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Trauma-Related Symptomatology in Horizontal Nurse-to-Nurse Bullying: An Integrative Review of Direct and Indirect Exposure Pathways.

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Citation:

WATSON, Adrianna Lorraine, BOND, Carmel, AVEYARD, Helen, SMITH, Graeme Drummond and JACKSON, Debra (2026). Trauma-Related Symptomatology in Horizontal Nurse-to-Nurse Bullying: An Integrative Review of Direct and Indirect Exposure Pathways. Issues in mental health nursing, 47 (9), 944-957. [Article]

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Trauma-Related Symptomatology in Horizontal Nurse-to-Nurse Bullying:

An Integrative Review of Direct and Indirect Exposure Pathways

Abstract

Aims: This integrative review synthesized empirical and conceptual literature on horizontal nurse-to-nurse bullying and trauma-related symptomatology, with particular attention to how secondary traumatic stress has been theoretically conceptualized and operationalized in relation to direct versus indirect exposure pathways.

Methods: Guided by Whittemore and Knafl, an integrative review was conducted. Searches were completed on 6 May 2026 across three databases. Empirical and theoretical studies examining horizontal bullying and trauma-related symptoms in nurses were included. Methodological quality was appraised using Joanna Briggs Institute tools. Data were analyzed using a constant-comparative approach, with reporting aligned to PRISMA 2020.

Results: The literature represented over 3,000 nurses across multiple countries. Four themes emerged: (1) measurement-exposure misalignment, with secondary traumatic stress instruments frequently applied to directly victimized nurses despite the construct's grounding in indirect exposure; (2) aggregation of horizontal bullying within broader workplace violence constructs, limiting relational specificity; (3) under-measurement of witnessing, despite its role as a plausible indirect trauma pathway that may intensify symptoms when combined with direct victimization; and (4) contextual vulnerabilities, particularly among novice and critical care nurses. Common limitations included cross-sectional designs, reliance on self-report, and inconsistent definitions of trauma exposure.

Conclusions: Horizontal bullying is associated with trauma-consistent symptom patterns, but conceptual and measurement precision remains limited. Distinguishing direct and indirect exposure pathways, explicitly measuring witnessing, and implementing trauma-informed leadership are critical to protecting nurse well-being and supporting patient safety.

Keywords: *Workplace bullying, Horizontal Violence, Secondary Traumatic Stress, Nursing Workforce, Trauma-related symptomatology*

Introduction

Bearing witness to suffering has long been recognized as an inherent duty of the nurse; the risk of trauma-related symptoms associated with such work is widely recognised as a known occupational hazard (Isobel & Thomas, 2022). Nurses are frequently exposed to traumatic events across clinical settings, and repeated exposure to occupational trauma may contribute to both adaptive and maladaptive coping responses (Felion et al., 2026; Hutchens et al., 2025). In an effort to identify and mitigate the rising wave of symptoms associated with workplace-generated trauma, researchers have drawn attention to events such as incivility, bullying, and verbal or physical acts of hostility and aggression (Foli, 2022; Wu et al., 2024).

Acts of horizontal bullying (including mobbing), defined as nurse-to-nurse incivility or aggression, and often classified as a form of *workplace violence* (WPV), are an increasing cause of concern in the nursing workforce. Yet these same behaviors are often rationalized and normalized despite the potential harm to both nurses and patients (Travaini et al., 2024). Although workplace bullying in nursing has been widely documented, its psychological consequences are often framed in terms of occupational stress, burnout, or job dissatisfaction rather than trauma-related responses. Consequently, the ways in which horizontal bullying or related workplace aggression constructs may contribute to trauma-related symptomatology, particularly through both direct victimization and indirect exposure pathways, remain insufficiently examined.

To enhance conceptual clarity, it is important to distinguish key terms and exposure pathways used throughout this review. In this paper, *horizontal bullying* refers specifically to peer-to-peer aggression among nurses, including behaviors such as exclusion, undermining, and verbal hostility. While these behaviors are often examined within broader constructs such as

workplace bullying, *incivility*, or workplace violence, workplace incivility itself is generally conceptualized as lower-intensity behavior with ambiguous intent to harm and may originate from coworkers, supervisors, or patients (Guidroz et al., 2010).

In examining trauma-related outcomes, it is also essential to further differentiate between direct and indirect exposure pathways. *Direct exposure* refers to being the target of horizontal bullying, whereas *indirect exposure* refers to witnessing the mistreatment of colleagues. This distinction is theoretically important, as *secondary traumatic stress* (STS) has been traditionally conceptualized as a response to indirect exposure to another individual's trauma. However, within the nursing literature, STS is frequently applied to experiences of direct interpersonal aggression, resulting in potential conceptual ambiguity. Nurses may experience both direct victimization and indirect exposure concurrently, particularly in clinical environments where bullying behaviors are visible and recurrent. In such cases, trauma-related symptoms may arise through multiple pathways, with witnessing peer aggression representing a plausible mechanism consistent with STS theory. Establishing these distinctions at the outset is critical for interpreting how trauma-related symptomatology has been conceptualized and measured within the existing literature.

Horizontal bullying

Horizontal bullying in nursing has been described as repeated behaviors, such as humiliation, exclusion, undermining, gossip, intimidation, and abuse of power, enacted by peers rather than by supervisors or patients (Recla-Vamenta et al., 2023; Reguera-Carrasco et al., 2025). Workplace bullying is characterized by repeated exposure to negative acts over time, often escalating from lower-intensity behaviors into sustained patterns of interpersonal harm (Einarsen et al., 2009). Unlike episodic workplace conflict, bullying is characterized by

chronicity and the target's limited ability to defend themselves, resulting in sustained psychological strain (Begjani et al., 2025; Ebrahimzadeh, 2026). Despite the prevalence of horizontal workplace bullying in nursing (Xie et al., 2024; Zhang et al., 2022), consequences have frequently been framed in terms of burnout, job dissatisfaction, or turnover intention (Li et al., 2026), with comparatively less attention to trauma-based outcomes (Foli & Thompson, 2019).

Secondary traumatic stress

Secondary traumatic stress (STS) is a trauma response that arises from indirect exposure to another individual's traumatic experience and manifests through symptoms of intrusion, avoidance, emotional numbing, and hyperarousal (Ludick & Figley, 2017). It has traditionally been studied in relation to patient care, particularly in emergency, critical care, forensic, and mental health nursing (Ferguson & Carnevale, 2025). However, emerging evidence suggests that interpersonal workplace trauma may also produce trauma-consistent symptomatology (Tracy & Zadinsky, 2025). When peer aggression occurs repeatedly within environments where safety, collegial trust, and professional identity are essential, the resulting psychological impact may extend beyond occupational stress and be experienced as a form of trauma-related distress (Fujii & Iwasa, 2025).

Trauma-consistent symptomatology

Of note, the term *trauma-consistent symptomatology* is used descriptively to denote symptom patterns aligned with DSM-5 posttraumatic stress clusters, without implying that formal diagnostic criteria were met for post-traumatic stress disorder (PTSD). This terminology maintains conceptual consistency with established PTSD symptom architecture while preserving diagnostic boundaries regarding qualifying exposure (American Psychiatric Association [APA],

2022; Marx et al., 2024). Specifically, trauma-consistent symptomatology reflects patterns of intrusion, avoidance, negative alterations in cognition and mood, and heightened arousal or reactivity as outlined in the DSM-5-TR (APA, 2022). Intrusive manifestations may include recurrent, involuntary distressing memories of workplace events or sleep disturbance marked by event-related dreams. Avoidant responses may involve efforts to suppress thoughts or emotions associated with workplace encounters or behavioral withdrawal from settings, colleagues, or patient populations that serve as reminders. Negative alterations in cognition and mood may present as persistent fear, anger, guilt, shame, emotional numbing, or feelings of detachment. Heightened arousal and reactivity may include irritability, hypervigilance, an exaggerated startle response, difficulty with concentration, or disrupted sleep (APA, 2022). These domains are therefore examined as indicators of trauma-aligned distress associated with exposure to interpersonal workplace aggression.

Intersections of nurse-to-nurse bullying and STS

The intersection of horizontal bullying and STS is particularly concerning in nursing, as peer relationships are foundational to safe practice, learning, and emotional containment in clinical contexts (Mashsha et al., 2025; Watson et al., 2025). Nurse-to-nurse bullying not only disrupts teamwork and patient safety but may also constitute a form of *relational trauma* (Erişen et al., 2025), particularly when leadership responses are dismissive or punitive (Cleary et al., 2026). In such contexts, being harmed by colleagues (rather than "external" parties, for example) may intensify feelings of betrayal, isolation, and psychological threat. Witnessing colleague mistreatment (i.e., an indirect exposure) may also impair concentration and team functioning (Aristidou et al., 2020; Gale et al., 2024; Porath & Erez, 2009). Qualitative evidence additionally

suggests that trauma-related responses may arise not only from direct exposure but also from witnessing or engaging with another person's traumatic experiences (Güler et al., 2025).

Literature gap

Unfortunately, trauma-specific outcomes from witnessing horizontal bullying appear under-examined in nursing literature. Existing reviews largely conceptualize bullying as a broad workplace exposure and prioritize outcomes such as turnover, burnout, patient safety, and organizational climate rather than STS. For example, Sun et al. (2025) demonstrated a significant association between workplace bullying and turnover intentions but did not evaluate trauma-related outcomes. Other reviews linked horizontal and lateral violence to patient safety while noting definitional variability, yet trauma sequelae were not synthesized (Fujii & Iwasa, 2025). Reviews in high-acuity settings similarly emphasize prevalence, contributing factors, and retention without examining trauma-specific psychological harm (Camarda et al., 2025; Zhang et al., 2025). Thus, although workplace bullying appears to be well documented, the specific relationship between direct and indirect exposure to horizontal nurse-to-nurse bullying and trauma-related symptomatology remains underrepresented, thereby justifying the present integrative review.

Purpose of the Review

The purpose of this integrative review was to synthesize both empirical and conceptual literature examining associations between horizontal nurse-to-nurse bullying and trauma-related symptomatology. Particular attention was given to how direct and indirect exposure pathways have been conceptualized and measured in nursing literature. The potential for overlapping exposure pathways was also examined to inform future conceptual applications of STS.

Methods

Design

An integrative literature review design was guided by the methodological approach described by Whittemore and Knafl (2005). Reporting followed PRISMA 2020 guidelines (Page et al., 2021). An integrative review was chosen to comprehensively address both the theoretical and conceptual underpinnings of STS alongside the current operationalization of the phenomenon in empirical works within the nursing discipline. After full-text screening and team consensus on inclusion decisions, data were synthesized using constant comparative analysis as described by Aveyard et al. (2021).

Search Strategy

The search strategy was designed in collaboration with a university health sciences nursing librarian. The final search was conducted on May 6th, 2026. Three electronic databases were included: CINAHL, MEDLINE, and Embase. The primary search string used was:

> *(secondary trauma* or vicarious trauma* or second victim syndrome) AND nurs* AND (bullying or workplace violence or verbal abuse or violen* or incivility or toxic* or aggress* or harrass*)*

All searches were limited to peer-reviewed articles published in English. No restrictions on publication date were used to include a comprehensive picture of the conceptualisation and operationalisation of the phenomenon. The term *vicarious trauma* was intentionally included to ensure comprehensive retrieval of relevant literature; however, it is acknowledged that this construct is conceptually distinct from STS and was not a primary analytic focus of this review.

Inclusion and Exclusion Criteria

As an integrative review, both empirical and conceptual papers were eligible for inclusion. Eligible articles were required to address horizontal nurse-to-nurse bullying or peer incivility and examine STS, trauma-related symptomatology, or psychological trauma in nurses. Conceptual papers were defined as peer-reviewed articles that did not report primary empirical data but instead used an explicit conceptual, theoretical, or concept analysis method. Articles were eligible for inclusion if they met the following criteria:

a) Examined horizontal bullying or incivility.
    1. Specifically including nurse-to-nurse or peer-to-peer mistreatment.
    2. Contributed directly to the review purpose by clarifying exposure pathways, trauma constructs, or theoretical relationships relevant to nurse-to-nurse bullying and trauma-related outcomes.
b) Included discussion of STS or trauma-related symptoms.
c) Were peer-reviewed and published in English.
d) Met the criteria for either theoretical or empirical literature.
    1. Theoretical and conceptual works included concept analyses, critical analyses, discursive articles, and middle-range theories.
    2. The empirical literature included quantitative, qualitative, mixed-methods, and multiple-methods reports.

Articles were excluded if they:

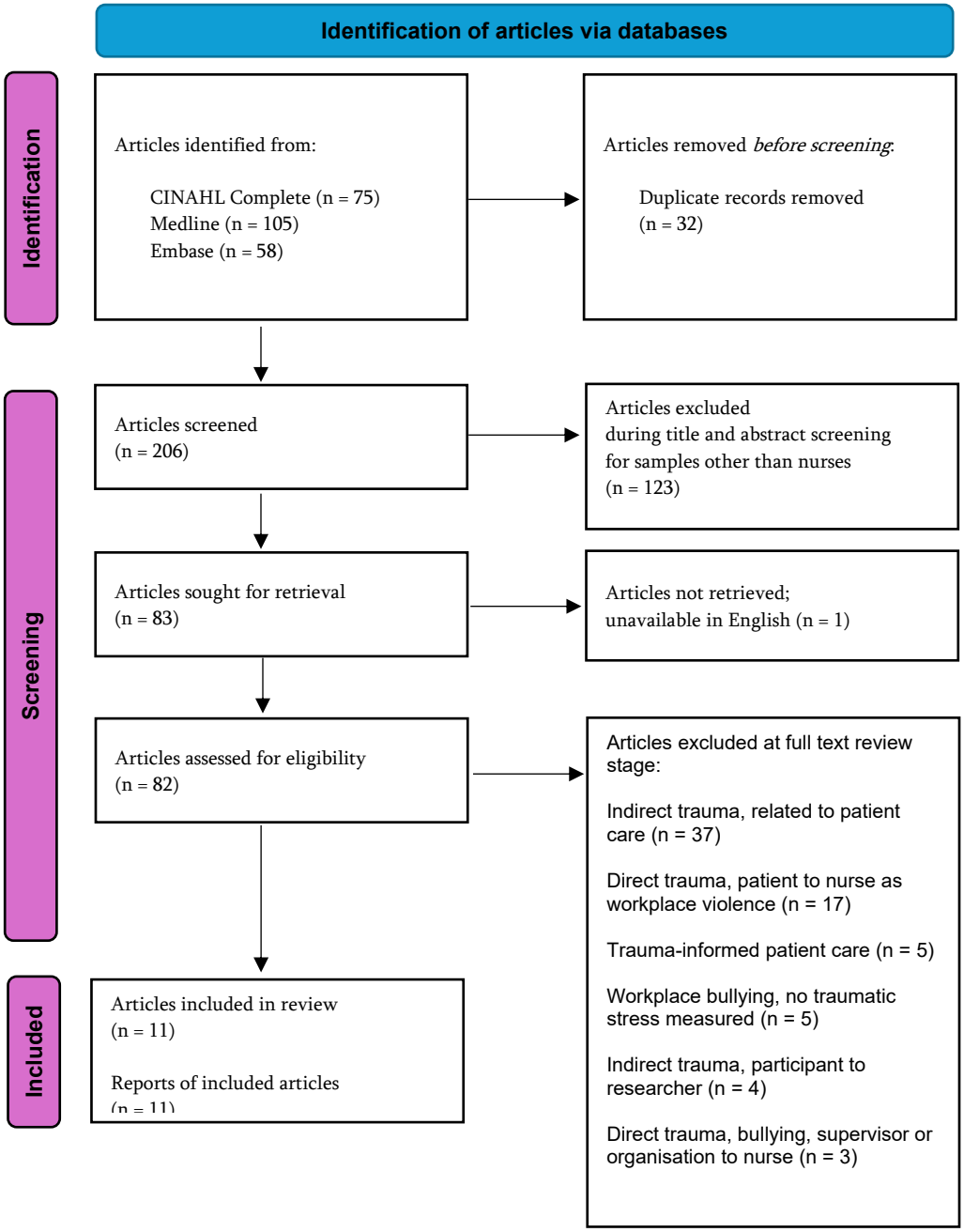
a) Focused solely on patient- or visitor-initiated violence (i.e. originated from "external" parties).
b) Examined workplace bullying without operationalizing STS.
c) Focused on nursing students as the population of interest.

d) Were grey literature (e.g., non-peer reviewed literature or reports).

Study Selection

Database searches yielded a total of 238 records across CINAHL (n = 75), MEDLINE (n = 105), and Embase (n = 58). Hand-searching of the reference list was not conducted as part of the formal search strategy. Articles were independently reviewed by two members of the research team (XX and XX) against the inclusion and exclusion criteria. Disagreements between the two initial reviewers were resolved by a third member of the research team (XX). For further details regarding the screening process, please see the PRISMA flowchart in Figure 1.

Figure 1. *PRISMA 2020 flow diagram of article selection. Adapted from Page et al. (2021).*



Quality Appraisal

The methodological quality of the included studies was appraised using the Joanna Briggs Institute (JBI) critical appraisal tools appropriate to each article type (Aromataris & Munn, 2020). Empirical cross-sectional and correlational studies were appraised using the JBI checklist for analytical cross-sectional studies. Conceptual and theoretical papers were appraised for clarity of purpose, grounding in existing literature, coherence of argument, and relevance to the review question. No articles were excluded based on quality appraisal, as all contributed relevant empirical or conceptual evidence to the integrative synthesis. However, appraisal findings informed the interpretation of the strength of evidence. Two reviewers (XX & XX) independently conducted quality appraisal for each included study. Discrepancies were resolved through discussion and consensus. Common limitations included cross-sectional designs, nonprobability sampling, reliance on self-report measures, limited differentiation between direct and indirect exposure pathways, and inconsistent operationalization of STS. A summary-level appraisal of article type, applicable JBI tool, key methodological limitations, and implications for interpretation is presented in Table 1.

Table 1. *Quality Appraisal Summary*

Author/year	Design/type	Joanna Briggs Institute (JBI) tool applied	Relevant limitations	Results of appraisal
Alshehry et al. (2019)	Cross-sectional	JBI analytical cross-sectional (Barker et al., 2026).	Cross-sectional design; self-report; limited causal inference	Included; interpreted cautiously due to cross-sectional self-report design

Aristidou et al. (2020)	Cross-sectional correlational		Convenience sample; modified secondary traumatic stress scale; self-report	Included; interpreted cautiously due to cross-sectional self-report design
Dong et al. (2025)	Cross-sectional Structural Equation Modeling (SEM)		Cross-sectional mediation; self-report; snowball sampling	Included; interpreted cautiously due to cross-sectional self-report design
Jiao et al. (2023)	Cross-sectional SEM		Convenience sample; self-report; limited causal inference	Included; interpreted cautiously due to cross-sectional self-report design
Kim et al. (2019)	Cross-sectional		Cross-sectional design; self-report	Included; interpreted cautiously due to cross-sectional self-report design
Mashsha et al. (2025)	Cross-sectional		Convenience sample; self-report; limited generalizability	Included; interpreted cautiously due to cross-sectional self-report design
Nazari et al. (2024)	Cross-sectional correlational		Cross-sectional design; single setting; self-report	Included; interpreted cautiously due to cross-sectional self-report design
Peng et al. (2022)	Cross-sectional SEM		Cross-sectional mediation; self-report;	Included; interpreted cautiously due to cross-

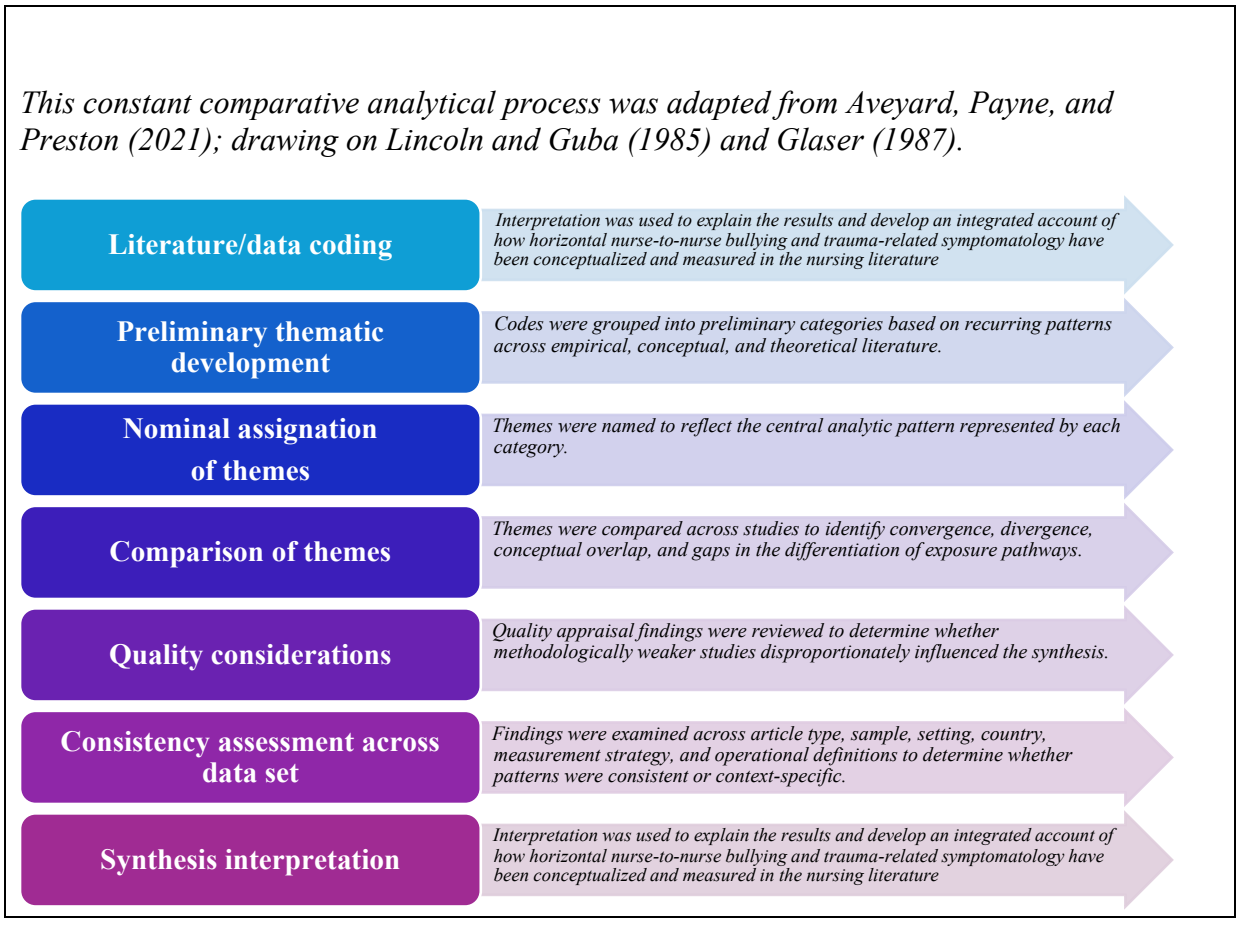
			convenience sample	sectional self-report design
Wolf et al. (2021)	Cross-sectional correlational/grounded theory validation		Cross-sectional design; self-report; specialty specific sample	Included; interpreted cautiously due to cross-sectional self-report design
Foli (2022)	Middle-range theory	JBI narrative appraisal (McArthur et al., 2025)	Theoretical paper; not empirical	Included; conceptual contribution used to support theoretical framing.
Runyon et al. (2025)	Concept analysis		Specialty specific concept analysis; not empirical	Included; concept-analysis contribution used to support conceptual synthesis.

Note: *Runyon et al. (2025) was retained in this literature review because it used Walker and Avant's concept analysis method to examine psychological trauma in labor and delivery nurses and identified workplace incivility as a potential antecedent of nurse-specific psychological trauma.*

Data Extraction and Synthesis

Following quality appraisal, data were manually extracted into a structured extraction matrix. Data were extracted by one reviewer (XX) and verified by a second reviewer (XX), with no discrepancies identified. Data were then synthesized using constant comparative analysis as described by Aveyard et al. (2021), which drew on work by both Lincoln and Guba (1985) and Glaser (1987). The analytic process is summarized in Figure 2. This process generated four themes, which are discussed in Results; each theme was checked against the included studies to ensure that the synthesis remained grounded in the reviewed evidence.

Figure 2. *Constant comparative analysis process*



Extracted data included author/year, country of origin, article type, sample, data collection and analysis approach, operationalization of secondary traumatic stress and nurse-to-nurse bullying, and key findings. See Table 2 for the completed data extraction matrix.

Table 2. *Data Extraction Matrix*

Author / Year	Country	Design	Sample	Data Collection & Analysis	Operationalization of Constructs	Key Findings
Alshehry et al., 2019	Saudi Arabia	Cross-sectional	N=378 hospital nurses; multicultural workforce	Collection via survey: Nursing Incivility Scale (NIS); Professional Quality of Life Scale, version 5 (ProQOL-5). Analysis by multivariate multiple regression. Of note, the NIS captures lower-intensity forms of interpersonal mistreatment, which are conceptually distinct from, but may overlap with, horizontal bullying. When experienced repeatedly, incivility may escalate into patterns consistent with bullying and	Secondary traumatic stress (STS) measured via the ProQOL-5 using the included STS subscale. Nurse-to-nurse incivility captured within NIS (general, nurse, supervisor, physician, patient incivility). Horizontal incivility embedded within broader workplace incivility framework.	Incivility from multiple sources significantly predicted higher STS, burnout, and lower compassion satisfaction.

				contribute to cumulative psychological harm.		
Aristidou et al., 2020	Cyprus	Cross-sectional correlational	N=113 emergency & critical care nurses	Collection via survey: WVHS-CCSRI Part C.II-M; Modified STSS. Analysis by ANOVA & correlational analysis.	STS operationalized using modified STSS reflecting PTSD symptom clusters (intrusion, avoidance, arousal). Nurse-to-nurse bullying measured as mobbing (victimization and witnessing).	High-frequency bullying associated with greater trauma symptom severity. Witnessing plus direct exposure intensified STS. ED nurses had higher STS than ICU nurses.
Dong et al., 2025	China	Cross-sectional SEM	N=832 novice nurses (1–3 yrs experience)	Collection via survey: NAQ; ProQOL; Turnover Intention. Analysis by SEM mediation model.	STS measured via ProQOL STS subscale. Nurse-to-nurse bullying categorized as person-related, work-related (including "professional devaluation"), and organizational injustice. Work-related negative behaviors had a significant positive	Bullying predicted turnover intention directly and indirectly via burnout and STS. Novice nurses particularly vulnerable.

					relationship with STS.	
Foli, 2022	United States	Middle-range theory	Not applicable	Theoretical	STS conceptualized as one of seven nurse-specific traumas. Horizontal bullying included under workplace violence and historical/intergenerational trauma; not isolated as distinct trauma domain.	Provided nurse-specific trauma framework distinguishing multiple trauma sources in nursing, including workplace violence and incivility.
Jiao et al., 2023	China	Cross-sectional SEM	N=297 clinical nurses	Collection via survey: NAQR; ProQOL; Coping Style Questionnaire. Analysis by SEM.	STS measured via ProQOL STS subscale. Workplace bullying defined as repeated negative acts; horizontal aggression included.	Workplace bullying negatively affected compassion satisfaction and positively predicted burnout and STS. Coping styles mediated effects.
Kim et al., 2019	South Korea	Cross-sectional	N=324 clinical nurses	Collection via survey: NAQ-R; MBI; ProQOL. Analysis by regression.	STS operationalized as ProQOL compassion fatigue (secondary trauma stress).	Workplace bullying significantly predicted emotional exhaustion, depersonalization, compassion

					Nurse-to-nurse bullying measured via NAQ-R personal, work-related, intimidation categories.	fatigue, and turnover intention.
Mashsha et al., 2025	Jordan	Cross-sectional	N=150 ED and CCU nurses	Collection via survey: NAQ-R; ProQOL (STS subscale); TO scale. Analysis by regression.	STS measured via ProQOL STS subscale. Horizontal bullying captured via NAQ-R.	89.3% categorized as victims of bullying. Bullying uniquely predicted STS and turnover intention.
Nazari et al., 2024	Iran	Cross-sectional correlational	N=200 hospital nurses	Collection via Nursing Incivility Scale; ProQOL Analysis by regression.	STS measured via ProQOL STS subscale. Nurse-to-nurse incivility included within general, supervisor, and patient sources.	Supervisor and patient incivility predicted burnout and compassion satisfaction; patient incivility predicted STS.
Peng et al., 2022	China	Cross-sectional SEM	N=493 clinical nurses	Collection via survey: NAQR; CD-RISC (resilience); ProQOL. Analysis by SEM.	STS measured via ProQOL subscale. Bullying categorized into person-, work-, and organization-related negative acts.	Workplace bullying reduced professional quality of life; resilience partially mediated STS and burnout effects.

Runyon et al., 2025	United States	Concept analysis	56 articles reviewed	Walker & Avant's method	STS defined as PTSD-like symptoms (intrusion, avoidance, hyperarousal). In this framework, nurse-to-nurse incivility is conceptualized as a potential precursor to psychological trauma.	Identified characteristics, antecedents, and consequences of psychological trauma in labor & delivery nurses.
Wolf et al., 2021	United States	Cross-sectional correlational; grounded theory validation	N=1,794 emergency nurses	Collection via survey: SNAQ (bullying); STSS; PES-NWI. Analysis by logistic regression.	STS measured via STSS (DSM-5 aligned intrusion, avoidance, arousal; cutoff ≥39 moderate STS). Nurse-to-nurse bullying measured via SNAQ frequency (daily/weekly exposure).	Daily bullying associated with 67.6% intent to leave. Higher STSS scores correlated with increased intention to leave. "Calling it out" reduced turnover risk.

Results

The constant comparative synthesis generated four themes describing how horizontal nurse-to-nurse bullying, workplace incivility, STS, and trauma-related symptomatology were

conceptualized and measured across the included literature. These themes were: (1) *measurement-exposure misalignment,* (2) *horizontal bullying embedded in workplace violence frameworks,* (3) *witnessing as an indirect trauma pathway*, and (4) *contextual vulnerabilities among novice and high-acuity nurses.* Table 3 presents the thematic synthesis, including convergent and divergent points across the included literature.

Table 3. *Thematic Synthesis*

Theme	Description of Themes	Convergent Points	Divergent Points
Measurement-Exposure Misalignment (Indirect vs. Direct Trauma)	STS is frequently used to measure trauma-related symptoms among nurses directly targeted by horizontal bullying, despite STS being theoretically grounded in indirect trauma exposure.	Across several included studies, horizontal bullying or related workplace aggression constructs were associated with elevated STS scores or trauma-related symptom clusters (Jiao et al., 2023; Mashsha et al., 2025; Wolf et al., 2021).	Few studies distinguished primary trauma responses in direct victims from secondary trauma constructs; Aristidou et al. (2020) was the primary exception, explicitly separating victimization, witnessing, and combined exposure.
Horizontal Bullying Embedded in Workplace Violence Frameworks	Nurse-to-nurse bullying is commonly aggregated within broader workplace violence or incivility frameworks that include supervisory and patient aggression.	Workplace aggression constructs that included peer aggression were associated with burnout, STS, professional quality of life, or turnover intention (Alshehry et al., 2019; Kim et al., 2019; Nazari et al., 2024).	Most studies did not isolate horizontal bullying as a discrete exposure, limiting understanding of its unique relational impact compared with patient, supervisory, or broader organizational aggression (Aristidou et al., 2020; Nazari et al., 2024; Peng et al., 2022).
Witnessing as an Indirect Trauma Pathway	Witnessing nurse-to-nurse bullying may constitute indirect trauma exposure more aligned with the theoretical	Limited evidence suggests that combined victimization and witnessing may intensify trauma symptom severity	Witnessing was infrequently operationalized as a standalone variable, and most empirical studies focused on direct bullying, incivility, or workplace

	foundations of STS. However, witnessing is rarely operationalized as a discrete exposure variable and remains under-measured and under-theorized in the current literature.	(Aristidou et al., 2020). Conceptual papers also support the relevance of relational and structural antecedents of nurse trauma (Foli, 2022; Runyon et al., 2025).	aggression without separating indirect exposure pathways (Mashsha et al., 2025; Nazari et al., 2024; Wolf et al., 2021).
Contextual Vulnerabilities (Novice & Critical Care Nurses)	Exposure to horizontal bullying and trauma-related outcomes is patterned by professional experience and clinical setting.	Novice nurses and nurses working in emergency or critical care settings appeared as important subgroups in the included literature (Aristidou et al., 2020; Dong et al., 2025; Mashsha et al., 2025; Wolf et al., 2021).	Cultural norms, reporting behaviors, and overrepresentation of high-acuity settings may influence prevalence estimates and limit comparison across settings (Aristidou et al., 2020; Dong et al., 2025; Mashsha et al., 2025).

Study Characteristics

The literature included in this review reflects a range of inquiry into workplace bullying and trauma-related symptomatology in nursing populations. Most empirical studies (n = 9) used cross-sectional or correlational survey designs (i.e., Alshehry et al., 2019; Aristidou et al., 2020; Dong et al., 2025; Jiao et al., 2023; Kim et al., 2019; Mashsha et al., 2025; Nazari et al., 2024; Peng et al., 2022; Wolf et al., 2021). Validated instruments included the Negative Acts Questionnaire or Negative Acts Questionnaire-Revised (NAQ/NAQ-R) (n = 5), the Nursing Incivility Scale (NIS) (n = 2), the Professional Quality of Life Scale (ProQOL) (n = 7), and the Secondary Traumatic Stress Scale or a modified version of the scale (n = 2). Incivility was sometimes (n = 3) measured alongside or within broader workplace aggression constructs, reflecting its conceptual proximity to horizontal bullying when exposure is chronic or repeated (i.e., Alshehry et al., 2019; Aristidou et al., 2020; Nazari et al., 2024). Several studies (n = 6) also

examined burnout, turnover intention, resilience, and coping styles, with analyses typically involving correlation, regression, or structural equation modeling.

The total sample from selected articles included over 3,000 nurses. Participants were predominantly hospital-based nurses who had been recruited through convenience, purposive, random, or snowball sampling approaches (Alshehry et al., 2019; Aristidou et al., 2020; Dong et al., 2025; Jiao et al., 2023; Kim et al., 2019; Mashsha et al., 2025; Nazari et al., 2024; Peng et al., 2022; Wolf et al., 2021). Several studies focused on high-acuity settings, including emergency departments and critical care units (Aristidou et al., 2020; Mashsha et al., 2025; Wolf et al., 2021). One study specifically targeted novice nurses within the first three years of practice (Dong et al., 2025). Conceptual contributions included one concept analysis and one middle-range theory paper. Runyon et al. (2025) advanced conceptual understanding of psychological trauma in nurses, including workplace incivility as a potential antecedent, while Foli (2022) provided a middle-range theory of nurses' psychological trauma that positioned STS within a broader typology of nurse-specific trauma.

The empirical studies reflected international representation, with studies conducted in Saudi Arabia, Cyprus, China, South Korea, Jordan, Iran, and the United States (Alshehry et al., 2019; Aristidou et al., 2020; Dong et al., 2025; Jiao et al., 2023; Kim et al., 2019; Mashsha et al., 2025; Nazari et al., 2024; Peng et al., 2022; Wolf et al., 2021). In contrast, the conceptual and theoretical papers included in the review were U.S.-based (Foli, 2022; Runyon et al., 2025). This pattern may suggest that empirical evidence on bullying and trauma-related outcomes is geographically diverse, whereas the conceptual framing of nurse-specific trauma remains more concentrated in U.S.-based scholarship.

Across the included literature, most studies measured trauma-related outcomes using either the ProQOL STS subscale or the STSS (Alshehry et al., 2019; Aristidou et al., 2020; Dong et al., 2025; Jiao et al., 2023; Kim et al., 2019; Mashsha et al., 2025; Nazari et al., 2024; Peng et al., 2022; Wolf et al., 2021). These measures were applied primarily to nurses reporting direct bullying, incivility, or workplace aggression. Only Aristidou et al. (2020) explicitly differentiated nurses who witnessed bullying, experienced direct victimization, or experienced both. Limited differentiation, therefore, constrained comparison of direct and indirect exposure pathways across studies.

Theme 1: ***Measurement-Exposure Misalignment (Indirect vs. Direct Trauma)***

Trauma-related symptomatology in relation to workplace bullying was most commonly measured using either the Professional Quality of Life Scale secondary traumatic stress subscale or the Secondary Traumatic Stress Scale. The ProQOL STS subscale was used in studies by Alshehry et al. (2019), Dong et al. (2025), Jiao et al. (2023), Kim et al. (2019), Mashsha et al. (2025), Nazari et al. (2024), and Peng et al. (2022). In contrast, Aristidou et al. (2020) and Wolf et al. (2021) used the STSS or a modified version of the STSS. Across these studies, STS measures were generally applied to nurses reporting direct exposure to bullying, incivility, or workplace aggression.

This pattern created a measurement-exposure misalignment. STS was originally conceptualized to describe trauma responses resulting from indirect exposure to another individual's traumatic experience (Bride et al., 2004). However, most included studies used STS instruments with nurses who reported direct interpersonal aggression, rather than clearly differentiated indirect exposure. This limited the ability to distinguish primary trauma responses

among directly victimized nurses from secondary traumatic stress responses among nurses indirectly exposed through witnessing or relational proximity.

Aristidou et al. (2020) was the only empirical study in this review that explicitly distinguished between nurses who experienced direct victimization, nurses who witnessed bullying, and nurses who experienced both. This study found greater trauma symptom severity among nurses exposed to both victimization and witnessing, suggesting that combined exposure may intensify trauma-related symptoms. Across the broader literature, however, direct and indirect exposure pathways were not consistently separated, leaving the theoretical classification of these symptoms conceptually ambiguous.

Theme 2: ***Horizontal Bullying Embedded in Workplace Violence Frameworks***

A second theme was the frequent aggregation of horizontal nurse-to-nurse bullying within broader workplace violence, workplace bullying, or incivility frameworks. Aristidou et al. (2020) assessed bullying and mobbing within a modified workplace violence instrument, while Alshehry et al. (2019) and Nazari et al. (2024) measured incivility across multiple sources, including nurses, supervisors, physicians, patients, or visitors. In these studies, horizontal bullying or related workplace aggression constructs were embedded within broader typologies of workplace aggression rather than analyzed as a distinct relational exposure.

This aggregation reflects the complexity of aggression within healthcare settings. However, incivility and bullying remain conceptually distinct, with incivility often characterized as lower-intensity behavior that may escalate into sustained interpersonal mistreatment when repeated over time (Einarsen et al., 2009; Guidroz et al., 2010). Similarly, studies using the NAQ or NAQ-R measured repeated negative acts across personal, work-related, or intimidation-related domains, but did not always isolate horizontal bullying from broader workplace bullying

constructs. This pattern was evident in studies by Jiao et al. (2023), Kim et al. (2019), Mashsha et al. (2025), Peng et al. (2022), and Dong et al. (2025).

Across the included literature, broader workplace aggression constructs were associated with burnout, STS, reduced professional quality of life, or turnover intention. However, the studies varied in how specifically they defined the source of aggression. This limited relational specificity makes it difficult to determine whether horizontal bullying or related workplace aggression constructs produce distinct psychological sequelae compared with patient-originated, supervisory, or organizational aggression.

Theme 3: ***Witnessing as an Indirect Trauma Pathway***

Limited evidence was identified regarding indirect trauma exposure through witnessing horizontal bullying. Most empirical studies focused on nurses' direct exposure to workplace bullying, incivility, or workplace aggression rather than differentiating direct victimization from witnessing. Aristidou et al. (2020) was the only empirical study in this review that explicitly distinguished among nurses who were direct targets of bullying, nurses who witnessed bullying, and nurses who experienced both. In that study, trauma symptom severity was higher among nurses exposed to both victimization and witnessing, suggesting that combined exposure may be associated with greater trauma-related symptom burden.

Across the remaining empirical studies, witnessing was rarely operationalized as a standalone exposure variable. Studies by Mashsha et al. (2025), Nazari et al. (2024), and Wolf et al. (2021), for example, linked workplace bullying, incivility, or peer aggression with STS or trauma-related symptoms but did not consistently separate direct and indirect exposure pathways. Theoretical and conceptual papers included in this review support the relevance of relational and structural antecedents of nurse trauma, but empirical measurement has not yet systematically

captured witnessing as a discrete exposure type (Foli, 2022; Runyon et al., 2025). This limited the ability to compare direct victimization, witnessing, and combined exposure pathways across the included literature.

Theme 4: ***Contextual Vulnerabilities (Novice & Critical Care Nurses)***

Contextual vulnerability was observed among novice nurses and nurses working in high-acuity settings. Dong et al. (2025) specifically examined novice nurses within the first three years of practice and found that workplace bullying was associated with turnover intention both directly and indirectly through burnout and STS. This study identified early-career nurses as an important subgroup for understanding the relationship between workplace bullying, professional quality of life, and workforce outcomes.

High-acuity settings were also prominent across the included literature. Wolf et al. (2021) examined emergency nurses and found that frequent bullying was associated with higher intent to leave and elevated STS scores. Mashsha et al. (2025) studied emergency and critical care nurses in Jordan and found that workplace bullying uniquely predicted both STS and turnover intention. Aristidou et al. (2020) also examined emergency and critical care nurses and reported higher trauma symptom severity among emergency nurses compared with ICU nurses.

The conceptual literature also pointed to specialty-specific vulnerability. Runyon et al. (2025) described labor and delivery nurses as potentially vulnerable to psychological trauma due to the high-consequence and relationally intensive nature of perinatal care. However, across the review, comparisons between high-acuity and lower-acuity environments were limited. Findings therefore suggest that novice nurses and nurses in high-acuity settings may represent important subgroups for future research, although comparisons across clinical contexts remain constrained by the current evidence base.

Discussion

Findings of this review suggest that horizontal bullying, workplace incivility, and broader workplace violence exposures may be associated with trauma-related symptoms, reduced professional quality of life, burnout, and turnover intention among nurses. The following section interprets these findings in relation to measurement, exposure pathways, and current literature.

Interpretation of Findings

One central contribution of this review is the identification of measurement-exposure misalignment in the use of STS instruments. STS is theoretically grounded in indirect exposure to another person's trauma (Bride et al., 2004). However, several included studies used STS measures to assess nurses who experienced bullying, incivility, or workplace aggression. For example, Jiao et al. (2023) examined workplace bullying in relation to the ProQOL STS subscale, while Mashsha et al. (2025) examined workplace bullying and STS among emergency and critical care nurses. These findings suggest the need for greater precision in naming and measuring exposure pathways. Direct nurse-to-nurse bullying may be better understood as primary trauma-related distress or PTSD-aligned symptoms, whereas witnessing colleague mistreatment may align more closely with STS because the nurse is indirectly exposed to another person's victimization. Observing, listening to, or repeatedly engaging with another person's traumatic experiences may contribute to trauma-related responses among nurses (Güler et al., 2025).

This distinction matters because direct victimization and witnessing may produce overlapping symptoms, including intrusion, avoidance, emotional numbing, hypervigilance, and sleep disturbance, which are consistent with PTSD-aligned symptom clusters (American Psychiatric Association, 2022). However, the mechanism of exposure differs. Figley's (1995) formulation of secondary traumatic stress emphasizes symptoms arising through exposure to

another person's traumatic experience, whereas direct victimization involves firsthand exposure to interpersonal harm. When these pathways are collapsed into a single STS framework, it becomes difficult to determine whether symptoms arise from direct victimization, witnessing, or both. Aristidou et al. (2020), the only empirical study in this review to differentiate these pathways, found that nurses exposed to both victimization and witnessing reported greater trauma symptom severity, suggesting a possible cumulative psychological burden.

Conceptual ambiguity is also increased when horizontal bullying is grouped within broader workplace violence frameworks. Alshehry et al. (2019) and Nazari et al. (2024), for example, measured incivility across multiple sources, including nurses, supervisors, physicians, patients, or visitors. Aristidou et al. (2020) similarly assessed bullying and mobbing within a modified workplace violence instrument. Although this approach reflects the complexity of healthcare environments, where nurses may experience multiple forms of aggression simultaneously, it limits the ability to determine whether horizontal bullying is associated with distinct psychological effects compared with patient-originated, supervisory, or general workplace aggression. Isolating peer-directed aggression remains important because it occurs within collegial relationships central to teamwork, professional identity, and psychological safety.

Patterns of vulnerability also warrant caution. Dong et al. (2025) focused specifically on novice nurses, identifying early-career nurses as an important subgroup in relation to workplace bullying, professional quality of life, and turnover intention. Aristidou et al. (2020), Mashsha et al. (2025), and Wolf et al. (2021) examined emergency or critical care nurses, making high-acuity settings prominent in the included literature. These patterns may reflect, in part, hierarchical power dynamics, professional socialization, exposure to patient trauma, workload

intensity, and the relational demands of high-acuity nursing work. However, the prominence of high-acuity settings limits comparison with lower-acuity settings. Future research should therefore examine how unit culture, hierarchy, staffing, and exposure type interact across diverse clinical contexts.

Synthesis With Current Literature

The findings of this review align with broader literature showing that workplace bullying, incivility, lateral violence, and horizontal violence remain persistent threats to nurse well-being, professional quality of life, patient safety, and workforce retention. Recent reviews report associations with psychological distress, burnout, reduced job satisfaction, and turnover intention (Reguera-Carrasco et al., 2025; Zhang et al., 2025). Sun et al. (2025) similarly found an association between workplace bullying and turnover intention across occupational groups.

This review adds a trauma-focused lens by examining trauma-related symptoms and exposure pathways. Prior reviews have often centered on burnout, retention, organizational climate, and patient safety, but have less often examined how bullying-related symptoms are classified. The current synthesis suggests that trauma-related outcomes are present in the literature, but their theoretical classification remains inconsistent, which is consistent with broader nursing scholarship showing overlap among STS, compassion fatigue, burnout, vicarious trauma, and nurse-specific psychological trauma (Arnold, 2020; Foli, 2022; Wu et al., 2024).

The under-measurement of witnessing is especially important in light of evidence that witnessing rudeness or incivility can impair cognition and team functioning. Experimental and field-based studies have shown that witnessing rudeness or incivility may impair cognitive performance, increase emotional labor demands, reduce information sharing, and disrupt coordination (Andel et al., 2022; Gale et al., 2024; Riskin et al., 2015). In high-acuity

environments, indirect exposure to peer mistreatment may therefore affect not only individual distress but also patient safety through disrupted attention, communication, and teamwork. Research on second victim distress similarly demonstrates links among occupational trauma exposure, compassion fatigue, and patient safety outcomes in high-acuity nursing environments (Huo et al., 2026).

The review also fits with nurse-specific trauma frameworks that locate psychological trauma in interpersonal, organizational, and structural sources. Foli's (2022) middle-range theory of nurses' psychological trauma situates STS within a broader typology of nurse-specific trauma, while Runyon et al. (2025) identify workplace incivility as a potential antecedent of psychological trauma in labor and delivery nurses. Together, these frameworks support a broader understanding of trauma in nursing that extends beyond patient-related suffering alone. What remains unclear is the extent to which horizontal bullying functions as a distinct relational trauma exposure.

Limitations

Several limitations warrant consideration. The search was limited to English-language publications, which may have introduced language bias and excluded relevant international evidence. Because reference list hand-searching was not undertaken, it is possible that relevant conceptual or empirical papers not indexed in the selected databases were missed. Most included studies employed cross-sectional, self-report designs, limiting causal inference and temporal clarity between exposure to workplace bullying and trauma-related outcomes. Although self-report measures are appropriate for assessing subjective psychological phenomena such as trauma-related symptomatology and STS, they may introduce recall and response bias.

Measurement overlaps across constructs, including STS, burnout, compassion fatigue, and professional quality of life, further complicates interpretation, particularly when STS is embedded within broader instruments such as the ProQOL. Additionally, horizontal nurse-to-nurse bullying was rarely isolated as an independent exposure variable and was frequently aggregated within broader workplace violence frameworks, limiting the ability to distinguish its unique relational impact. Witnessing of bullying was infrequently measured as a discrete exposure, restricting insight into indirect trauma pathways. Finally, the predominance of hospital-based samples, particularly in high-acuity settings, may limit generalizability across clinical contexts, while cultural variations in hierarchy and reporting norms may influence both exposure and symptom appraisal. Reviewed literature focused primarily on trauma-related symptoms rather than longitudinal trauma trajectories, limiting understanding of how exposure and coping evolve over time (Güler et al., 2025; Hutchens et al., 2025).

Implications for Nursing

The Nursing Workforce

Nurses should recognize horizontal bullying as a source of psychological harm. Training should help nurses identify trauma-related symptoms such as hypervigilance, emotional withdrawal, and intrusive thoughts. Nurses should be encouraged to address bullying behaviors directly and use structured reporting systems and the chain of command rather than avoiding conflict.

However, it is important to acknowledge that responding to workplace bullying is rarely straightforward. Nurses who directly experience or witness peer aggression may face complex professional and interpersonal constraints, including hierarchical power dynamics, fear of retaliation, and concerns about social isolation within tightly knit clinical teams (Hutchinson &

Jackson, 2013). These realities may discourage reporting or confrontation, even when bullying behaviors are clearly recognized. As such, responsibility for addressing horizontal bullying cannot rest solely with individual nurses but requires organizational structures that ensure psychological safety, protect those who report concerns, and actively disrupt cultures that normalize peer aggression.

Peer-support and debriefing programs should include discussion of witnessing colleague mistreatment, especially in high-acuity units. Social support has consistently been identified as a primary coping mechanism among nurses exposed to traumatic workplace experiences (Hutchens et al., 2025). Providing structured spaces for reflection may help nurses process the emotional impact of both direct victimization and bystander exposure while reducing the normalization of relational aggression within clinical teams. Confidential mental health resources should be easily accessible for nurses experiencing repeated relational aggression.

Nurse Educators

Nurse educators have an important role in preparing nurses to recognize and respond to workplace relational aggression as a potential source of psychological harm. Conceptual distinctions between direct interpersonal victimization and secondary trauma arising from witnessing colleague mistreatment should be introduced early in professional development so that nurses can identify trauma-related responses in themselves and others. Education should also explicitly distinguish between the psychological impacts of direct victimization and those arising from witnessing colleague mistreatment, enabling nurses to recognize both as legitimate sources of trauma-related distress.

Transition-to-practice programs are particularly well-positioned to address power dynamics, workplace culture, and bystander response skills. Mentorship and preceptor models

should also prepare and support novice nurses in navigating workplace incivility while reinforcing norms of psychological safety, professional accountability, and collective responsibility for challenging harmful peer behaviours. Educators can further strengthen professional resilience by teaching nurses to recognize bystander exposure to bullying as a legitimate source of psychological strain, thereby reducing the normalization of peer aggression within clinical learning environments.

Nurse Leaders

Nurse leaders must treat horizontal bullying as a workplace safety issue. A trauma-informed leadership approach may provide a structured framework for addressing horizontal nurse-to-nurse bullying at the systems level. A trauma-informed organization is one that realizes the widespread impact of trauma, recognizes its signs and symptoms, responds by integrating trauma knowledge into policies and practices, and actively resists re-traumatization (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Within this framework, leaders must also recognize that trauma may arise not only from direct victimization but also from witnessing peer aggression and ensure that both exposure pathways are acknowledged in policy, reporting processes, and staff support initiatives.

Applying this framework within nursing environments requires leaders to move beyond individual coping strategies and instead embed principles of safety, transparency, peer support, collaboration, empowerment, and cultural responsiveness into unit culture and organizational policy. Such an approach can shift the focus from managing individual distress to redesigning relational and structural conditions that contribute to trauma-consistent symptoms. In doing so, trauma-informed leadership may simultaneously strengthen nurse well-being, retention, and patient safety. Operationalizing this approach requires leaders to embed measurable

accountability mechanisms, including routine monitoring of workplace culture, transparent reporting of outcomes, and leadership performance indicators linked to psychological safety and staff well-being.

Clear behavioral expectations, zero-tolerance policies, and non-punitive reporting systems should be implemented and enforced. High-acuity units should routinely assess workplace climate and screen for trauma-related symptoms. Leaders should respond quickly to reported incidents and protect those who report them. Attention to workplace incivility and peer aggression is particularly important because emotional exhaustion and emotional labor associated with workplace mistreatment may negatively influence safety-related behaviors (Andel et al., 2022). Resilience training must not replace structural reform. Leadership accountability and culture audits are essential to prevent normalization of nurse-to-nurse aggression. Addressing relational aggression directly can improve retention, strengthen nurse well-being, and protect patient safety.

Conclusion

Horizontal nurse-to-nurse bullying should be recognized as a potentially trauma-producing occupational exposure rather than solely a matter of professionalism or interpersonal conflict. Across settings and countries, peer-directed aggression is associated with trauma-related symptoms; however, the distinction between responses to direct victimization and those arising through indirect exposure remains insufficiently developed, highlighting the need for greater conceptual and measurement precision. Nursing organizations play a critical role in addressing this risk through trauma-informed leadership, non-punitive reporting systems, and active efforts to dismantle cultures that normalize peer aggression, thereby promoting psychological safety and supporting patient care. Future research should explicitly differentiate direct victimization from

witnessing and examine how these exposure pathways contribute to trauma-related outcomes, as addressing horizontal bullying as a potential source of psychological trauma is both a workforce well-being priority and a patient safety imperative.

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