Responses to workplace verbal abuse: The influence of the gender and role of the perpetrator, the situation, and recipient assertiveness.

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ABSTRACT

The present study investigated the extent to which responses to verbal abuse scenarios varied as a function of the role and gender of the perpetrator, the situation in which the verbal abuse occurred and the participant’s level of assertiveness. Participants were 70 female registered nurses. Data were analysed using a series of repeated measures ANOVAs. Support for the hypotheses was mixed as there was some evidence of variation in cognitive, affective and behavioural attitudes toward the verbal abuse described, attributed to the independent variables. The results of this study lend support to both social role theory and attribution theory in relation to their predictions about responses to workplace verbal abuse. This study also supports assertiveness training for nurses.

Keywords: workplace verbal abuse, gender, role, situation, assertiveness, nurses.

INTRODUCTION

Verbal abuse in organisations is a central feature in the conceptualisations of counter productive work behaviour, workplace incivility, aggressive interpersonal behaviour, overt bullying and workplace violence, phenomena that have serious consequences for individuals and organisations (Arway, 2002; Barron, 2002; Fox & Spector, 2005). Nurses have been identified as a group who report frequent verbal abuse attacks from their colleagues. Verbal abuse has been identified as one of the strongest factors that contribute to dissatisfaction and high rates of attrition in nurses (Bush & Gilliland, 1995; Smith, 1997; Sofield & Salmond, 2003; Vogt, Cox, Velthouse & Thames, 1983). Previous research in this area has been largely atheoretical and lacked empirical evidence (Cusack, 2000; Douglas & Martinko, 2000; Gill, Fisher & Bowie, 2002; Keashly, 1998).

The present study aimed to convert a theoretical analysis of verbal abuse in the workplace to a range of testable propositions by simulating verbal abuse in the form of scenarios and gauging participant’s likely responses to such events. Gender, role, and situational variables were
manipulated in the scenarios and the effect of individual differences in assertiveness among participants on responses to verbal abuse was also examined. The range of responses to the scenarios included how frequently participants had experienced behaviour similar to that described in the scenario, how acceptable they thought the behaviour was, what sort of emotional response they would be likely to have and their intended behavioural strategy for dealing with the behaviour.

Substantial literature has documented that doctors are a frequent source of verbal abuse attacks on nurses (Begany, 1995; Bruder, 2001; Buback, 2004; Cook, Green & Topp, 2001; Farrell, 1997; Lopez, 1993; Simms, 2000; Sofield & Salmond, 2003). Hospital culture is patriarchal with power invested in doctors derived from both expert and legitimate power ascribed by the organisation, as well as power drawn from gender inequality, reflecting the fact that the majority of doctors are male and the majority of nurses are female (Pokalo, 1991; Woodward & House, 1997; Worchel et al., 2000). It is argued that verbal abuse is one strategy used by men as a method of asserting and maintaining dominance (Bruder, 2001).

Moreover, strong gender roles (Eagly, 1987) are reflected in hospital cultures. The ‘communal’ characteristics associated with the social role of women, such as concern for the welfare of others aligns with the nursing role, whilst the ‘agentic’ characteristics associated with the social role of men such as independence and assertiveness aligns with the medical role. Women’s increasing access to previously male-dominated roles, such as medicine could be seen as evidence that gender roles are converging and the power gradient between men and women is fading (Diekman & Eagly, 2000). However recent literature shows that very little has changed in the area of gender roles for doctors and nurses (Bruder, 2001; Cook et al., 2001; Dunn, 2003; Inglehart & Norris, 2003; Simms, 2000; Sofield & Salmond, 2003).

An analysis of this behaviour informed by issues of power, status and social roles support the expectation that verbal abuse is more likely to occur with doctors as perpetrators and nurses
as victims (known as vertical violence). However, it is important to note that the verbal abuse of nurses is not restricted to doctors alone. Hegney et al. (2003) also reports that apart from patients and doctors, other nurses are a frequent source of verbal abuse. The phenomenon is known as horizontal violence, a negative adaptation of oppressed group behaviour (Bowie, 2002; Duffy, 1995; Dunn, 2003; McCall, 1996; Roberts, 1997, 2000; Smith et al., 1996; Taylor, 2001).

The analysis of verbal abuse at the group level leads to further insight provided by Social Identity Theory (Tajfel, 1972a, cited in Hogg & Abrams, 1988) which argues that individuals construct and maintaining their identity through perceived membership (known as in-groups) and resultant non-membership (known as out-groups) of groups. It could be suggested that vertical violence would be consistent with the negative qualities usually ascribed to out-group members, and although offensive, it would not be an unexpected outcome. On the other hand, verbal abuse that targeted a member of one's own in-group (other nurses, or other women) would be considered more offensive, as in-group members have higher expectations of positive characteristics amongst members and may include beliefs that members should respect one another and demonstrate ‘solidarity’.

Several predictions were made in relation to nurses' responses to verbal abuse as a function of the gender of the actor. As the participants were all female, we predicted that if the actor of verbal abuse was the same gender, it would be considered less acceptable and more upsetting, but the participant would be more likely to report an intention to deal with it assertively as power and social role issues are less relevant.

**H1:** It was predicted that verbal abuse would be considered less acceptable when the actor was a female rather than a male.
**H2:** It was predicted that affective response to verbal abuse would be greater when the actor was another female rather than a male.
**H3:** It was predicted that the intended behavioural response would be more assertive towards a female than a male.
Similarly, we predicted that if the actor of verbal abuse was the same role as the participant it would be considered less acceptable and more upsetting, but the participant would be more likely to report an intention to deal with it assertively.

**H4:** It was predicted that verbal abuse would be considered less acceptable when the actor was a nurse rather than a doctor.

**H5:** It was predicted that affective response to verbal abuse would be greater when the actor was a nurse rather than a doctor.

**H6:** It was predicted that the intended behavioural response would be more assertive when the actor of verbal abuse was a nurse rather than a doctor.

Another important contribution to developing an understanding of responses to verbal abuse is offered by attribution theory (Heider, 1958) which suggests that people explain a particular behaviour a person exhibits as either caused by personal disposition (an internal attribution) or induced by the situation in which the behaviour occurs (external attribution). When external attribution are made during conflict situations, the actor is perceived as having less malevolent intent (Fiske & Taylor, 1984), and lower levels of arousal, such as anger, and retaliation are observed (Ferguson & Rule, 1983, cited in Baron, 1985). Emergency situations could be expected to induce an external attribution to be assigned to the actor of verbal abuse and influence the perceived acceptability of the behaviour, level of emotional reaction and likely behavioural response.

**H7:** It was predicted that verbal abuse would be considered less acceptable in a non-emergency situation than an emergency situation.

**H8:** It was predicted that affective arousal to verbal abuse would be greater in a non-emergency situation than an emergency situation.

**H9:** It was predicted that the intended behavioural response would be more assertive in a non-emergency situation than an emergency situation.

Finally, assertiveness training programs are seen as an effective means of enabling nurses to cope with verbal abuse (Numerof, 1978; McIntyre et al., 1984). In order to examine variation in participant’s responses to the verbal abuse that may occur as a function of their level of assertiveness, an additional set of predictions were made:

**H10:** It was predicted that verbal abuse would be considered less acceptable by assertive participants than non-assertive participants.

**H11:** It was predicted that affective arousal would be greater for non-assertive participants than assertive participants.
H12: It was predicted that the intended behavioural response would be more assertive for assertive participants than non-assertive participants.

METHOD

The participants for this study were a convenience sample of volunteers recruited from registered nurses working at a regional Australian private hospital. Two hundred questionnaires were distributed via Nurse Unit Managers. A total of 70 questionnaires were returned, which yielded a response rate of 35%. The sample consisted of female registered nurses aged 20 to 60 years, \( M = 38.87, SD = 10.67 \), with years of experience as a registered nurse being 0.5 to 43 years \( M = 16.91, SD = 11.01 \). Eight participants were excluded from the study due to incomplete data, reducing the sample size to 62.

The pen and paper questionnaire distributed to the participants included an information sheet outlining the voluntary and confidential nature of the study, demographic questions such as age, and length of time working as a nurse, a vignette questionnaire and an assertiveness inventory. The eight verbal abuse scenarios were adapted from vignettes used by Buback (2004), which depicted verbal abuse within a hospital operating theatre. The questionnaire asked the participants to assess each of the eight scenarios using ten, seven-point Likert scales. The first item assessed the frequency of experience or witness of the communication depicted in the scenarios. The second item assessed the respondent's view of acceptability of the communication. The following four items assessed the participant's emotional response to the communication. The final four items assessed the participant's intended behavioural response to the communication. Four behavioural intentions identified within the study could be positioned on a continuum from passive through to aggressive e.g. "ignore the verbal abuser"; "report the incident to your supervisor"; “tell the verbal abuser that the communication was not acceptable”; and "shout back at the verbal abuser". Participants rated how likely they would be to use each of these responses in relation to the behaviour described in the scenario.
In an endeavour to circumvent priming effects, the 30 item Rathus Assertiveness Schedule (RAS) was placed at the end of the questionnaire, on a separate sheet of paper, so that the scenarios would be answered first. It was anticipated that this sequencing would also reduce the incidence of participants guessing the hypotheses of the study and inadvertently affecting the results. The RAS has been shown to have moderate to high test-retest reliability \( (r = .78) \) and split-half reliability \( (r = .77) \). Criterion validity in terms of behavioural responses in specific situations was also satisfactory \( (r = .70) \) (Rathus, 1973). Although the RAS is more than 30 years old, recent psychometric tests have supported its continued use (Gustafson, 1992). Total scale scores can range from -90 to +90. Scores were converted to a dichotomous variable (assertive/non-assertive) to allow for inclusion as a grouping (between subjects factor) variable in the ANOVAS.

RESULTS

A series of seven repeated measures ANOVAS were performed in order to test the hypotheses. There were three within subjects independent variables (role - doctor or nurse, gender - male or female, and situation - emergency or non-emergency) and one between subjects independent variable (assertive or non-assertive) specified in each ANOVA. Dependent variables were the participant’s responses to the scenarios: frequency of similar episodes, acceptability of the episode, affective response to the episode and the likelihood of a range of behavioural responses. For the present analysis, results are restricted to main effects only.

Table 1 shows that verbal abuse was reported to be more frequently exhibited by males \( (M = 2.73, SE = .13) \) than females \( (M = 2.50, SE = .12) \), by doctors \( (M = 2.88, SE = .14) \) than nurses \( (M = 2.88, SE = .14) \) and in non-emergency situations \( (M = 2.8, SE = .13) \) than in emergency situations \( (M = 2.44, SE = .14) \). Non-assertive participants \( (M = 2.98, SE = .17) \) reported more frequent experience of similar verbal abuse scenarios than assertive
participants ($M = 2.25, SE = .12$). Table 2 shows that verbal abuse in non-emergency situations ($M = 1.50, SE = .09$) was considered to be less acceptable than in emergency situations ($M = 2.66, SE = .21$). Table 3 shows that male verbal abusers ($M = 16.86, SE = .67$) elicited a higher level of affective response than female verbal abusers ($M = 16.56, SE = .68$). Participants were more upset by verbal abuse that occurred in non-emergency situations ($M = 18.16, SE = .68$) than emergency situations ($M = 15.26, SE = .78$). Non-assertive participants ($M = 18.25, SE = .94$) demonstrated a higher level of affective response to the verbal abuse scenarios than assertive participants ($M = 15.17, SE = .97$).

Table 4 shows that doctors ($M = 3.76, SE = .22$) were more likely to be ignored after a verbal abuse episode than nurses ($M = 3.21, SE = .20$) and that participants were more likely to ignore the verbal abuse in a non-emergency situation ($M = 3.76, SE = .19$), than in an emergency situation ($M = 3.21, SE = .25$). Participants were more likely to tell a nurse ($M = 4.46, SE = .19$), than a doctor ($M = 3.85, SE = .17$), that the verbal communication was not acceptable. Participants were more likely to tell the abuser that the verbal communication was not acceptable in a non-emergency situation ($M = 4.58, SE = .18$), rather than in an emergency situation ($M = 3.73, SE = .21$). Assertive participants ($M = 4.78, SE = .24$) were more likely to tell the abuser that the verbal communication was not acceptable, than non-assertive participants ($M = 3.53, SE = .23$). Participants were more likely to shout back at a nurse ($M = 2.21, SE = .15$), than a doctor ($M = 2.03, SE = .13$). Participants in a non-emergency situation were more likely to report the verbal abuse incident to their supervisor ($M = 5.28, SE = .19$), than when the incident occurred in an emergency situation ($M = 4.28, SE = .25$).

**DISCUSSION**

Although no specific hypotheses were made regarding the prevalence of verbal abuse in hospital settings, an exploratory aim of the study was to examine how frequently scenarios similar to those described in the questionnaire had been observed or experienced by practising
nurses. The results suggested that when frequencies across all scenarios were collapsed, approximately 52% rated verbal abuse as moderately or very frequent. Examination of the results for each of the independent variables, revealed that participants reported doctors to be a more frequent source of verbal abuse than other nurses which is generally consistent with the literature (Begany, 1995; Bruder, 2001; Buback, 2004; Cook et al., 2001). Unlike previous work, this study also investigated the gender of the perpetrators of verbal abuse and the situation in which the verbal abuse occurred. Males were more likely to have been reported as a source of verbal abuse than females. These results support a feminist analysis of verbal abuse, implicating power inequality as the source of the behaviour (Bruder, 2001). Assertive participants were less likely to report having experienced or witnessed similar episodes of verbal abuse, suggesting assertive nurses may be less likely to be abused. The results also indicated that verbal abuse enacted by doctors or nurses of either gender, was more frequent during non-emergency situations than emergency situations. It could be argued that this result is contrary to what might be expected, in that stress is cited as a common reason for the occurrence of verbal abuse.

The first three hypotheses related to the manipulation of gender in the scenarios. Specifically it was hypothesised that verbal abuse would be considered less acceptable and more upsetting when it was enacted by a member of the same sex (female) than the opposite sex (male). This was expected as it was theorised that aggressive communication is less aligned with a female social role, and that as members of an in-group (according to social identity theory), females should be affiliated with one another and are expected to possess more positive qualities than out-group members (males) (Worchel et al., 2000). The results did not support these hypotheses (1&2). Instead, these results indicated that nurses found verbal abuse from either gender to be equally unacceptable, and contrary to expectation, male verbal abusers elicited a higher level of affective response in the participants than female verbal abusers. Perhaps the perception that men misuse their higher status and power related to gender may lead to higher affective arousal, especially anger. Based on social role theory and gender-power inequality,
it was also predicted that participant’s behavioural intentions towards the scenario would be less assertive or aggressive towards a male than a female. Support for this hypothesis (3) was not found for any of the behavioural intentions.

The next group of hypotheses related to the manipulation of professional role in the scenarios. Using the same theoretical rationale outlined above, it was expected that it would be less acceptable and more upsetting to be verbally abused by another nurse than by a doctor. Again, these hypotheses (4&5) were not supported as participants (nurses) found verbal abuse equally unacceptable and upsetting regardless of whether it was enacted by a doctor or a nurse. Some evidence supporting Hypothesis 6 was found in relation to the intended behavioural response; “ignore the verbal abuser”. Participants’ reported being more likely to use this response in scenarios were verbal abuse was enacted by a doctor than a nurse. As the intended behaviour "ignore the verbal abuser" was considered to be a passive behaviour, this behaviour could be seen to support the expectation that assertive behaviour is less likely to be used when a status difference (based on role) exists. Further support for hypothesis 6 was found in relation to participants’ intentions to "tell the verbal abuser that the way he/she spoke was not acceptable” or "shout back at the verbal abuser". These assertive and aggressive behavioural responses (respectively) were more likely to be employed when the perpetrator was a nurse, rather than a doctor. Again, this finding could be related to the social rules that people consider are appropriate behaviour when responding to someone of higher status, such as a doctor (Wilson, et al., 2001).

The next set of hypotheses were based on attribution theory, predicting that emergency situations would provide an ‘external reason’ for verbal abuse to be more acceptable, less upsetting and less amenable to assertive intervention. These hypotheses were generally supported by the results of this study. Nurses were rated verbal abuse as more acceptable and elicited lower levels of emotional arousal when it occurred during an emergency, rather than a non-emergency situation (hypotheses 7&8). Thus, as described by Heider's (1958) Attribution
In relation to behavioural intentions, participants were more likely to “ignore the verbal abuse” (considered a passive response) in a non-emergency situation, than in an emergency situation. This result did not support hypothesis 9 and appears counter intuitive, considering other results had indicated that participants may be making external attributions about verbal abuse in an emergency situation, and would thus be more likely to ignore the verbal abuse. However, partial for hypothesis 9 was found, as participants were more likely to "tell the verbal abuser that the way he/she spoke was not acceptable" (an assertive response), in a non-emergency situation than an emergency situation. Further support comes from the finding that participants were less likely to "report the incident to their supervisor" (considered a non-assertive response) in an emergency situation than a non-emergency situation. This result also suggests an external attribution may be operating.

The final set of hypotheses related to the role of the assertiveness of participants as simulated ‘recipients’ of verbal abuse in determining their responses to the scenarios. It was predicted that assertive participants would consider verbal abuse as less acceptable than non-assertive respondents. However, hypothesis 10 was not supported as non-assertive participants did not find verbal abuse communication any more acceptable than their assertive peers. It was also predicted that assertive respondents would report less affective arousal to verbal abuse than non-assertive respondents, due to common coping strategies associated with assertiveness (e.g. see the behaviour as problem with the actor of the abuse and not let it affect their self-esteem). This hypothesis (11) was supported in that non-assertive nurses reported higher levels of emotional arousal than their assertive counterparts. As suggested by Sofield and Salmond (2003), states of high emotional arousal, which in this study included being
bothered, upset, depressed, or angry, can lead to increased stress and a reduced capacity to cope (Antari-Otong, 2001).

Assertive participants were more likely to respond to the verbal abuse scenarios with the assertive response “tell the verbal abuser that his/her behaviour was not acceptable” than non-assertive respondents. Thus, assertive participants would be more able to employ assertive behaviours, such as expressing their feelings, and expressing their rights (Alberti & Emmons, 1982), which would aid them in confrontational situations. The results lend further justification to previous researchers’ arguments that assertiveness training can assist nurses to cope with the stress of verbal abuse attacks (Cook, et al., 2001; McIntyre et al., 1984; Mimura & Griffiths, 2003). However, it should be noted that this approach has been criticized as promoting employee tolerance of unacceptable work conditions (De Frank & Cooper, 1987) and a primary prevention approach targeting the organisational culture, although challenging, should be used in conjunction with secondary approaches such as assertiveness training.

The present study provided an initial empirical test of a set of theoretically derived hypotheses related to perceptions of workplace verbal abuse. However, there are limitations of the study that should be addressed in future research. A large number of statistical tests were performed on a small convenience sample. Future studies should aim to obtain larger samples from multiple hospitals. In addition, male participants could be added to the design if the sample size were larger. Issues of common method variance, social desirability and the effectiveness of the quasi-experimental manipulations were not addressed in the present study. Hence, future research should employ a more sophisticated design in order to improve the methodology.
CONCLUSION

The present research found some evidence that nurses cognitive, affective and behavioural attitudes towards verbal abuse scenarios varied as a function of the gender and role of the actor and the situation in which it occurred. Attribution theory provided a strong rationale for predicting responses to verbal abuse. Verbal abuse has been identified as one of the strongest factors that contribute to dissatisfaction within nursing and the high nurse attrition rates. Hospital administrators must recognise the emotional impact of such behaviour and implement strategies to prevent and manage it.
REFERENCES


### TABLE 1: Significant main effects

<table>
<thead>
<tr>
<th>Frequency of verbal abuse</th>
<th>$F (1, 60)$</th>
<th>$p &lt;$</th>
<th>$\eta^2$</th>
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<tr>
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<td>Gender</td>
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</tr>
<tr>
<td>Situation</td>
<td>8.2</td>
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<td>0.12</td>
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<tr>
<td>Assertiveness</td>
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<td>.01</td>
<td>0.13</td>
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<tr>
<td>Acceptability of verbal abuse</td>
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<td></td>
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<tr>
<td>Situation</td>
<td>34.9</td>
<td>.001</td>
<td>0.37</td>
</tr>
<tr>
<td>Affective response to verbal abuse</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Gender</td>
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<td>Behavioural intention – ignore the behaviour</td>
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<td></td>
</tr>
<tr>
<td>Role</td>
<td>8.9</td>
<td>.01</td>
<td>0.13</td>
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