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An Analysis of Verbal Abuse Directed at Certified Registered Nurse Anesthetists

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AN ANALYSIS OF VERBAL ABUSE DIRECTED AT CERTIFIED REGISTERED NURSE ANESTHETISTS

by

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This thesis, submitted by Kevin C. Buettner in partial fulfillment of the requirements for the Degree of Master of Science from the University of North Dakota, has been read by the Faculty Advisory Committee under whom the work has been done and is hereby approved.

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This thesis meets the standards for appearance, conforms to the style and format requirements of the Graduate School of the University of North Dakota, and is hereby approved.

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Signature Kim C Sutton

Date 4/18/2006

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To those affected by verbal abuse-
My greatest wish is that your resolve and wherewithal will sustain you and allow you to persevere.

ABSTRACT

The concept of a healthy workplace environment is one that does not tolerate verbal abusiveness. Recent literature indicates that verbally abusive behavior may cause increased levels of stress, increased probability of errors, and feelings of frustration and powerlessness. Roy's Adaptation Model was used as the conceptual framework. There is a lack of research looking at incidence, frequency, and the impact of verbal abuse with respect to the CRNA (Certified Registered Nurse Anesthetist) population. One hundred seventy eight CRNA's from an upper Midwestern state in the United States that were mailed questionnaires, 115 were returned and statistically analyzed for this study. The analysis of the data included frequency distributions and Chi-Square test for independence. Eighty-seven (76%) CRNA's reported experiencing some form of verbal abuse in the past six months of their practice and 67 (77%) respondents reported the physician was the most common perpetrator. Over half of the CRNA's who indicated an experience of verbal abuse in the past six months did not officially report any episodes. There was no significant correlation between demographic variables and the reporting of verbal abuse. The study concludes with recommendations for nursing practice, education, and further research.

CHAPTER I

INTRODUCTION

Verbal abuse and it's presence in the healthcare workplace environment has been the focus of nursing research for over two decades. Many of these authors, using different theories and definitions, examined verbal abuse and the impact that it has on nurses and the nursing profession (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Cox, 1987; Manderino & Berkey, 1997; Sofield & Salmond, 2003).

The most common form of violence experienced in the nursing profession is verbal abuse (Cameron, 1998). Where a physical attack may leave a visible mark on a victim, verbal abuse strikes deeper within the victim and may have devastating emotional consequences (Elgin, 1980). In an attempt to make this applicable to the nursing profession, Cox (1991) noted that verbal abuse is, "any communication a nurse perceives to be a harsh, condemnatory attack upon herself or himself, professionally or personally" (p.32). Verbal abuse can take the form of swearing, yelling, belittling, or other verbal insults.

Studies looking at workplace violence and verbal abuse have been done in many parts of the United States as well as across the world. There has been recent research on verbal abuse and its effect on the pediatric nurse population (Pejic, 2005). In addition, there have been studies looking at the perioperative nurse population (Cook, Green, & Topp, 2001; Smailes, 2003).

their level of satisfaction which may serve to benefit the institution. Finally, the healthcare organization could benefit through retention of a skilled population of CRNA's, which will save the institution valuable recruiting and training dollars.

Purpose of the Study

The purpose of this research was to gain a better understanding of verbal abuse and to determine its presence in the perioperative environment. The aim of the research was to explore the prevalence, frequency, sources, and impact of verbal abuse that is directed at CRNA's.

Theoretical Framework

The theoretical framework for this research study was the Roy Adaptation Model (1984). This model is based both on systems theory and adaptation-level theory. The focus of this model is the central concept of man's adaptation to the environment. Roy's concepts of person, environment, health, and nursing are all related not only to each other, but also to the central concept.

According to Roy and Andrews, humans are "holistic adaptive systems functioning as wholes in one unified expression of meaningful behavior" (1999, p.35). Roy defines adaptation as "the process and outcome whereby thinking and feeling persons, as individuals or in groups, use conscious awareness and choice to create human and environmental integration" (Roy & Andrews, 1999, p. 30). The person is the adaptive system that responds to an internal or external stimuli in the environment (Roy, 1984). For the purpose of this study, the stimuli is verbal abuse and the environment is the perioperative environment.

stimuli are all other environmentally related factors present to the human system, either external or internal but not the center of attention or energy. These factors can affect how individuals deal with focal stimuli. To put this into context, these are the factors that may affect the response of the nurse anesthetist when they are verbally abused. Such factors may include the stress of a complex surgical case or a recent negative performance evaluation by an employer. These factors will have diminished the CRNA's ability to cope with, or even attend to the incident of verbal abuse on a given day.

Residual stimuli are defined as, "environmental factors within or without human systems, the effects of which are unclear in the current situation" (Roy & Andrews, 1999, p. 39). The individual may not have an awareness of these factors and how they influence their ability to cope with a particular situation. A CRNA's past experience of verbal abuse in a previous position or having a relationship with an individual who recently has become verbally aggressive are examples of these factors. These experiences affect the anesthetist's response to, and ability to cope with the incident of verbal abuse.

It is important to note that the human system and environment do indeed constantly interact with each other. The nurse's behavior and the ability to respond to these stimuli are a function of the nurses' adaptation level. This level is determined through the combined effect of the focal, contextual, and residual stimuli. The level represents a standard against which feedback can be compared (Roy & Andrews, 1999).

Adaptation Levels

Roy and Andrews (1999) describe three adaptation levels: integrated; compensatory; and compromised life processes. Integrated life processes are the adaptation levels that "describe the structures and functions of the life process working as

The second major coping process is the cognator subsystem. This subsystem "responds through four cognitive-emotive channels: perceptual and information processing, learning, judgment, and emotion" (Roy & Andrews, 1999, p.31). Learning involves insight, imitation, and reinforcement. In contrast, the judgment process involves problem solving and decision making. Affective appraisal and attachments are made through a person's emotions. Defense mechanisms are also developed through the person's emotions to reduce the effects of anxiety.

Both the regulator and cognator subsystems have internal and external stimuli that act as inputs. These factors include: psychological, social, physical, and physiologic. The information is then sent through the four cognitive-emotive channels and the end result is that responses are produced. Directly measuring the functionality of these subsystems is not possible. What is observed as behavior in others is the result of the processing of input through the subsystem.

Control processes are important not only for the functioning of individuals, but to functioning of human social systems. In these social systems or groups, the control mechanisms are categorized as the stabilizer and the innovator subsystems. These coincide with the regulator and cognator subsystems that are seen with individuals. The stabilizer subsystem involves "the established structures, values, and daily activities whereby participants accomplish the primary purpose of the group and contribute to common purposes of society" (Roy & Andrews, 1999, p. 47).

The innovator subsystem involves "the structures and processes for change and growth in human social systems" (Roy & Andrews, 1999, p. 48). The dynamic relationship between individual and group systems substantiate the holistic nature of

The role function mode for both the individual and group is "the category of behavior pertaining to roles in human systems" (Roy & Andrews, 1999, p. 49). This mode reflects the roles that the individual holds within society. The basic need for this mode is social integrity which is defined as, "the need to know who one is in relation to others so that one can act" (Roy & Andrews, 1999, p. 50). In group functioning, the basic need is role clarity which is the ability to "understand and commit to fulfill expected tasks so that the group can achieve common goals" (Roy & Andrews, 1999, p. 50). An individual can perform primary, secondary, and tertiary roles and can be carried out with instrumental and expressive behaviors.

The last mode as described by Roy is interdependence. The focus of this mode is the transactions of giving and receiving love, respect and value. The basic need is for relational integrity which is defined by Roy and Andrews as, "the feeling of security in nurturing relationships (1999, p.50) These different modes all are related to each other; a stimulus can have an affect on more than one mode as adaptation may take place in more than one mode.

Roy and Andrews (1999) defines the environment as "all conditions, circumstances, and influences that surround and affect the development and behavior of humans as adaptive systems, with particular consideration of person and earth resources" (p. 31). As the environment changes and evolves, humans have the opportunity to grow, develop, and become better equipped to adapt to it. Factors in the environment that can affect the person are categorized as focal, contextual, and residual stimuli (Marriner-Tomey & Alligood, 2002).

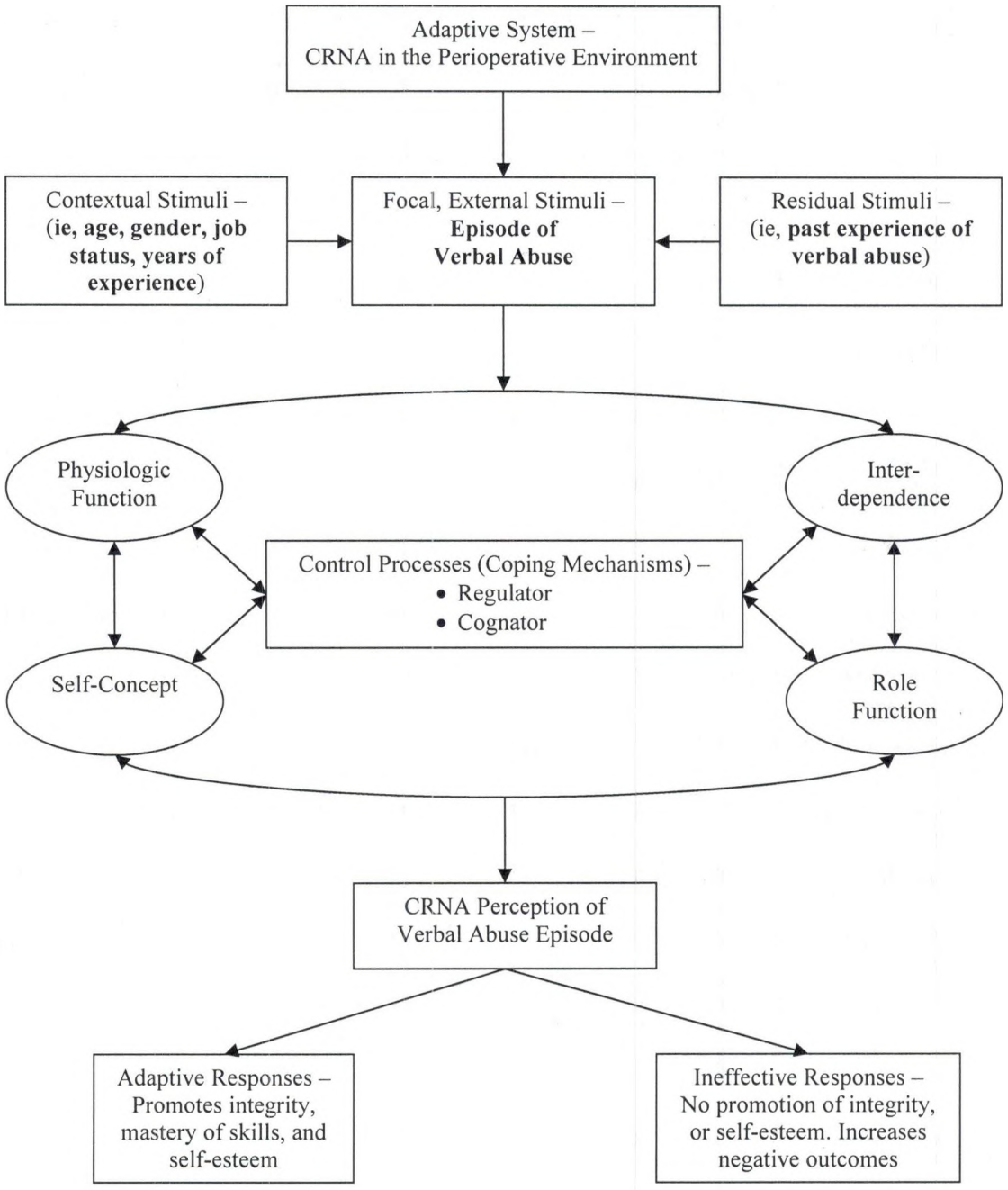

Figure 1. Model depicting relationship between episode of verbal abuse and Roy's Adaptation Model.[1] Bolded areas represent variables in this study; non-bolded areas represent concepts of Roy's Adaptation Model.

[1] From *The Roy Adaptation Model,* by C. Roy and H.A. Andrews, 1999, Stamford, CT: Appleton & Lange.

4) Do the demographic characteristics of experience, age, or gender alter the nurse anesthetist's experience of verbal abuse with respect to level of reporting of abuse?

Definitions

For the purpose of this study, the following terms were defined:

Certified Registered Nurse Anesthetist (CRNA): A licensed CRNA who provides care for patients in the perioperative environment. This term is used synonymously with nurse anesthetist.

Level of Reporting of Verbal Abuse: Refers to whether or not a formal employee incident report is completed and submitted after a verbal abuse incident.

Perioperative Environment: The surgical department that specifically includes the patient holding areas, operating rooms, nurses, surgeons, technology, patients, policies, and where surgical procedures and interventions are carried out on any given day.

Selected Demographics: Includes age, years of experience as a CRNA, employment status, and gender.

Sources of Verbal Abuse: Includes patients, family members, visitors, physicians, and other staff members. "Other staff members" include all other people employed by the organization. The term visitors includes significant others, siblings, extended family, and friends.

Verbal Abuse: Any dysfunctional verbal communication where the intent is to show a lack of either professional or personal respect. It may be described as those kinds of verbal behaviors that humiliate, degrade, or otherwise indicate a lack of respect for

to Anderson, "categories of workplace violence include emotional, verbal, physical, and sexual abuse" (2002, p. 352). Research studies for almost two decades have identified that verbal abuse is a problem within the nursing profession (Braun, Christle, Walker, & Tiwanak, 1991; Cox, 1987; Jackson, Clare, & Mannix, 2002; Manderino & Berkey, 1997; Sofield & Salmond, 2003). "Verbal abuse is a form of workplace violence that leaves no visible scars, however the emotional damage to the inner core of the victim's self can be devastating" (Sofield & Salmond, 2003, p. 274).

There are many definitions of verbal abuse in the literature. The lack of a consistent definition makes research in this area difficult. Cox (1987) defined verbal abuse as "any communication a nurse perceives to be a harsh, condemnatory attack on herself or himself, professionally or personally" (p. 32). Hadley defined verbal abuse as "those kinds of verbal behaviors that humiliate, degrade, or otherwise indicate a lack of respect for the dignity and worth of another individual" (1990, p. 6).

In a 1991 study of 500 registered nurses, Diaz and McMillin defined abusive behavior as "behavior of one person which, through words, tone, manner, or other nonverbal cues, uses the power of the dominant position inappropriately towards an actual or perceived subordinate" (p. 98). Cameron defined verbal abuse as "any communication that attacks a person professionally or personally; it may refer to behaviors such as yelling, verbal insults, or threats of harm" (1998, p. 34).

For the purposes of this study, the definition of verbal abuse by Manderino and Berkey (1997) in their study on verbal abuse of staff nurses by physicians has been utilized. This definition was originally formulated by Hadley (1990) and defines verbal abuse as "verbal behavior designed to humiliate, degrade, or otherwise demonstrate a

reported having seen disruptive behavior by other nurses. This finding certainly contrasts with previous research. Cox (1987) fails to mention "other nurses" as a source. Braun et al. (1991) reported "other nurses" as a common source in only 12% of their respondents. Sofield & Salmond (2003) identified "peers/other nurses" as the common source in 28% of their respondents. A study of 213 nurses conducted by Rowe & Sherlock (2005) found the most frequent source of verbal abuse against nurses were other nurses (27%). These findings show that nurses are increasingly becoming more common sources of verbal abuse.

Cook, Green, and Topp (2001) investigated verbal abuse that occurs specifically from the physician to the nurse. They studied 78 perioperative nurses and found that 91% reported experiencing some type of verbal abuse from a physician during the past year, while 45% reported experiencing verbal abuse several times a year. Emotional reactions to verbal abuse included feelings of frustration, anger, disgust, embarrassment, and powerlessness. Long-term negative effects of verbal abuse that were identified include job satisfaction, self-esteem, self-confidence, performance of job responsibilities, and relationship with the physician. According to Cook et al., abusive behavior is identified as "the most frequent and stressful type of abuse and the effects of this anger seem to alienate the nurse and the physician (2001, p. 327). Rosenstein's (2002) study of nurse-physician relationships reported that behaviors such as these may inhibit teamwork, and affect the outcomes of patient care.

Incidence of Verbal Abuse

Healthcare workers, particularly nurses, are considered to be a high-risk occupational group and are more likely to experience violence when compared to other

Reporting of Verbal Abuse

There were no statistics found in United States research relating to the level of verbal abuse experiences that are formally reported. In their study of hospitals in Canada, Duncan et al. (2001) found that one in five incidents of verbal abuse of nurses is formally reported. The lack of documentation and reporting of verbal abuse contributes to the confusion. According to Lanza and Campbell (1991), "Compared with physical assault that may result in reportable injuries, verbal abuse and threats are less likely to be documented" (p. 61).

Cameron (1998) found that one half of verbal abuse incidents were reported to a supervisor. In addition, when the abuse was reported, supervisors intervened approximately two-thirds of the time. Reasons cited for not reporting the incident included that the matter was not of great importance, the situation had been handled, or that the nurse believed that verbal abuse was just part of his/her job. Anderson (2001) cited the most common reasons for not reporting abuse included fear, shame, humiliation, and powerlessness. Rosenstein (2002) reported 78% of 561 nurses surveyed acknowledged the existence of a non-punitive reporting environment for nurses who witness or experience disruptive behavior in their workplace. Almost half (47.5%) of those nurses perceived barriers or the resistance to reporting of abuse. The most common barriers cited included fear of retribution, lack of confidentiality, lack or administrative support, and physician lack of awareness or unwillingness to change (Rosenstein, 2002).

Some researchers have hypothesized that the level of under-reporting may originate from oppressed behavior. The nurse will blame himself or herself instead of placing the blame on the abuser. This may lead the nurse to believe that verbal abuse is

workforce, staffing cutbacks, hospital restructuring, increased case loads, and lack of administrative concerns (Aiken et al., 2002).

Summary

The review of the literature has demonstrated that verbal abuse of nurses and hospital staff exists in the workplace environment. While physicians and patients are still commonly identified as the perpetrators of verbal abuse, the increasing trend of nurses identified as sources of verbal abuse cannot be ignored. The lack of reporting of incidents remains low and is influenced by concerns over fears of retribution, powerlessness, and lack of administrative support. Long term effects of verbal abuse include decreased job satisfaction and morale, increased staff turnover, and may lead to adverse patient outcomes. The review indicated that verbal abuse in the specific population of CRNA's has not been adequately studied. Thus, there was a need to conduct this research study. Chapter II summarizes the procedure for the collection and treatment of data.

questions on this tool were closed ended, with space available for respondents to fill in additional answers as they chose. The tool was used to address the research questions proposed in Chapter I. The study tool is found in Appendix A.

Data Collection Methods/Procedures

An application to the University of North Dakota Institutional Review Board (IRB) was submitted for approval to conduct the study. After the approval was received, surveys were mailed to all CRNA's in the state who met the inclusion criteria.

The packet that was mailed to the participants included a cover letter explaining the purpose of the study, human rights protection, contact information, a prepaid addressed envelope for the return of the questionnaire, and a copy of the questionnaire. Surveys were printed on white paper and were numerically coded to track the responders and non-responders. The projected response rate for this study was 35%, which was considered to be an appropriate response rate for statistical analysis. The projected time frame for data collection was four weeks from when the first survey was sent. Although the response rate threshold was met by the end of week two, a post-card reminder was sent to elicit as many responses as possible. Ultimately, the data collection process took approximately five weeks to complete. It was proposed that the questionnaire would take approximately 25 minutes to complete. The response rate exceeded the 35% threshold, reaching 66%.

Instrument Reliability and Validity

The survey instrument developed by the researcher is based on a tool developed by Manderino and Berkey (1994) titled "The Verbal Abuse Scale." The original instrument was a 65-item, self-report questionnaire that was comprised of eight subscales

(SPSS) to analyze the data. The descriptive statistics used for the first three research questions included frequencies. The Chi-Square test for independence and cross tabulations were used for the fourth research question to determine if any relationship existed in the collected data between the demographic variables and the level of reporting.

Protection of Human Subjects

Full approval was obtained from the University of North Dakota Institutional Review Board prior to the collection of any data. A letter containing information about implied consent and human rights protection of the participants was mailed in the packets. The participants were informed that their participation in the study was strictly voluntary and that their identity would remain anonymous. They were instructed to not write their name or sign their name anywhere on the paperwork that was to be submitted. A codebook was maintained to protect their identity. Contact data for the researcher and committee chair was provided for the participants should they have had any questions. Materials and data will be kept in a double lock system for a period of 3 years and then destroyed by shredding. These materials were only be viewed by the researcher, major advisor, and statistician.

Data Collection Procedures

The population used for this study was CRNA's who are licensed, residing, and working in North Dakota. A list of CRNA's for the state of was obtained from the North Dakota Association of Nurse Anesthetists (NDANA), and a cover letter, questionnaire, and self addressed stamped envelope were sent to each name on the list.

The initial mailing yielded 113 responses. Approximately two weeks after the initial mailing, a follow-up postcard was mailed to those who had not responded to the survey. This yielded four additional surveys. Out of 178 questionnaires mailed to CRNA's, 117 were returned which is a response rate of 66%. Two surveys were incomplete, and thus were not used in the study. Total time spent securing the sample was approximately five weeks.

Results

Demographic Data

The demographic data were obtained in questions one through four on the survey instrument and are represented in Tables 2 through 5. The first question asked participants to indicate the number of years they have worked as a CRNA. Table 2 shows the "less than 2 years" range had 10 respondents (9%), "2 to 5 year" range had 20 respondents (17%), "6 to 10 year" range had 11 respondents (10%), "11 to 15" year range had 28 respondents (24%), "16 to 20 year" range had eight respondents (7%). The majority of respondents had more than 21 years of experience, 38 (33%). (See Table 2).

Participants were asked in question two to indicate their job status. Table 3 shows the majority of respondents were employed on a full time basis, 105 (91%), with the remaining 10 (9%), employed on a part-time basis.

Table 5. Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Female	58	50.4	53.2	53.2
	Male	51	44.3	46.8	100.0
	Total	109	94.8	100.0	
Missing	System	6	5.2		
Total		115	100.0		

Research Question 1

The first research question asked: What is the prevalence of verbal abuse encountered by CRNA's? Participants were asked if in the past six months they had experienced any form of verbal abuse (questions 5 though 12). Of 115 respondents, only 28 (24%) indicated that they had not experienced any form of verbal abuse in the past six months. The other 87 respondents (76%) reported at least one episode of verbal abuse in the past six months. Table 6 shows the eight separate categories of verbal abuse that were identified for investigation in this study and the frequency and percentage of these categories of verbal abuse.

In the past six months, 56 respondents (49%) indicated that they experienced a person yelling at them or raising his/her voice in an angry fashion, with the most frequent number of episodes ranging from 1-5 times. Twenty-two (19%) reported that a person swore or directed obscene comments at them; however, 93 (81%) reported that they had not encountered this type of abuse. Forty-two (37%) reported they had encountered insulting comments with the most frequent number of episodes ranging from 1-5 times. A majority of the respondents, 113 (98%), indicated that they were not victims of direct threats of harm. Eighteen (16%) of respondents reported that someone made an indirect

an angry fashion; and 4) a person makes a humiliating or abusive comment disguised as a joke.

There was space provided for respondents to list any other forms of verbal abuse they had experienced. One respondent indicated that he/she had received verbal abuse from degrading emails, although a frequency was not indicated. Another respondent wrote, "makes false statements about my anesthesia in front of non-anesthesia people," although no perpetrator or frequency was indicated.

Research Question 2

The second research question asked: What are the sources of verbal abuse encountered by CRNA's? If the respondent had answered "never" to all questions in part II of the survey, then they did not proceed to part III, which includes questions 14 and 15. This applied to 28 of the 115 respondents (24%), which left 87 respondents (76%) to provide data for questions 14 and 15. Question 14 asked the respondent to identify all the perpetrators of verbal abuse that they have experienced in the past 6 months. Question 15 asked the respondent to then identify the most common source of these groups. The perpetrators were categorized as patient, patient's family, immediate supervisor, peer, physician, in unit subordinate, out of unit subordinate, or other staff member. Eight respondents filled in answers under the category for other staff member, and the researcher was able to place them under the categories listed above.

The results are outlined in Table 7 and show that CRNA's encounter verbal abuse from every category. Respondents reported the least frequent sources of verbal abuse are the patient's family (5%) and the CRNA's immediate supervisor (8%). Seventy respondents (61%) indicated the perpetrator was the physician. Twenty-four respondents

Table 8. Most Common Source of Verbal Abuse of CRNA's

Perpetrator	Frequency	Percent
Patient	4	4.6
Immediate Supervisor	2	2.3
Peer	7	8
Physician	67	77
In Unit Subordinate	3	3.5
Out of Unit Subordinate	4	4.6

This research question is operationalized in questions 16 to 19 in the questionnaire. Respondents were asked to indicate how many times they officially reported an episode of verbal abuse. They were then asked if they did not officially report the incident, did they talk with someone, and if so, with whom did they talk to. There was some ambiguity to questions 18 and 19, and some respondents filled in their own answers.

The surveys yielded 87 valid responses for the number of times a respondent officially reported an episode of verbal abuse. These results are analyzed in Table 9. The results indicated that 63 respondents (72%) had never reported an episode of verbal abuse. Twenty-one respondents (18%) indicated that they had reported between 1-5 times during the past six months. One participant (1%) indicated that they had reported between 6-10 times. One participant (1%) indicated that they had reported between 11-20 episodes of verbal abuse. One participant indicated that they had reported more than 20 episodes of verbal abuse in the past six months.

The questionnaires yielded 87 valid responses for the number of times a respondent decided not to officially report an episode of verbal abuse. These results are

Table 10. Number of Times CRNA Decided Not to Officially Report Episode of Verbal Abuse

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	39	33.9	44.8	44.8
	1 to 5 times	41	35.7	47.1	92.0
	6 to 10 times	1	.9	1.1	93.1
	11 to 20 times	3	2.6	3.4	96.6
	More than 20 times	3	2.6	3.4	100.0
	Total	87	75.7	100.0	
Missing	System	28	24.3		
Total		115	100.0		

supervisor about the incident. One respondent reported he had spoken with his wife. Another respondent reported that he had spoken with another supervisor.

Table 11. Talked with Other Employee

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Peer	17	14.8	47.2	47.2
	Supervisor	14	12.2	38.9	86.1
	Both	5	4.3	13.9	100.0
	Total	36	31.3	100.0	
Missing	System	79	68.7		
Total		115	100.0		

Research Question 4

Research question 4 asked: To what extent do selected demographics affect the reporting of verbal abuse? The demographics that were analyzed for this research question were years worked as a CRNA, age, and gender. In the past six months, 87 respondents (76%) indicated they had experienced some form of verbal abuse in the workplace whereas 28 respondents (24%) indicated no incidents of verbal abuse. Chi-square tests were performed on the demographic variables of years worked as a CRNA,

CHAPTER IV

DISCUSSION

Introduction

The purpose of this chapter is to summarize the findings of the research data by reviewing the purpose of the study and analyzing the literature review and then applying this information to the data set that was gathered in the study. This chapter will conclude with implications for practice, management, education, and recommendations for future research.

Findings

Research Question 1

What is the prevalence of verbal abuse encountered by CRNA's? This study found that of 115 CRNA's responses, 87 (76%) reported being exposed to some form of verbal abuse in the past six months of their practice. The findings of the present study compare closely with those of Cook, Green, and Topp (2001), Cox (1987), Manderino and Berkey (1997), and Sofield and Salmond (2003), which reported frequencies between 82% and 96% of nurses experience verbal abuse.

It would appear that the prevalence of verbal abuse is high regardless of the population studied or specialization. Although this study did show a slightly lower prevalence, the numbers are consistent with previous studies. The confounding question is why verbal abuse continues to be pervasive within healthcare. One explanation could be that the healthcare environment which is in a constant state of change and evolution.

source of verbal abuse (Cook, Green, & Topp, 2001; Cox, 1987; Espin & Lingard, 2001; Sofield & Salmond, 2003).

The literature suggests that there is an increasing trend of nurses being identified as common perpetrators of verbal abuse (Braun et al., 1991; Cox, 1987; Rosenstein & O'Daniel, 2005; Rowe & Sherlock, 2005; Sofield & Salmond, 2003). In this study, peers were identified as a common perpetrator of verbal abuse by 24 respondents (28%).

Research Question 3

How frequently is verbal abuse reported by nurse anesthetists? If not formally reported, what other reporting methods are utilized? Respondents were asked to indicate how many times they officially reported an episode of verbal abuse. Then they were asked if they didn't officially report the incident, did they talk with someone about the incident, and if so, with whom did they talk to. In this study, 72% of the respondents indicated they had experienced an episode of verbal abuse in the past six months, but did not officially report any episodes. Twenty-four percent of the respondents said they had reported an incident between one to five times in the past six months.

These findings closely compare with other research findings with regard to underreporting verbal abuse (Duncan et al., 2001; Pejic, 2005; Rosenstein, 2002; Sofield & Salmond, 2003). The literature suggests several reasons for the lack of reporting. Rosenstein (2002) reported the most common barriers being fear of retribution, lack of confidentiality, lack or administrative support, and physician lack of awareness or unwillingness to change.

Oppressed behavior has also been suggested as a culprit. A nurse will blame himself or herself instead of placing the blame on the abuser. This may lead the nurse to

Other possible negative outcomes may include job dissatisfaction, diminished morale, and possible psychological effects.

Limitations

While this study did reproduce many of the results previously investigated in other studies, it is important to take into consideration the study's limitations. The tool that was used may limit this study. Certain areas of the tool appear to be limiting for the participants and the researcher. Factors such as length and wording of certain questions may have impacted the respondent's decision to participate or fully complete the questionnaire. Rearrangement of the tool and deleting extraneous questions may have increased the quantity and completeness of the questionnaire.

The sample size was relatively small and was taken from a region in the Midwestern United States. This could limit the strength of the representativeness of findings in this study because all respondents were from one selected state. Findings cannot be generalized to other states or geographic areas.

Implications

This study reaffirms that not only is verbal abuse still a problem, but it maintains a presence at many different levels of nursing. The physician continues to be identified as the main perpetrator of verbal abuse directed at nurses at all levels. Specific education targeted at CRNA's needs to be developed and implemented to guard against verbal abuse. Healthcare organizations must institute and enforce strict policies addressing all forms of abuse. Further, they must ensure that there is no retribution for reporting cases of verbal abuse. A mandatory counseling program should be utilized for all individuals that choose to engage in the abuse of others, verbal or otherwise.

most frequently identified perpetrator, the physician and their respective specialty, would also be interesting to investigate.

Nursing Education and Practice

Verbal abuse within the workplace should not be tolerated. Yet, this study only adds credence to the literature that this type of abuse continues to pollute the nursing profession. Action must be taken to mitigate the detrimental and harmful cycle of verbal abuse. Educational programs for staff should be directed at faster recognition, anonymous reporting, and conflict resolution. This will equip the employee with the skills necessary to deal with episodes of verbal abuse positively. Topics of verbal abuse recognition, conflict resolution, effective communication, stress management, and anger management needs to be incorporated into undergraduate nursing education as well as hospital orientation for new employees.

Organizations should have policies and procedures in effect mandating "zero-tolerance" with guidelines preventing abuse. Enforcement of policies must be mandatory and cover all disciplines. They should also have a tracking mechanism in place to track and trend episodes of verbal abuse. This tool could be used to identify individuals or departments that have an increased prevalence of verbal abuse. Managers must be able to deal with episodes of verbal abuse at the time that it occurs. In addition, Employee Assistance Programs should be available to victims of verbal abuse so that potential negative outcomes or effects can be minimized.

Conclusion

This study was conducted to identify the prevalence, frequency, sources, and reporting level of verbal abuse with respect to CRNA's. This study indicates that verbal

APPENDICES

	Never	1-5 times	6-10 times	11-20 times	more than 20 times
11. A person makes a humiliating or abusive comment disguised as a joke.	☐	☐	☐	☐	☐
12. A person i gnores you, controls the conversation, or refuses to comment.	☐	☐	☐	☐	☐
13. Please list an y other form of verbal abuse you have experienced:	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐

If you answered NEVER to all questions in PART II, your survey is now complete. Please place it in the supplied envelope and return it to the researcher. Thank you for your time.

Part III

Based on your last 6 months of practice, please identify all the perpetrators of verbal abuse you have experienced by placing an X in the box. PLEASE CHECK ALL THAT APPLY.

14. ☐ Patient
- ☐ Patient's Family
- ☐ Immediate Supervisor
- ☐ Peer (e.g. other CRNA)
- ☐ Physician
- ☐ In Unit Subordinate
- ☐ Out of Unit Subordinate
- ☐ Other PLEASE SPECIFY_____

Of these groups, please identify the most <u>common</u> source of verbal abuse. <u>ONLY CHECK ONE</u>.

15. ☐ Patient
- ☐ Patient's Family
- ☐ Immediate Supervisor
- ☐ Peer (e.g. other CRNA)
- ☐ Physician
- ☐ In Unit Subordinate
- ☐ Out of Unit Subordinate
- ☐ Other PLEASE SPECIFY_____

Part IV

Please answer the following questions by placing an X in the most appropriate box. Base your answers on your last 6 months of practice.

	Never	1-5 times	6-10 times	11-20 times	more than 20 times
16. The nu mber of times you have officially reported an episode of verbal abuse.	☐	☐	☐	☐	☐
17. The nu mber of times you have decided not to officially report an incident of verbal abuse.	☐	☐	☐	☐	☐

43. Feelin g unsupported.	☐	☐	☐	☐	☐
44. Fear of retribution/bla me.	☐	☐	☐	☐	☐
45. Decreased jo b satisfaction.	☐	☐	☐	☐	☐
46. Negati ve effects on job performance.	☐	☐	☐	☐	☐
47. Please list an y other personal or professional effects of verbal abuse:					
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐

If you would like to receive a summary of this research, please contact the researcher by phone at (218) 779-0242 or by email at kevinbuettner@mail.und.nodak.edu. Thank you for participating in the project.

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