a mutual language, as facilitating communication (33, 34). In a study by Caldwell et al. (2003) it was found that ideological differences among the members of a medical care team could act as an impediment in forming effective inter-professional communications (35).

Another important concept in the present study was “complex conditions of nursing as an occupation”. This concept may be explained through its connection with nurses as an oppressed group, always treated apart from the doctors who make up a far more powerful group within medical care organizations. Values inherent in the occupation are ignored to such an extent that nurses lose their sense of belonging even to their own group. To be neglected and marginalized can cause individual nurses to lose self-esteem and to despise themselves, have no self-confidence, harbor strong anger inside against all others and ultimately behave in a destructive manner (36). Other sources, too, have recognized the oppression that the nursing staff is subjected to. Katz (1969) identifies teachers, laborers and nurses as semi-professionals (37). Roberts, too, perceives doctors as a strong and powerful group and nurses as belonging to an oppressed one. Thus the internalization of the values of the profession of medicine in nurses makes the latter feel neglected and marginalized and breeds self-hatred and lack of self-confidence so that finally both groups suffer a lack of respect for the values and culture of nursing with the nurses hating their own profession. The lack of self-respect coupled with a sense of powerlessness can cause destructive behaviors (38).

Yet another secondary concept in our study was “job-related stress and tension”. Other sources also cite high stress levels and inattention to prescribed ways of mitigating stress as bringing about fatigue and burnout. Burnout is a reaction to continual emotional and interpersonal stressors and causes the worker to be mistrustful of others and to tend to grumble (39, 40).

“Unprofessional standards of teaching and training of nurses” was another key concept in the study of factors promoting destructive behaviors among nurses. In a great many studies clinical skills of newly educated nursing staff have been questioned. With the advent of academic education programs, it was decided by some nursing personnel in management positions that quite often newly graduated nurses had a broad theoretical and procedural knowledge and yet they lacked the necessary skills to perform clinical duties (41). These deficiencies point to a failure of academic education to build up clinical skills in their nursing students, and to deficiencies in management and all other aspects of the organizations, as well as to a general mistrust felt about the skillfulness of individual nurses (42).

Freshly educated nurses worked more slowly than their colleagues, wondering while they worked whether they would be able to handle all the work and the assigned tasks, meeting their coworkers’ expectations. And, they wondered whether they would know if they were acting within the bounds of normal behavior or if they had in fact strayed outside those bounds (43).
In the study by Candela and Boweles (2008), 51% of the new nurses felt unprepared in the area of medication prescription while 77% were apprehensive about their ability to access and manage electrical monitoring information. Also, most of them expressed doubt as to whether the hours of clinical training received at the university had been enough to prepare them for actual clinical duties (44).

In the present study the deficiencies in training provided to newly educated nurses, be it ongoing or as an orientation given upon their arrival at health care centers, were considered as important. New nurses were not put through an apprenticeship beyond a few days’ worth of introductory rounds in the wards, so that they began their shifts in specialized wards and busy units such as the emergency unit while still unprepared for clinical duties. This process imposed a double stress on those nurses and lowered their excitability threshold thus making them prone to exhibit destructive behaviors.

On the other hand, inadequate practical skills put the nurses at the mercy of more experienced nurses, physicians and workers in other occupations. Other studies have mentioned lack of readiness of freshly graduated nurses to enter the field (45). Inadequate continuous education also prevented practical skills from developing. Also, information and knowledge held by the nurses were not brought up to date. Analysis of data showed that physicians could not trust insufficiently skilled nurses and treated them inappropriately. Other studies, too, mention trust as vitally important to the forging of effective communications (46).

Deficiency in continuous education has been discussed in other studies as well. For instance, Gotlib et al. (2012) refer to lack of sufficient communication skills among the members of the medical care team, and consider continuous education of the personnel as crucial to gaining skills in interdisciplinary communication (47).

Rosenstein et al. (2011), too, recommend continuous education for enhancement of knowledge, skills, and reduction of inappropriate interdisciplinary communication. They maintain that courses in stress control, anger control, and conflict management and consultation sessions will help the staff control their anxieties and exhibit correct behavior (48).

The same study discusses poor communication skills, lack of training in communication and interaction, lack of training in interpersonal and managerial relationships at the beginning, the need by nurses for extensive interaction, lack of interdisciplinary training needed in the field of provision of medical care which is always done by teams, all played major roles in the formation of destructive behaviors. Their findings corroborate those by Zeighami et al. The latter authors have found that the most important factor in the relationship between physicians and nurses is the two groups’ interpersonal communication skills (49).

Shannon (2012), too, has found that lack of training in communication skills causes a deficiency in professional relations (50). The results of research by Azimi et al. where a phenomenological approach has been adopted show that deficient communication skills block the development of interdisciplinary communication (51).
Conclusion:

Destructive behavior is a complex and key issue in medical care organizations. It is important to fully identify the breeding grounds and the promoters for the emergence and continuation of such behaviors within an organization. Furthermore, to better understand the methods of prevention and effective intervention in order to eliminate such behavior it is necessary first to determine the factors that play a role in bringing about and encouraging such behavior. Our study has shown that the most important factors and promoters in Iranian medical care organizations are organizational factors. To resolve the issue of destructive behaviors it is recommended to first deal with organizational problems such as ineffectual management, shortage of manpower, organizational injustices born of an oligarchy of physicians and a culture of bullying. In addition, since personal contributions also facilitate destructive behaviors, a way to attract suitable individuals and to screen for them during the process of employment is vital to ensuring destructive behaviors are not encouraged.

Limitations:

Of the existing problems in this study can be attributed to the participant's lack of trust and their poor cooperation in the research. In order to solve this problem, several interviews were conducted with each participant to conduct an interview in this field after obtaining the participants trust.

Declarations:

Ethics approval and consent to participate

This research was approved by the Baqiyatallah University of Medical Sciences Research Ethics Committee (IR.bmsu.rec.1395.223). And after received a letter of introduction through the research directorate at the Baqiyatallah University of Medical Sciences along with other necessary permits issued by the dean's office and the offices of the nursing staff, the researcher entered the location of the research to familiarize the participants with the aim and process of the research and to obtain their informed verbal and written consent to participation in the research by giving interviews and being observed. Measures were put in place to ensure that the identity of each participant remained confidential. The researcher provided the participants with contact information and was ready at all times to answer their queries about the research.

Consent for publication

Not applicable.

Availability of data and materials

All our study-related information is stored in secure folders with limited access. Electronic data files are stored on a file system with access restricted to designated researchers and data managers. The dataset
is available from the corresponding author at Baqiyatallah University of Medical Sciences.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

**Jamileh Mokhtari** conceived of the idea and research questions and assisted with analyses, aided in the interpretation of the results, and assisted in writing the results section. **Milad Rezaiye** helped to conceive the research questions, conducted interviews with the participants, conducted the analyses, and prepared the first complete draft of the manuscript. **Mahboobeh Afzali** and **Abbas Ebadi** helped to conceive the research questions, assisted with analyses, aided in the interpretation of the results, and contributed to the writing of the manuscript. All authors approved the final article.

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Disclosure

The authors declare no conflict of interest.

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Tables:
## Table 1:

The demographics of participants.

| Variables               | Means ± SD / n (%) |
|-------------------------|--------------------|
| Age (years)             | 38.2               |
| Gender                  |                    |
| Male                    | 19 (65.5%)         |
| Female                  | 11 (34.5%)         |
| Marital status          |                    |
| Single                  | 5 (26.6%)          |
| Married                 | 24 (17.2%)         |
| Educational level       |                    |
| BS                      | 22 (76%)           |
| MSc                     | 7 (24%)            |
| Work experience (years) | 16.5               |
Table 2:
Main categories and subcategories.

| Category                                      | Subcategories                                                                 |
|-----------------------------------------------|-------------------------------------------------------------------------------|
| Inappropriate organizational mindset          | Distorted perception of organizational justice.                               |
|                                               | Culture of bullying.                                                          |
|                                               | Organization’s expectations in the absence of an appropriate infrastructure.   |
|                                               | Existence of an atmosphere of discontent across the organization.             |
|                                               | Impact of the organization being a learning institution.                      |
| Ineffectual management                        | Governance of ineffectual management.                                         |
|                                               | Ineffective planning.                                                         |
|                                               | Ineffective organization.                                                     |
|                                               | Ineffective provision of human resources.                                     |
|                                               | Ineffective control.                                                          |
| Complex conditions of work in the nursing occupation | Oversight of the nursing profession across the organization.               |
|                                               | Pressure of work.                                                             |
|                                               | Long and frequent shifts.                                                     |
|                                               | Occupational stress and tension.                                              |
|                                               | Impact of the specialist duties and resulting variety of interactions.        |
| Unprofessional education and training for nurses | Inadequate education provided to nursing students, inadequate ongoing hospital training, and inadequate scientific and practical nursing skills. |
| Personal contributions                        | Personality traits.                                                           |
|                                               | Prior knowledge of individuals.                                               |
|                                               | Experience of past destructive behaviors.                                     |
|                                               | Impact of personality on behavior.                                            |
|                                               | Negative personal characteristics.                                            |
|                                               | Frustrated needs of individuals.                                              |
|                                               | Problems related to home and family.                                          |
|                                               | The role of gender.                                                           |
|                                               | Religious beliefs and their positive impact.                                  |