Mosaic of verbal abuse experienced by nurses in their everyday work

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Mosaic of verbal abuse experienced by nurses in their everyday work

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Abstract
Aims. To report observational data collected as part of a multi-phased study examining violence in the health sector. The findings presented detail the nature of verbal abuse experienced by nurses during their everyday interactions with patient, their families, or companions.

Background. Nurses have unacceptably high levels of exposure to violence, which commonly includes verbal abuse. However, relatively little is known about the nature of verbal abuse against nurses.

Design. Observational design.

Methods. During 2010, 1150 hours of observation resulted in data on 220 patients displaying cues for physical violence and 210 qualitative observational notes. These observational notes constitute the data for this paper and reveal the nature of verbal abuse experienced by nurses in their everyday work.

Results. A mosaic of abuse was revealed through three major categories: a discourse of gendered verbal abuse that was largely: sexual; insults, ridicule, and unreasonable demands; and hostility, threats, and menacing language.

Conclusions. For the nurses observed in this study, everyday nursing practice occurred in a backdrop of verbal abuse and hostility, which had a strong theme of gendered and sexualized overtones. We recommend that interventions that target verbal abuse should address the gendered and sexualized nature of the abuse experienced by nurses.

Keywords: nurses, nurse–patient interactions, nursing, violence, workforce issues

Introduction
It is well accepted in the literature that nursing is an occupation with an unacceptably high risk of exposure to violence in its various forms (Gacki-Smith et al. 2009, Pich et al. 2010). However, relatively little is known about the nature of verbal abuse against nurses. Although a plethora of evidence into the prevalence and nature of workplace violence in nursing exists, much of this literature is based on self-reports from both qualitative and survey-based studies (Farrell et al. 2006, Chapman et al. 2009, Stone et al. 2011) and there are very few observational studies (Luck et al. 2007). In many self-report studies, respondents are asked simply to indicate their exposure to verbal abuse with a yes/no response, providing little elucidation of the nature of the abuse, the language used, or the context. This paper reports findings of an observational study that sought to more fully describe the...
nature of verbal abuse that nurses are exposed to in the work environment.

Background

There remains a persistent discussion in the literature about the definition of violence (Luck et al. 2007, Child & Mentes 2010). The World Health Organization promotes a broad definition of violence that encompasses threatened and actual use of power or physical force (Di Martino 2002). It is generally agreed that violence encompasses behaviours that are classified as verbal, physical, emotional, or sexual harm and abuse (Nachreiner et al. 2007, Hahn et al. 2010). Workplace violence and abuse are a common feature of working life for many nurses (Lanza et al. 2006). Survey studies of violence against nurses have shown that verbal abuse occurs more frequently and is often a precursor to the escalation of physical violence (Chapman et al. 2010). For this study, verbal abuse is defined as language that is humiliating, degrading, or disrespectful; it may include the threat of ‘physical force, sexual or psychological harm, or other negative consequences’ (Di Martino 2002, p. 12).

There is compelling evidence that verbal abuse is the most common form of patient-to-nurse violence with threats, aggressive, and demeaning language being most common (Stone et al. 2011) and is recognized to be widespread (Pich et al. 2010). Verbal abuse is reported to be of concern internationally. In Japan, 29% of nurses reported experiencing verbal abuse in the previous year. The adjusted odds ratios of verbal abuse were significantly higher in psychiatric wards, long-term care wards, outpatient departments, and dialysis departments (Fujita et al. 2011). In a study of 210 Canadian hospitals, verbal sexual harassment was reported by 7-6% of nurses and emotional abuse by 38% (Duncan et al. 2001).

It cannot be assumed that verbal abuse in commonplace is devoid of any negative ramifications for those targeted. Gender role stereotyping, sexualized commentary, and demeaning sexist language are known to contribute to psychiatric symptoms in targets (Berg 2006) as the personalized nature of these forms of attack can degrade self-worth and erode self-esteem. By reinforcing the personal power of the aggressor to control, humiliate, and degrade, demeaning sexualized language and swearing exploit individuals for the gratification of the aggressor (Rowe & Sherlock 2005). Among Turkish nurses, it has been reported that common reactions to verbal abuse include helplessness, humiliation, and depression (Celik & Celik 2007).

Demeaning swearing has been identified by Australian nurses as the most offensive form of verbal aggression, particularly among female nurses. Swearing associated with threats has been reported to cause less distress than swearing associated with personally demeaning comments (Stone et al. 2011). A mixed-method study on nurses exposure to swearing in Australia using a database analysis of violent incidents and surveys and interviews with nurses suggests that nurses found ‘sexual/excretory words’ (Stone et al. 2011) to be the most offensive and that abusive language from relatives was experienced as more distressing than that coming from patients. Use of ‘sexual/excretory words’ fits in the construct of taboo language (Jay 2009a, Stone et al. 2011). Jay (2009b, p. 153) defines taboo language as ‘offensive’ and ‘emotional’ and suggests that it is used contextually for different personal, interpersonal, cultural, societal and institutional reasons. Furthermore, there are many motivations to use taboo words including the expression of frustration, anger, surprise, insult, to wish harm, and as part of a larger picture of violence and sexual harassment. The harm thesis on offensive language argues that it is the context that is important rather than the language itself (Jay 2009b, Stone et al. 2011) and it is recognized that taboo words can also be used with humour and may, on occasions, be personally cathartic (McEnery & Xiao 2004).

Despite these arguments about the contextual use of offensive emotional language, verbal abuse targeting nurses remains a concern. Literature suggests that nurses are more concerned about abuse when it involves attack on their personhood (Luck et al. 2008). There are clear occupational health and safety issues that surround verbal abuse towards nurses and to support nurses experiencing this type of abuse in the best way, the nature, context and effects, both immediate and cumulative, of such abuse need to be understood.

The study

Aims

This paper reports on one aspect of the second stage of a multi-phased study that sought to develop and test a predictive instrument for physical violence against healthcare staff. In the context of this larger study, the aim of this phase of the study was to collect observational data on the nature of verbal abuse experienced by nurses during their everyday interactions with patients and their families or companions.

Design

Phase one of the study used a Delphi approach to refine several behavioural cues that could be used to predict physical
violence and has been reported elsewhere (Wilkes et al. 2010). To address the lack of observational data on violence experienced by nurses, the second phase of the study further validated the behavioural cues for violence by collecting detailed observational records on violence occurrences. The second phase of the study was conducted at inpatient and emergency departments in a large acute metropolitan teaching hospital on the outskirts of a major Australian city. To ensure privacy of patients and staff, observations were only undertaken in thoroughfares and waiting areas of the hospital. Records of observations were made in the settings being observed at the time of carrying out the observation. The primary aim of the observation was to record the detail of behaviours that fell in the definition of violence and there was no attempt to record explanatory details.

The instrument used to collect the observational data included a check list of 17 behavioural cues for physical violence drawn from the first phase of the study (Luck et al. 2007, Wilkes et al. 2010), this checklist included space for recording additional qualitative information, including outcomes in relation to the observations. The narrative text collected during these observations constitutes the data for this paper. Observational records included the date, exact time the observation commenced and ceased, location/setting or situational context, actors in the setting, actions and reactions of actors such as behavioural acts and characteristics of the behaviour, observed dynamics or interactive patterns, gestures and non-verbal behaviour, language – tone and content and details on space and objects in the setting where relevant.

Data collection

The advantage of non-participant unstructured observation is that it enables researchers to gather data about usual and unusual events in the world (Gray 2009) and has value in capturing social action and interaction (Caldwell & Atwal 2005). The observer is detached from the events being observed, but is able to see actions and behaviours firsthand (Bucknell 2000, Polit & Beck 2012). The use of non-participant unstructured observation has the potential to record taken-for-granted or everyday occurrences, to reveal previously unknown characteristics of violence towards nurses by capturing events and interactions in the hospital setting.

The observations were overt and conducted in thoroughfares and waiting areas in several departments in the hospital including delivery unit, acute general wards, geriatric assessment ward, and the emergency department. Most observations were conducted in the emergency department; as early in the data collection process, it was found that this is where most physical violence and verbal abuse occurred. The observations were conducted in 2010 overall shifts, for 4 months in the later part of the year. Each episode of observations was 4–8 hours in length. All observers (n = 9) were experienced nurses and participated in training workshops prior to entering the field to ensure their familiarity and confidence in the use of the observation tool. The workshops provided opportunities to test their accuracy and consistency in using the tool and recording observations. Observers were provided ongoing support and access to counselling services at all times during the data collection period.

Given the nature of the observations, it was also not possible to observe the total occurrences of violence or draw conclusions about the proportion of incidents observed as observers may have missed some violence and abuse and some non-violent/abusive patient/nurse encounters. During the period of observation, a total of 1501 cues for potential physical violence were observed from 220 patients. Additional notes were recorded by the nine observers on 210 occasions providing a total of 1150 hours of observation, which detailed the nature of violence occurrences; 918 hours of these observations were conducted in the emergency department.

Ethical considerations

This research was approved by university and hospital human ethics committees. Due to the sensitive nature of undertaking observations in a hospital setting, precautions to protect the privacy of patients and staff were put in place. Observers were placed in thoroughfares and waiting areas of the hospital, rather than more private treatment spaces, such as individual cubicles. In this way, observers did not intrude on the therapeutic encounter between patients and health professionals. Because of this and the undertaking that we would collect no identifying data on patients or staff themselves, the institutional ethics committee deemed that individual consent was not necessary (National Health & Medical Research Council 2007).

Respect for the personal privacy of health professional staff and patients remained a priority throughout the project. Notices were displayed in the departments where the observers were located, detailing their role and the nature of data collected. Additional verbal information was provided to anyone who inquired. As there was an opportunity of vicarious trauma (Kadambi & Ennis 2004) on the observers, special attention was made to provide telephone
contact with the team and debriefing or counselling was made available. There were two occasions early in the data collection where debriefing was necessary, but no observer required further counselling.

Data analysis

Qualitative content analysis is widely used in exploratory and descriptive studies. It is a method of analysing written, verbal, or visual data to condense a description of the phenomenon under study by deriving concepts or categories (Elo & Kyngäs 2008). In this study, content analysis was used inductively to develop a condensed description of violence observations (Graneheim & Lundman 2004, Elo & Kyngäs 2008). The unit of analysis for content analysis can be words, sentences, or paragraphs that are related to each other because of their content or context. Data are coded and categorized (Graneheim & Lundman 2004, Elo & Kyngäs 2008) and a conceptual system or a model developed. In this study, text from the observational tool was transcribed and initially analysed for words and phrases denoting verbal abuse and abuse such as threats, raised voice, swearing, and humiliating or degrading language.

Rigour

An audit trail was established from the conception of the project (Borbasi et al. 2008). Data analysis was initially undertaken by two members of the research team. Following this initial analysis, emergent categories were cross-checked by other team members for rigour including audibility and confirmability (Graneheim & Lundman 2004).

Results

Analysis of data revealed a variety of forms of abuse occurring in the everyday interactions among nurses, patients and persons accompanying patients. Sustained in the backdrop of care delivery were indirect and non-verbal threatening behaviours and verbal insults, attacks on competence, threats, and physical assault. This created, on occasions, a milieu of hostility where nurse–patient interactions were enacted. We have conceptualized this as a mosaic of verbal abuse.

A mosaic of verbal abuse

The montage of interconnecting acts of verbal abuse formed an interconnected mosaic of abuse described through three major categories. These were as follows: discourse of gendered verbal abuse that is largely sexual; ridicule and unreasonable demands; and hostility, threats, and menacing language. These categories formed the basis for the in-depth interpretation and description of the nature of nurses’ experiences of verbal violence and abuse in their everyday working lives. Each of these categories of abuse is explored in more detail in the following section.

**Discourse of gendered verbal abuse that is largely sexual**

Central to the mosaic of abuse experienced by nurses in their routine work interactions was heavily gendered verbal insult and threat of harm. This form of verbal abuse was not simply a raised voice or terse words. Instead, language was used in a way, which conveyed a discourse that was imbued with gendered insults and demeaning statements about nurses and their character as women. At this point, it should be noted that many of the threats observed to be made against nurses contained a gendered overtone – most commonly directs at nurses as women.

Patients and less commonly their family and friends were observed to make sexualized insults, judgements, threats, or suggestions that targeted nurses through sexualized demeaning language. The sexualized taunts and insults conveyed stereotypical gendered assumptions about nursing and nurses. The sexualized and strongly pejorative language included descriptions of nurses as ‘c*nts’, ‘bitches’, ‘whores’, and ‘sluts’. The insults were made in public spaces in front of others. By labelling their femininity as deviant, these insults explicitly debased the character of a particular nurse by drawing attention to their supposed sexual worth. The following interaction was observed to occur in a busy waiting room; the outburst was triggered when a nurse did not bring ice quickly enough when requested.

Patients Friend (said about the nurses): ‘All these f*cking lazy c*nts, we pay taxes for this! She’s a f*cking whore’ (directed at the individual nurse).

The gendered verbal attacks not only implied that nurses were debased or deviant by way of their sexuality, they also focused on denigrating their intelligence. Much of the gendered verbal violence contained language that was coloured by notions of gendered stupidity, which was used to malign the intelligence or capability of individuals. This type of insult included taunts such as ‘that’s the bitch one’ (one patient to another), ‘this nurse doesn’t know anything – silly cow’ (patient to nurse) and ‘this place is full of uneducated f*cking sluts. They should be ashamed’ (patient to nurse). These types of verbal attacks bracketed nurses under the stereotypes of battleaxe, uncaring, stupid, and shameful. Through these verbal gendered insults, nurses were simultaneously
demeaned by having their sexuality sullied and their intelligence questioned. The following verbal abuse contained gendered denigration of a nurse’s intelligence and was directed at the nurse while she prepared treatment for the patient. During the interaction, three police and a security guard were also in attendance:

Patient (said to nurse): ‘You’re f*cking useless’... You’re a f*cking nurse, how can you agree to take my liberty away. For f*cks sake. You bitch. Are you sure you know what you’re doing?... You f*cking stupid twat.’

By grounding the abuse on gender, attention was drawn to essential supposed female stupidity, ignoring the individual’s personal qualities or capabilities, they were cast as lesser, soiled, or stupid by way of their female gender. Framed in this way, nurses were depicted as warranting or encouraging of sexual advances and were open to sexualized commentary that publicly positioned them as deserving or inviting of sexual advances. This was reflected in the taunt from one patient: ‘Come up here baby, come up here’ and the comments made by a patient’s companion (in a group of three) who called out loudly about one nurse: ‘She’s hot... Sexy bitch, come home with me’.

Gendered verbal abuse was also employed by patients as a means to gain dominance or control over a situation. The types of verbal threat noted ranged from an incident where, frustrated about having to wait, a patient’s companion said to the patient ‘Go sort those bitches out!’ through to more menacing implied threats made directly to nurses by patients such as: ‘I will get you, you f*cking cunt sluts’ and another ‘I hope you’re scared bitch. I hope your quivering in your little nurse sneakers’.

This theme draws attention to the place of gendered and sexualized abuse directed at nurses from patients and their companions and the construction of gender in everyday and routine nurse–patient interactions. It is known that language can be used to inflict harm by attacking or questioning character, dignity, or integrity (Gabriel 1998). Among nurses, guilt and shame have been reported as one of the most common responses to patient aggression (Needham et al. 2005, Felblinger 2008). This category highlights the way gendered and sexualized verbal abuse can be directed towards nurses to erode their self-image and self-worth and threaten their personal safety.

Insults, ridicule, and unreasonable demands

Episodes of verbal abuse that did not include a gendered overtone were also observed to be day-to-day experiences for the nurses we observed. This form of abuse involved demeaning insults or comments, ridicule and sarcasm, and was often said loudly or in front of others to draw negative attention to those targeted. By publicly questioning skills and capabilities, this behaviour denigrated professional identity and competence. Ridicule through loud comments that called into question the competence of nurses and the care they provided were observed to be enacted through the comments ‘f*cking hopeless’ and ‘f*cking idiot’.

Demeaning insults included openly questioning whether ‘they (nurses) know how to do their jobs’ and debasing the character and competence of nurses was observed to occur through such accusations as: ‘You’re lying, you’re falsifying’, and ‘You are animals’, ‘You bastards... this is a joke’. Associated with these insults were attacks on services provided with remarks that they were ‘disgraceful’ and swearing and cursing that was directed at the actions of nurses through comments such as ‘bullshit’ and ‘for God’s sake get it right’. Patients and their visitors demanded nurses act more quickly, fetch the doctor ‘I need the bloody doctor’, or bring food when demanded ‘NOW’. Demands that followed gendered and sexualized attacks had an implied overtone of slovenliness: ‘Hurry up, there’s people waiting here, not only me, everybody else. F*cking hurry up’.

It was evident that nurses were regularly subjected to swearing, which can be considered to be part of the territory of many forms of nursing work (Luck et al. 2008). The perception or likelihood of harm may be influenced by the combination or frequency of demeaning insults, swearing, ridicule and unreasonable demands. Demands may take on a more menacing overtone when delivered in combination with insults and threats and repeated over time.

Hostility, threats, and menacing language

Forms of non-verbal hostility and verbal threat featured throughout the observed interactions. Non-verbal hostility included damaging property such as the patient in a waiting area who picked up a magazine and tore it up before returning it, with another observed to state ‘I’ll knock that wheelchair off’. Other forms of non-verbal hostility expressed by patients and their companions included behaviours such as ‘crossing their arms’, ‘glaring’ at staff’, ‘throwing their arms up in the air’, ‘pacing’ and ‘rolling and shaking their head around’ while talking to staff. In one instance in a waiting room, it was observed that a patient and their companion ‘moved to sit directly in front of the nurses’ station – both sitting forward and staring intensely at the nursing staff’.

By sustaining the hostile dynamic, these behaviours served to provide further opportunities for an escalation or continuation of the violence. Threats of complaint or legal action followed several incidents of verbal abuse and demand. In one
incident, a family member complained: ‘Your hospital is going to be all over the media’ while she filmed staff on her camera phone. Threats of harm were observed to be directed occasionally at other treating staff (ambulance officer and doctor), but were most commonly aimed at nurses, either as a group or individually. The threats included several different types of violence: killing, shooting, blowing up, punching, and stabbing with a needle. In some instances, threats came from patients’ companions, who were individuals, families or larger groups. In one recorded incident, a group of ten hostile visitors were observed to be swearing and making loud threatening statements. Direct threats and physical violence were most often directed at nursing staff and were observed to occur almost entirely during the delivery of care interventions. Threats ranged from generalized statements such as: ‘Don’t touch me. I’ll get you’ ‘I’ll punch you’ and ‘I’ll do my block here in a minute’ to more specific threats to individuals: Patient to nurse: ‘When I get out of here I’m going to come back and kill you all, or if I see you in the street...’ And another, Patient to nurse: ‘I hate you all... I’ll kill you, I’ll shoot you all... I’ll get you’.

**Discussion**

The broad categories identified in this study resonate with previous research on aggression and violence in the nursing context (Chappell & Di Martino 2000, Ferns & Meerabeau 2007). What is original in our study is the insight provided into the potential magnitude, density, scope, and complexity of the mosaic of verbal abuse evidenced in nurse-patient interactions. The observational data provides insight into the gendered and sexualized nature of verbal aggression and threat of harm experienced by nurses; the cumulative nature of the violence experienced; and the potential for individual acts to be magnified by their co-occurrence with other acts over time. The findings suggest that narrow interpretations of violence are inadequate to understand the complex nature of abuse directed towards nurses and the context where it occurs.

In many contexts, nursing is still considered as woman’s work (Bilgin & Buzlu 2006). Founded on notions of female subservience, the masculinized discourse of gendered violence enacted by patients, their families, and companions observed in this study reflect a power dynamic that served to disempower nurses through sexualized connotations that legitimate violence. It is now more than a decade since studies confirmed that women in several occupations are more at risk of violence than their male counterparts and women are more at risk of sexual violence in the workplace (Fisher & Gunnison 2001, Leiter et al. 2001).

Few studies of violence in the nursing context explicate the gendered nature of aggressive language or threat perpetrated. Although the place of gender in shaping organizational relationships, power dynamics and oppressive behaviours that enable ‘insider’ perpetrated violence has been explored (Roberts 2000, Speedy 2004, Strauss 2008), the gendered and sexualized nature of physical, emotional, and verbal violence and abuse directed towards nurses by those not employed in the organization has been largely overlooked (Lawoko et al. 2004, Rowe & Sherlock 2005, Roche 2010). In the nursing context, sexual harassment has been largely considered a separate issue to violence and aggression and studies of sexual harassment do not always include an examination of patients as perpetrators (Finnis et al. 1993, Leiter et al. 2001, Valent & Bullough 2004, Celik et al. 2007). Furthermore, narrow definitions of sexual violence have been adopted, with only physical acts included in the category of sexual violence in some studies (Oliveira & Flava 2008). Investigations that have examined sexual harassment towards nurses have repeatedly identified patients as the most common source of this form of violence, with more than 50% of nurses sampled reporting sexual harassment from patients (Hibino et al. 2006, 2009, Cogin & Fish 2009).

Examining the effect of workplace discrimination on justice perceptions, well-being, and job satisfaction for mental health workers (Wood et al. 2012) reported that discrimination from patients had negative effects on anxiety and job satisfaction and eroded enthusiasm and engagement. Little research has specifically examined how gendered and sexualized verbal abuse has an impact on the well-being of nurses and no studies have examined the interaction between gender and this type of abuse in terms of outcomes, particularly when it is accompanied by physical violence or threat of violence. In this study, the pattern of gendered sexualized demeaning insults and verbal threats that preceded or surrounded other verbal or physical forms of violence provides further insight into the under-reporting of nurse violence. It is known that sexual harassment and unwanted sexual attention is still accepted by many women as a fact of life. Among nurses, the tendency to under-acknowledge sexual harassment has been reported (Madison & Minichiello 2000, Hibino et al. 2006). It has been assumed that under-reporting of violence among nurses stems from assumptions that violence is simply part of the job, taken for granted and accepted (Jackson et al. 2002) or reflective of a fear of reporting (Hegney et al. 2003). Under-reporting may also be related to the emotional distress associated with violence, or reflective of cumulative patterns of exposure that
What is already known about this topic

- Survey studies of violence against nurses have shown that verbal abuse occurs most frequently and is often a precursor to the escalation of violence.
- Existing evidence on the prevalence and nature of workplace abuse towards nurses is most often based on self-reports; there are very limited observational studies.

What this paper adds

- The paper highlights the place of verbal abuse in the construction of gender in nurse–patient interactions.
- Attention is drawn to the complex nature of verbal abuse experienced by nurses in their routine work.
- The paper illustrates how verbal abuse, particularly sexualized offensive abuse, can be used as a coercive device to pressure nurses.

Implications for practice and policy

- Current prohibitive and zero tolerance approaches may be insufficient to address gendered and sexualized verbal abuse.
- Human resource managers and nurse managers should ensure intervention strategies aimed at health personnel, consumers, and the wider community to specifically address sexualized and gendered verbal abuse are designed.
- Future longitudinal research could usefully explore how gendered and sexualized abuse interacts with gender in terms of outcomes for nurses and non-abusive patients.

make it difficult to discern discrete acts. Given the prevalence of intimate partner violence reported among nurses (Oliveira & Flava 2008) and the shame and fear associated with sexualized violence when it occurs in the workplace, victims may remain silent as the violence is integrally associated with the forms of violence they have experienced in their private lives.

Findings of this study highlight the need to develop innovative ways of dealing with verbal abuse directed at healthcare personnel. Strategies should be multi-layered and target both the need to reduce levels of verbal abuse and also reduce the risk of trauma or distress to personnel arising from exposure to verbal abuse. The nature of the abuse reported suggests that strategies to address bystander non-intervention or tolerance of gendered and sexualized abuse are important, particularly in light of the finding that these behaviours can be employed coercively by patients to gain advantage. Human resource managers and nurse managers should review the utility of zero tolerance approaches to managing violence and abuse and establish whether these types of policies fail to provide adequate protection, as they commonly rely on reports of abuse, which may be less likely to occur in the context of humiliating sexualized or gendered abuse.

The clear articulation of standards and the development of training in bystander intervention strategies may be of particular importance in addressing inaction that arises through taboo or tolerance reactions in the face of offensive gendered and sexualized verbal abuse. Given the previously reported levels of under-reporting of verbal abuse by nurses (Jackson et al. 2002), bystander intervention programmes are one strategy to reduce the tolerance of gendered abuse through openly addressing workgroup norms that tacitly condone such abuse. Furthermore, the effects of such abuse of non-abusive patients and their family members’ require exploration. In this study, observations were undertaken in public areas of the health facility and so other patients awaiting attention were witness to the abuse. Questions about how witnessing such abuse affects the view of others of hospitals as sanctuaries of health care and healing are raised.

Limitations

The major strength of this study was that it used observational data. Most studies contributing to the literature of workplace violence in the health environment are based on self-report only and often restricted to a yes/no response meaning that the nature of the workplace abuse is not fully elucidated. Furthermore, our choice of method meant that we were able to capture the abuse encountered by nurses in their everyday working lives. Nevertheless, there are several limitations to this study. One is associated with observation as method. Due to the observational nature of the data, it was not possible to record all incidents occurring during the observation period in their full detail and some events may have been missed. Furthermore, observation is a human activity and so the subjective nature of the data must be acknowledged. In addition and for ethical reasons, no patient data could be collected and information associated with their reasons for being in hospital, which may have been contributing factors for their violence, is not recorded. Similarly, data were not collected in private spaces and it is not possible to identify whether the violence continued in this context.
Conclusion

The findings of this study have implications for the development of intervention programmes and policy frameworks that address violence in the health sector. In particular, we recommend that nurse managers ensure that the nature and implications of sexual harassment and gendered abuse from care recipients, their family and companions, are addressed in intervention programmes. The findings of this study also confirm the utility of observational methods for understanding the nature of the nursing work environment. Further detailed studies using a similar approach are suggested for the systematic examination of the escalation dynamic in verbal abuse and the place of gendered and sexualized abuse in this dynamic. Further research might also usefully explore whether gendered and sexualized abuse directed towards nurses is employed as a form of provocation or to escalate pressure or coercion on nurses. Clearly, there is a need to recognize the effects, both initial and cumulative of verbal abuse in the health sector and to provide adequate infrastructure and support for those experiencing and witnessing such abuse. This study reports data from a snapshot in time and longitudinal studies that looked at the prevalence and effects of such abuse over time would be particularly helpful.

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Conflict of interest

No conflict of interest has been declared by the authors.

Author contributions

All authors meet at least one of the following criteria (recommended by the ICMJE: http://www.icmje.org/ethical_1author.html) and have agreed on the final version:

- substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content.

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