Stress and verbal abuse in nursing: do burned out nurses eat their young?

M. MICHELLE ROWE PhD and HOLLY SHERLOCK MS, RN
Associate Professor and Chair, Department of Health Services, Saint Joseph’s University, Philadelphia, PA, USA

Introduction

Historically, nurses have been subjected to physical, emotional and verbal abuse because the nature of the work places them in a prime position to be recipients. Previous studies addressing this topic have found that major sources of verbal abuse include patients, families, doctors and other health care workers (Cox 1987, Diaz...
& McMillan 1991). However, little research has been performed to determine whether or not nurses abuse each other. Such abuse is destructive and threatens the existence of a supposed caring and nurturing profession. Exposure to verbal abuse has been known to have negative effects on nurses’ self-esteem, job satisfaction, morale, patient care, work productivity and professional error rates (Cox 1991a). In fact, nurses who experience higher levels of occupational burnout are more likely to vent their frustration by abusing other nurses (Lazarus & Folkman 1984). Unfortunately, many nurses have been taught to simply ‘grin and bear it’ and as a result of prolonged abuse, nurses have become an oppressed group with nowhere to channel anger but at other nurses (Roberts 1983). Nurses have begun to utilize the behaviours they denounce in order to survive and preserve their self-concepts and self-esteem.

Background

The effects and consequences of verbal abuse can be devastating and long-lasting. Research that has focused on its consequences has found that it is both psychologically and psychologically damaging. For example, children who were verbally abused by their parents were more physically aggressive, more delinquent and suffered more interpersonal problems than those who were not verbally assaulted (Vissing et al. 1991). Research has shown that when parents verbally abused children, it is just as damaging as physical abuse (Ketterman 1992). Other studies have demonstrated that women who received frequent sarcasm, humiliation, threats and name-calling experienced low self-esteem, loss of control and powerlessness (Dobash & Dobash 1977–1978, Roy 1977, Walker 1979, 1983). Verbal abuse can occur between parent and child, husband and wife, brother and sister and between employees in the workplace.

Previous research

Specific to the nursing field, nurses may experience verbal abuse because of their subordinate status when compared with that of doctors. This oppression by doctors may lead to nurses fighting among themselves because direct conflict with the real oppressor is too risky (Roberts 1983, Thomas & Droppelman 1997). The impact on the nursing profession is costly. In fact, research has demonstrated that verbal abuse directly contributes to turnover, vacant positions and ongoing orientation of new staff (Cox 1987). Further, verbal abuse has been associated with compromised patient care, increased errors, poor morale, decreased job satisfaction and decreased productivity (Braun et al. 1991, Cox 1991a,b). Consequently, it is imperative for managers to take an honest look at verbal aggression in their institutions and departments.

Verbal aggression is the core of verbal abuse, and verbal aggression evolves into abuse when the attack is frequent and consistent (Kinney 1994). Verbal abuse is designed to humiliate and degrade (Hadley 1990). It is any statement to a victim that results in emotional damage, which limits his/her happiness and productivity (Metro Task Force on emotional abuse 1987). It is the inappropriate incorporating of verbal behaviours through tone, manner and even non-verbal cues to maintain a power position (Diaz & McMillan 1991). Ketterman (1992) identified seven different components of verbal abuse. These include victims feel rejected and devalued, victims feel isolated, victims feel worthless and hopeless, verbal abuse ignores basic needs such as unconditional acceptance, approval and consistency, the use of vulgar language and crude accusations may corrupt the values and behaviours of the victim, it degrades victims and destroys self-esteem, and it exploits others for the benefit of the abuser.

From a nursing perspective, verbal abuse is any communication perceived by another nurse as ruthless criticism, either personal or professional (Cox 1991a). Nurses have described verbal abuse in graphic terms such as backbiting, needling, cutting and blasting. Verbal abuse can be conveyed by silence, damaging gossip and other passive-aggressive behaviours, and such behaviours are highly stresses producing. In fact, interpersonal conflict has been noted as one of the major sources of stress for nurses (Grout 1980, Hipwell et al. 1989). Further, research has demonstrated that nursing staff turnover is directly related to interpersonal conflict and verbal abuse (Cox 1987, 1991a). Frequent exposure to angry communication from peers leads to alienation among nurses, which may cause them to resign instead of dealing with their anger and dismay (Dult 1992).

In conclusion, verbal abuse is a complicated behavioural pattern. Although considerable research has been dedicated to evaluating abuse patterns of nurses by doctors, patients and patient’s family members, more research on how and why nurses abuse each other is needed. Consequently, the purpose of this study is to explore the components, characteristics, consequences and effects of abuse in an effort to better understand the dynamics of verbal abuse of nurses in the workplace. Specifically, do nurses verbally abuse each other?
Further, if so, how and why do they do so? Finally, what impact does this abuse have on individual nurses, on the employers and on the nursing profession? Research into the nature, incidence and frequency of verbal abuse can have a definite impact on the healthcare field and direct patient care.

**Methodology**

**Sample**

The sample for this research study included a total of 213 Registered Nurses and Licensed Practical Nurses employed at a teaching hospital in the Philadelphia area. This teaching hospital consisted of a large level 1 trauma centre. This hospital is in a large metropolitan area, has a high patient volume and has approximately 500 beds. Nurses from all shifts were included, and full- and part-time nurses were included. Participants from Emergency, Intensive Care, Intermediate Care, Medical/Surgical, Pediatrics, Oncology, Senior Behavioral Health, Maternity, Labour and Delivery, the Nursery, the Operating Room, PostAnesthesia Care, and Short Procedures, Cardiac Care, IV Team and Nursing Administration were represented. Subjects included both male and female nurses from all levels of education, including LPN, RN – diploma, RN – Associates Degree, RN – Bachelor’s Degree and RN – Master’s Degree. Some nurses had degrees in other areas as well as specialty certifications. Staff registered nurses had varied years of experience, from the newly licensed to those with over 20 years of experience. Managers also had varying years of experience in their roles. Temporary staff and agency employees were not included in this study.

**Instrumentation**

Two surveys noted in the literature that pertain to verbal abuse of nurses include Cox’s (1987) Verbal Abuse Survey and the Verbal Abuse Scale by Manderino and Berkey (1997). Cox (1987) distributed a nationwide survey and then replicated the study in 1991 with similar results. Since that time, it has been replicated and adapted numerous times. Manderino and Berkey’s (1997) Verbal Abuse Scale was originally designed to analyse verbal abuse that nurses received from doctors in the context of Lazarus’ Stress Coping Model (Lazarus & Folkman 1984). According to the authors, during the development of the scale, earlier versions were assessed for content validity using a panel of experts who were knowledgeable of Lazarus’ Theory of Stress Coping as well as the concept of verbal abuse. Cronbach’s alpha is 0.81 and test–retest reliability is \( r = 0.65 \) (Manderino & Berkey 1997). The scale was used in this study, changing ‘doctor’ to ‘nurse’.

The current research utilized an adapted two-part survey combining the Verbal Abuse Survey and the Verbal Abuse Scale. Permission was secured and granted to utilize the two surveys. This was carried out because the two surveys best represented what the researchers were attempting to measure. A combination of the two was used because each subject needed to complete the survey in a short period of time during his/her shift. Using both surveys in full and a demographic questionnaire would have made completing the survey quickly (within 10 minutes) quite difficult. Items in the Verbal Abuse Survey were deleted if repeated in the Verbal Abuse Scale. For example, questions regarding reaction and coping with verbal abuse were deleted from part 1 as the scale in part 2 allowed for a more in-depth exploration of the area. Some items were eliminated if choices were fairly similar, for instance, fear and threatened. This was done so that the survey would be a reasonable length, and so that nurses could complete the scale within a 25-minute time period.

Part 1 of the survey included 10-items regarding the general experience of verbal abuse from all sources, its frequency, and the respondents’ perception of how well they handle verbally aggressive situations. An attempt to narrow down the source of verbal aggression to nurses was made by asking the participants if they could identify the nurse aggressor as either staff or management. Part 2 was completed only by those who selected a nurse as a source of verbal aggression. This part of the survey was divided into five subsections and involved identification of the types, the frequency and stressfulness of verbal aggression, the strength of feelings or reactions to verbal aggression, cognitive appraisal or personal significance of a verbally aggressive encounter, coping behaviours for both similarity and effectiveness, and long-term negative effects. Each section had a corresponding point scale (0–6) for response selection. Although the adapted survey was not thoroughly tested for validity and reliability, 10 registered nurses and two experts in test construction reviewed the final version for content, clarity and validity. In order to assess potential demographic variable effects, data including age, marital status, highest education level, employment status, years of experience as a staff nurse or manager, current work setting and shift worked were also assessed.
Procedures

In accordance with the Institutional Review Boards for the Protection of Human Subjects at both the hospital and the university (the boards which review all research to ensure the ethical treatment and protection of human research subjects), subjects received an introductory cover letter indicating that participation was strictly voluntary, the survey packet and a collection envelope. Any nurse who chose not to participate in the study was instructed to simply return the uncompleted survey packet in the collection envelope. Nurses who chose to participate in the study were instructed to complete the survey, place it in the collection envelope and seal it, and place the envelope into a centrally located collection mailbox.

Results

Of the 307 surveys distributed 213 were returned, for a response rate of 69%. Of the respondents, 204 were female and nine were male. About 75% were married. The sample included 32.7% Diploma Graduates, 31.8% Bachelor of Science Degree nurses, 25.5% Associates Degree nurses, 5.5% Master of Science Degree nurses and 4.5% Licensed Practical Nurses. Five nurses had degrees in other areas and 15 had certification in specialty areas. About 88% of the subjects were staff nurses; 53% worked full-time and 47% worked part-time. About 85% had more than 5 years experience. All major shifts were represented including 7–3 (44.5%), 3–11 (27.3%), 11–7 (24.5%) and other (3.7%). Work settings included Emergency Room (10.9%), Intensive Care (9.1%), Medical-Surgical (15.5%), Telemetry (10.9%), Senior Behavioral Health (7.3%), Operating Room (9.1%), PostAnesthesia Care Unit (2.7%), Short Procedure Unit (0.9%), Nursing Office (7.3%), Cardiac Care (0.9%), Maternity (20.9%) and IV Team (4.5%).

Of the nurses who participated in the study, 96.4% reported that they had been spoken into a verbally aggressive manner; 79% of the respondents reported that they had been verbally abused by patients, 75% by other nurses, 74% by attending doctors, 68% by patients’ family members, 37% by residents, 24% by interns and 19% by others, which included supervisors, ancillary departments, housekeeping, radiology, CT Scan Techs, Lab, insurance carrier, clergy, volunteers and pharmacy. Each participant then identified the most frequent source of verbal abuse. Respondents reported that the most frequent source was nurses (27%), followed by patients’ families (25%), doctors (22%), patients (17%), residents (4%), other (3%) and interns (2%). Of those who selected a nurse as the most frequent source, staff nurses were reported to be the most frequent nursing source (80%) followed by nurse managers (20%).

Only 5% of the subjects had called out sick following a verbally aggressive incident. Respondents indicated that females (60%) were a more frequent source of abuse than males (40%). About 70% of the respondents indicated that the duration of each verbal abuse situation was a few hours, 18% reported that the incident lasted a week and 16% reported that it still bothered them. Finally, 86% of the respondents replied that verbally abusive experiences had not caused them to make a caregiving error while 13% replied that it had.

Table 1 describes how frequently abuse by other nurses had occurred (0 = never, 1 = 1–6 times this year, 2 = once a month, 3 = 2–3 times per month, 4 = once a week, 5 = several times a week, 6 = everyday) as well as how stressful were the incidents (0 = not at all, 1 = very slightly stressful, 2 = mildly stressful, 3 = moderately stressful, 4 = stressful, 5 = very stressful, 6 = extremely stressful). In general, nurses reported experiencing verbal abuse and experienced stress as a consequence of the aggressive behaviour. Table 2 reports the intensity of the respondents’ feelings when reacting to verbal aggression (0 = no reaction, 1 = very mild feeling, 2 = mild feeling, 3 = moderate feeling, 4 = strong feeling, 5 = very strong feeling, 6 = extreme feeling). Most nurses reported mild-to-moderate reactions to the verbal aggression.

In the next section of the survey, each subject was asked to designate the similarity of his/her thoughts (1 = not similar, 2 = very slightly similar, 3 = moderately similar, 4 = similar, 5 = very similar, 6 = extremely similar) as he/she appraised the verbally
aggressive situation. These cognitive appraisal ratings on 5-items included: it must be my fault (mean = 1.00, SD = 1.35), I do not deserve this treatment (mean = 3.90, SD = 1.51), I have done nothing wrong (mean = 3.16, SD = 1.73), I cannot handle this (mean = 1.53, SD = 1.61) and I can deal with this (mean = 3.60, SD = 1.59). Generally, most nurses reported feeling that they had not deserved the abuse, but could handle it to some degree.

Next, the similarity and effectiveness of coping behaviours in response to verbal aggression from another nurse was addressed. First, each respondent was asked how similar his/her coping behaviours were to those listed (0 = not similar, 1 = very slightly similar, 2 = mildly similar, 3 = moderately similar, 4 = similar, 5 = very similar, 6 = extremely similar). In addition, the effectiveness of those responses was selected (0 = not effective at all, 1 = slightly effective, 2 = mildly effective, 3 = moderately effective, 4 = effective, 5 = very effective, 6 = extremely effective), and these findings are reported in Table 3. Typically, most nurses reported that they would attempt to clarify any misunderstandings, ask for support from others, and then deal directly with the abusive nurse.

Finally, the respondents were asked to report any severe long-term negative effects because of past experiences with verbal aggression by another nurse. Severity ranged from no effect (0), to extremely negative effects (6) and these items included self-esteem (mean = 1.70, SD = 1.38), self-confidence (mean = 1.61, SD = 1.46), sense of well-being (mean = 2.50, SD = 1.52), job satisfaction (mean = 3.01, SD = 1.78), job performance (mean = 1.35, SD = 1.44), trust and support in the work setting (mean = 2.47, SD = 1.69), relationship with the aggressive nurse (mean = 3.01, SD = 1.61), and relationship with other staff (mean = 1.16, SD = 1.37). Most frequently, the abuse directly impacts any potential relationship with the abusive nurse and impacted trust and support in the work setting and job satisfaction.

**Discussion**

The purpose of this study was to evaluate the frequency and impact of verbal abuse of nurses by other nurses. Results indicated that verbal abuse does, in fact, occur. Nurses were identified as the most frequent source of verbal aggression to other nurses. Doctors, patients and patients’ families continued to be major sources, but it is noteworthy that nurses surpassed all others. Anger, judging and criticizing, and condescension were the most frequently encountered types of verbal aggression. Judging and criticizing were found to be more stressful than condescension. It is important to note that although most nurses felt angry, sad/hurt and frustrated when confronted with a verbally aggressive incident by a peer, and most felt he/she did little to warrant the abuse and did not deserve to be treated that way, most did feel that he/she could handle the situation. The majority selected adaptive or positive coping skills by attempting to clarify any misunderstandings and dealing directly with the nurse about the aggression. However, many nurses did report response patterns of silence and passivity, negative coping skills, calling out sick after verbally abusive encounters, and complaining about the impact on job satisfaction and sense of well-being in the workplace as a result of the abuse. These results were consistent with previous research suggesting that nurses often feel angry and powerless when subjected to verbal abuse (Cox 1991a,b).

Verbal abuse in nursing is quite costly to the individual nurses, the hospitals and the patients. Nurses who regularly experience verbal abuse may be more stressed, may feel less satisfied with their jobs, may miss

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**Table 2**

<table>
<thead>
<tr>
<th>Feelings</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confusion</td>
<td>1.46</td>
<td>1.47</td>
</tr>
<tr>
<td>Anger</td>
<td>3.05</td>
<td>1.53</td>
</tr>
<tr>
<td>Sadness/hurt</td>
<td>2.68</td>
<td>1.62</td>
</tr>
<tr>
<td>Shock/surprise</td>
<td>2.23</td>
<td>1.55</td>
</tr>
<tr>
<td>Embarrassed/humiliated</td>
<td>2.15</td>
<td>1.70</td>
</tr>
<tr>
<td>Threatened</td>
<td>1.53</td>
<td>1.66</td>
</tr>
<tr>
<td>Frustrated</td>
<td>2.36</td>
<td>1.79</td>
</tr>
<tr>
<td>Powerless</td>
<td>1.85</td>
<td>1.73</td>
</tr>
<tr>
<td>Indifferent</td>
<td>1.36</td>
<td>1.68</td>
</tr>
<tr>
<td>Intimidated</td>
<td>1.60</td>
<td>1.60</td>
</tr>
</tbody>
</table>

**Table 3**

<table>
<thead>
<tr>
<th>Coping behaviour</th>
<th>Similarity Mean</th>
<th>Similarity SD</th>
<th>Effectiveness Mean</th>
<th>Effectiveness SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deal directly with nurse</td>
<td>3.26</td>
<td>1.76</td>
<td>3.03</td>
<td>1.76</td>
</tr>
<tr>
<td>Wish situation would go away</td>
<td>2.15</td>
<td>2.10</td>
<td>1.00</td>
<td>1.34</td>
</tr>
<tr>
<td>Attempt to clarify misunderstanding</td>
<td>4.03</td>
<td>1.24</td>
<td>3.20</td>
<td>1.60</td>
</tr>
<tr>
<td>Become silent with nurse</td>
<td>2.31</td>
<td>1.95</td>
<td>1.75</td>
<td>1.74</td>
</tr>
<tr>
<td>Go on like nothing happened</td>
<td>1.96</td>
<td>1.90</td>
<td>1.53</td>
<td>1.62</td>
</tr>
<tr>
<td>Ask for support from others</td>
<td>2.75</td>
<td>1.75</td>
<td>2.60</td>
<td>1.63</td>
</tr>
<tr>
<td>Blame myself</td>
<td>1.03</td>
<td>1.35</td>
<td>0.87</td>
<td>1.44</td>
</tr>
<tr>
<td>Withdraw</td>
<td>1.43</td>
<td>1.81</td>
<td>1.08</td>
<td>1.55</td>
</tr>
<tr>
<td>Talk to myself in reassuring way</td>
<td>2.06</td>
<td>1.76</td>
<td>2.01</td>
<td>1.84</td>
</tr>
<tr>
<td>Treat abuser the same way I was treated</td>
<td>1.31</td>
<td>1.67</td>
<td>1.11</td>
<td>1.56</td>
</tr>
</tbody>
</table>
more work and may provide a substandard quality of care to patients. Hospitals that have problems with abuse will likely experience increase in job turnover of nursing staff, leading to costly recruitment, training and discontinuity among nursing staff members. Finally, patients who are treated by verbally abusive nurses may be treated poorly and may become victims of dangerous errors in clinical care. Clearly, the potential for lawsuits to both nurses and hospitals increases as a consequence of verbal abuse.

With regard to practice management, there are a number of important techniques to reduce the frequency of verbal abuse. First, nurse managers must employ creative strategies to enhance morale in the current health care environment. For example, managers must attempt where possible to involve nursing in decisions regarding policies and procedures. Individuals are who involved and invested in these decisions are less likely to experience occupational burnout. Consequently, higher morale is less likely to result in abuse among nursing colleagues. Secondly, managers should institute strict policies on abuse and encourage nurses to immediately report case of abuse. When cases of abuse are suspected a thorough investigation should be conducted. In other words, alleged abuse should be taken seriously. Thirdly, educational programmes for all nurses regarding these policies should be conducted on a regular basis. Finally, a mandatory counselling programme should be instituted for all nurses who have abused others.

In conclusion, this study confirms the notion that verbal abuse is a very real problem for the health care industry. The problem is deep seated and has existed for many years. Nurses have become a significant source of verbal aggression, a position formerly held by doctors.

The implications for this research are many and varied. Education of staff, particularly those who are newly licensed, with respect to direct communication and immediate diplomatic response to verbal aggression is indicated. Education for more experienced staff is also warranted, especially for those who may have learned maladaptive and/or passive-aggressive behaviours in coping with stressful situations. Adoption of a zero tolerance policy for verbal aggression that is consistent among all managers is needed. Assertiveness training and support groups for self-esteem enhancement may be beneficial. Development of programmes such as Nurse–Physician Liaison Groups or Nursing Practice Committees may teach nurses to channel anger and frustration into more constructive areas. Finally, it is evident that more research in this area is necessary in order to combat this difficult problem.

The results of this study should be interpreted in light of the potential limitations. First, this research should be replicated using a larger sample size and various types of hospital settings (i.e. teaching and non-teaching, urban, suburban and rural). Secondly, as is the case with self-report measures some nurses may not have felt completely free to honestly express displeasure with other nurses despite reassurance of confidentiality and anonymity. Thirdly, gender differences in the experiences of verbal abuse should be thoroughly evaluated because most of the participants in the study were female. Future studies should address the differences in education levels in nursing with regard to verbal abuse, experiences levels, and differences between managers and staff. Finally, it would be prudent to study job turnover rates to inquire whether verbal aggression has been an etiology for resignations.

References


