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Research Article

Verbal Abuse and Turnover Intention among Emergency and Non-Emergency Nurses in The United States: A 2019 Cross-Sectional Survey

Mahmoud Mustafa Al-Qadi*, Hadya Abboud Abdel Fattah, Omar Melhem, Nathira Al Hmaimat, Fares Daradkeh

Nursing Department, Fatima College of Health Sciences, Abu Dhabi 3798, United Arab Emirates

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Background

Verbal abuse represents one of the most common forms of workplace violence encountered by nurses. In the United States (US), over half of nurses report experiencing verbal abuse from patients or their relatives. Nurses working in the emergency departments are particularly vulnerable due to high patient acuity, overcrowding, and the emotional demands of patient care. Although nurses in non-emergency settings may encounter verbal abuse less frequently, its detrimental effects on job satisfaction and retention remain substantial across clinical areas.

Objective

This study aims to (i) determine the proportion of nurses in the US who have experienced verbal abuse and their desire to leave the organization; (ii) evaluate and compare nurses' responses to verbal abuse in emergency and non-emergency settings; (iii) assess and compare nurses' perceptions of the causes of verbal abuse across these settings; and (iv) investigate differences in reported verbal abuse and turnover intention between emergency and non-emergency nurses across demographic factors.

Methods

A cross-sectional online survey was administered using convenience sampling through Facebook and the Emergency Nurses Association. The sample included emergency and non-emergency nurses practicing in the US (n = 112). Verbal abuse was measured using the verbal abuse subscale of the Workplace Violence Questionnaire, and turnover intention was assessed using the Turnover Intention Scale. Data were collected and managed using Qualtrics.

Results

Among the 112 nurses who met the inclusion criteria, 97.3% reported being verbally abused in the past 12 months. Nearly half of the participants worked as emergency nurses (46.4%), while 53.6% had never worked in the emergency department. Emergency nurses reported higher frequencies of verbal abuse (mean [M]= 14.5, standard deviation [SD] = 3.57) than non-emergency nurses (M = 8.5, SD = 4.21; t[107] = 7.98, $p < 0.001$). However, there was no statistically significant difference in mean turnover intention scores between emergency nurses (M = 21.4, SD = 5.75) and non-emergency nurses (M = 20.5, SD = 5.48; t[110] = 0.885, p = 0.378). Mean turnover intention scores for both groups were above 18, indicating a high desire to leave the organization.

***Corresponding author:**
Mahmoud Mustafa Al-Qadi
Nursing Department, Fatima College of Health Sciences, Abu Dhabi 3798, United Arab Emirates.
Email: Mahmoud.alqadi@actvet.gov.ae

Conclusion

Verbal abuse is highly prevalent among nurses in both emergency and non-emergency settings in the US. Although emergency nurses experience higher levels of verbal abuse, turnover intention is similarly elevated across clinical settings. These findings underscore the need for organizational strategies that address verbal abuse as a widespread occupational issue affecting nurses across clinical environments and compromising the quality and safety of patient care.

1. INTRODUCTION

Experience of violence and harassment—including physical assault, verbal threats, stalking, discrimination, and sexual harassment—has increased among healthcare workers (HCWs) across all disciplines and represents a global rise in hostility-related incidents against clinical personnel.[1,2] Evidence indicates that approximately 62% of HCWs worldwide report experiencing at least one form of workplace violence (WPV) annually, with verbal abuse being the most prevalent form.[1] Such incidents occur not only in high-acuity settings but also in outpatient clinics, long-term care facilities, and community placements, highlighting the extensive scope of this occupational hazard.[3] Recent studies in the United States (US) and other countries indicate that verbal abuse is commonly reported by nurses across clinical settings, often occurring repeatedly and normalized as an expected aspect of nursing work.[4,5] This normalization contributes to underreporting and limits organizational responses, allowing verbal abuse to persist as a routine occupational stressor rather than being addressed as a preventable safety issue.[6]

The psychological impacts of violence and harassment in healthcare settings include depression, anxiety, and moral injury, which ultimately lead to decreased clinical performance and increased burnout rates.[7] Systematic reviews reveal a high prevalence of emotional exhaustion and disengagement among HCWs due to exposure, which reduces workforce sustainability.[8] Furthermore, exposure to aggressive behaviors has been shown to undermine communication, decision-making, and the quality of patient interactions, creating downstream risks to patient safety.[9]

Multi-country studies also report that HCWs who experience violence are more likely to take sick leave, consider career changes, or reduce clinical hours, exacerbating workforce shortages.[2,7] Many healthcare settings lack adequate safety measures, staffing levels, and reporting systems, allowing incidents to persist unaddressed; coordinated, system-wide interventions are recommended.[10]

Workplace violence against nurses has emerged as a global crisis, posing risks to patient safety and threatening workforce sustainability.[11] Among its forms, verbal abuse—encompassing insulting language, threats, intimidation, and harassment—occurs most frequently and is consistently linked to adverse psychological outcomes, deteriorations in care quality, and increased intentions to leave the profession.[12]

Emergency department (ED) nurses are consistently identified as one of the highest-risk groups for verbal abuse, reporting significantly greater exposure than nurses working in non-emergency inpatient or outpatient settings.[13,14] The ED is defined as a healthcare setting where patients may present for medical treatment or acute care without a prior appointment. The COVID-19 pandemic further intensified verbal abuse toward nurses, particularly in ED settings, amplifying existing disparities between ED and non-ED environments.[15] Nurses reported increased hostility stemming from visitor restrictions, resource shortages, and public frustration, with ED nurses disproportionately affected given their frontline role.[16,17] Post-pandemic evidence indicates that elevated levels of verbal abuse and turnover intention have persisted, suggesting long-term implications for workforce retention, especially in emergency care.[15,18]

Turnover intention, defined as a nurse's conscious and deliberate willingness to leave their current position or profession, represents a critical organizational outcome in nursing workforce research.[19] High turnover intention among nurses has implications for staffing stability, organizational costs, and patient care quality.[20] Existing literature indicates that turnover intention commonly arises in nursing environments characterized by heightened occupational stress and exposure to workplace stressors, such as verbal abuse.[21] ED nurses have consistently reported higher turnover intention than non-ED nurses, reflecting the increased demands of emergency care practice.[22,23]

A study on 1,000 nurses across 48 states in the US revealed that 60% of registered nurses had reported changing, leaving, or considering leaving their job because of WPV.[24] The prevalence of WPV among nurses appears to be a global trend, as reported in previous studies: 35% in the USA,[25] 62.3% in Africa,[26] 84% in Egypt,[9] and 26.6% in China.[27] Registered nurses working in EDs continue to face an exceptionally high risk of WPV from patients and visitors due to 24-h accessibility, high levels of anxiety and distress among patients and family members, long waiting times, overcrowded and privacy-limited environments, and frequently insufficient security support.[28-30]

Therefore, this study aims to (i) determine the proportion of nurses in the US who have experienced verbal abuse and their desire to leave the organization; (ii) evaluate and compare nurses' responses to verbal abuse in emergency and non-emergency settings; (iii) assess and compare nurses' perceptions of the causes of verbal abuse across these settings; and (iv) investigate differences in reported verbal abuse and turnover intention between emergency and non-emergency nurses across demographic factors. Accordingly, descriptive statistics were used to summarize prevalence and response patterns, independent samples *t*-tests were used to compare emergency and non-emergency nurses, and one-way ANOVA with post hoc testing was used to examine group differences across demographic variables.

2. METHODS

This descriptive, cross-sectional study employed a self-reported questionnaire to collect data on ED and non-ED (inpatient or outpatient non-emergency) nurses' experiences of verbal abuse and turnover intention in the US. Data were collected between June and September 2019 using the verbal abuse subscale of the WPV Questionnaire and the

Turnover Intention Scale (TIS). Participants were recruited via two online venues: (i) a Facebook nursing-related group called "Show Me Your Stethoscope," which has over 600,000 members, and (ii) members of the Emergency Nurses Association (ENA) via the association website, which has approximately 43,000 members. The ENA posted the survey link on its website, where it remained active for up to three months. A convenience sample of male and female registered nurses from all ethnic and racial backgrounds was eligible to participate. Exclusion criteria included nurses who did not hold an active registered nurse license and have not worked in the US in the last 12 months.

Sample size estimation was guided by the study's primary comparative objective of detecting mean differences in verbal abuse experience and turnover intention scores between ED and non-ED nurses. Using G*Power software package (version 3.1.9.2, Heinrich-Heine-Universität Düsseldorf, Germany), a priori power analysis was conducted for an independent-samples *t*-test, assuming a two-tailed α of 0.05, statistical power (1-β) of 0.70, and a medium effect size (Cohen's $d = 0.50$), which is commonly used in group comparison studies when prior-specific estimates are limited. Although the power analysis required a sample of 102 participants (51 per group), the final sample included 112 participants who met the inclusion criteria and completed the survey, thereby exceeding the minimum required sample size and providing adequate power for the planned descriptive and comparative analyses. Figure 1 depicts the participant screening process.

2.1. INSTRUMENTS

Workplace violence includes "physical violence, sexual harassment, bullying/mobbing, verbal abuse, or threatening behaviors".[31(p.7),32(p.796)] Generally, the literature quantifies and describes two facets of WPV, namely verbal and physical abuse. "Verbal abuse" refers to threatening behaviors without physical contact—cursing/swearing, screaming/shouting, or humiliation. The WPV Instrument is a self-report questionnaire developed by the International Labour Office (ILO)/International Council of Nurses (ICN)/World Health Organization (WHO)/Public Services International (PSI). It includes four components: (i) physical WPV; (ii) psychological WPV, including verbal abuse, bullying, mobbing, sexual harassment, and racial harassment; (iii) health sector employers; and (iv) opinions on WPV.

In this study, participants were asked to respond only to the verbal abuse items to obtain information on verbal abuse among nurses in the US (e.g., "In the last 12 months, how often have you been verbally abused?"). The four-item measure was assessed on a seven-point Likert scale, ranging from 1 (never) to 7 (daily). The reliability and validity of the original questionnaire have been well established in several studies across different countries among professional nurses.[33-37] In the present study, the scale's reliability was high (α = 0.88). For the purpose of this study, verbal abuse was considered present if participants experienced at least one type of work-related verbal abuse in the 12 months prior to the study.

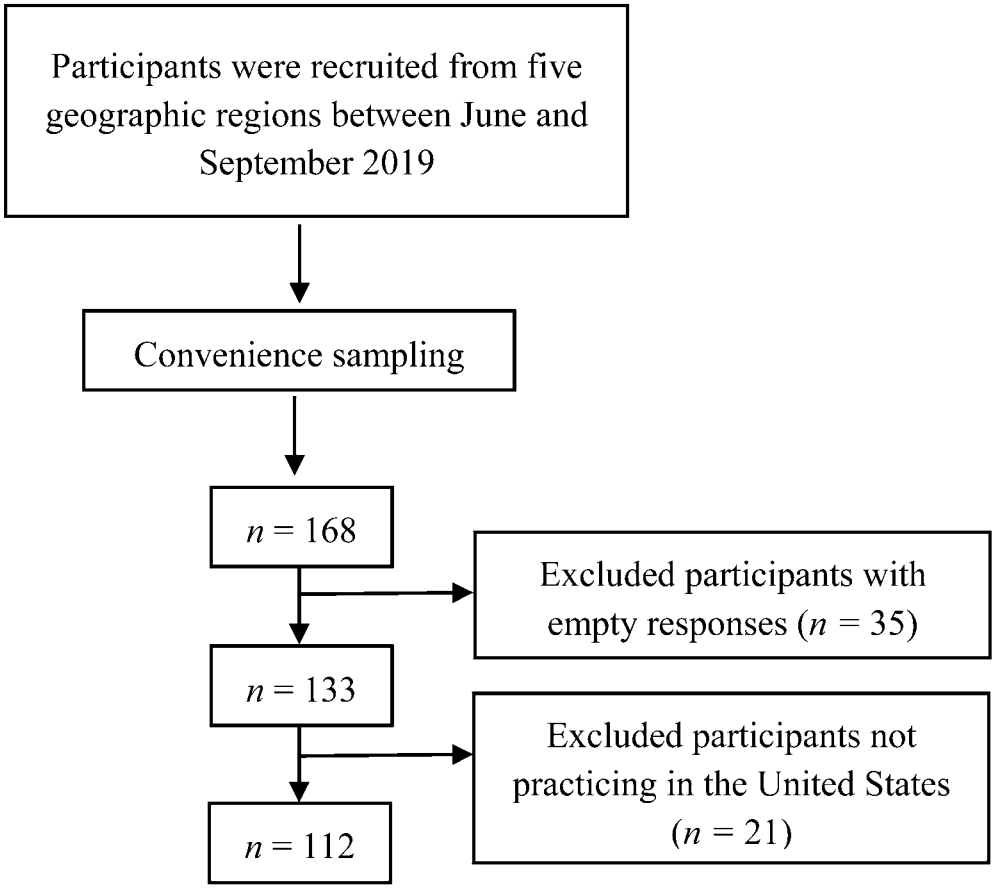

Figure 1. Participant recruitment process

Turnover intention was measured using the TIS.[38] The six-item TIS was measured on a five-point Likert scale (e.g., "How often have you considered leaving your job?"), with two opposing anchors defining responses (e.g., never–always; very satisfying–totally dissatisfying; highly unlikely–highly likely). The validity of the TIS has been confirmed in prior research.[39] Total scores range from 6 (6 × 1) to 30 (6 × 5), with a midpoint of 18 (6 × 3). Therefore, scores above 18 indicate a higher desire to leave the organization, while scores below 18 indicate a stronger desire to remain in the specialty. The TIS demonstrated internal consistency reliability, with Cronbach's α ranging from 0.84 to 0.91 in prior studies.[9,39,40] In this study, the scale's reliability was high (α = 0.87).

2.2. DATA COLLECTION

Only three advertisements were posted on the Facebook group to recruit participants. After the first advertisement, the second was posted one month later, and the third was posted one month after the second. An anonymous link to the questionnaires, including demographic information, was posted on the Facebook group and the ENA website. The link to the questionnaires remained active for three months. An information sheet (a detailed description of the study), demographic questionnaire, ILO/ICN/WHO/PSI verbal abuse instrument, and TIS were developed in Qualtrics (USA). The questionnaires employed the funnel technique, which begins with demographic information that nurses can quickly answer. The ILO/ICN/WHO/PSI questionnaire was placed in the middle because these questions require additional time and reflection. Finally, the TIS questionnaire was administered.

The University of Connecticut Institutional Review Board (approval number: X19-089) approved this study on June 13, 2019. Participation was voluntary and anonymous (i.e., no personal identifiers were collected or recorded). Brief information about the purpose of the study and self-screening of the criteria for participation was included in the electronic invitation. Detailed information about the study was provided to participants at the beginning of the questionnaire. Consent was implied if the nurse clicked "Yes" to agree to the following statement: "Please indicate whether you would like to participate in this survey, and then click the arrow at the lower right corner to continue."

2.3. STATISTICAL ANALYSIS

Data were analyzed using the Statistical Package for the Social Sciences (version 27, SPSS Inc., USA). Descriptive statistics were used to summarize participants' demographics and professional characteristics, including frequencies and percentages for categorical variables and means with standard deviations for continuous variables. Independent samples *t*-tests and one-way analyses of variance were conducted to compare mean verbal abuse experience and turnover intention scores between ED and non-ED nurses and across demographic factors, including age, gender, race, ethnicity, educational level, employer location, geographic region, and years of nursing experience. Pearson's chi-square (χ^2) was applied to examine group differences in categorical variables between ED and non-ED nurses. Internal consistency reliability of the study instruments was assessed using Cronbach's α coefficients. All statistical tests were two-tailed, and statistical significance was set at $p < 0.05$. Analyses were descriptive and comparative in nature; no analyses of associations, predictions, or causal relationships were conducted.

3. RESULTS

Nurses' demographic characteristics are presented in Table 1. Of the 168 nurses who accessed the survey, 112 met the inclusion criteria and completed all key items. A total of 35 responses were empty, and 21 responses were excluded because they were from individuals not practicing in the US; therefore, only eligible, complete responses were included in the analysis. The sample was predominantly female (84.85%) and Caucasian/White (91.96%). Nearly half of the participants were ED nurses (46.4%), while 53.6% were non-ED nurses. Most responses were obtained through Facebook, whereas a smaller proportion was obtained through the ENA website. One-third (33%) of the nurses were members of the ENA, were aged between 35 and 44 years, and had more than 20 years of work experience; however, 10.9% completed the survey through the ENA website. Almost half of the nurses held a Bachelor's degree, and their employers were located in urban areas (43.8% and 51.6%, respectively).

3.1. VERBAL ABUSE

Most nurses (97.32%) reported experiencing verbal abuse while working as licensed nurses in the past 12 months. Patients and their family members or visitors were the most frequent perpetrators of verbal abuse in the ED, whereas patients were the primary perpetrators in non-ED settings (Table 2). As shown in Table 3, the most frequent types of verbal abuse by patients in the ED were yelling/shouting, swearing, and threats of harm (88.5%, 86.5%, and 88.5%, respectively). In the non-ED settings, the most frequent types were yelling/shouting (55%) and swearing (50%). ED nurses reported experiencing humiliation from both patients and patients' family members/visitors more frequently than non-ED nurses. Verbal abuse was reported at a significantly higher frequency among ED nurses than non-ED nurses (mean [M] = 14.5, standard deviation [SD] = 3.57 vs. M = 8.5, SD = 4.21), with $t(107) = 7.98$ and $p < 0.001$.

3.2. RESPONSE TO VERBAL ABUSE

Participants reported varied responses to incidents of verbal abuse. Approximately 64.5% indicated that verbal abuse incidents occurred frequently, and 48.6% reported being highly dissatisfied with how incidents were handled. Additionally, 52.5% of nurses did not report verbal abuse because they believed reporting would be ineffective. Moreover, 7.14% of participants reported taking time off due to verbal abuse. Most ED nurses reported being worried about verbal abuse while working (84.6%), compared with 60.1% of non-ED nurses. Approximately 38.4% of participants reported they did not know how to use procedures for reporting incidents of verbal abuse.

3.3. CAUSES OF VERBAL ABUSE

Regarding the causes of verbal abuse reported by participants (Table 4), the most common cause in both ED and non-ED settings was the lack of penalties for perpetrators

Table 1. Demographic characteristics of participants

Demographic characteristic	Total		Emergency nurses		Non-emergency nurses		F	χ^2	*p*-value	Effect size
	n	%	*n*	%	*n*	%				
Age (years)										
20–34	27	24.11	12	23.1	15	25				
35–44	37	33.04	16	30.8	21	35				
45–54	27	24.11	14	26.9	13	21.7	0.22	1.33	0.716	0.09[a]
⩾55	21	18.75	10	19.2	11	18.3				
Gender										
Male	17	15.2	4	7.7	13	21.7	0.86	4.82	0.028	3.33[b]
Female	95	84.8	48	92.3	47	78.3				
Race										
Caucasian/White	103	91.96	46	88.5	57	95	1.09	0.03	0.855	0.39[b]
Other	9	8.04	6	11.5	3	5				
Ethnicity										
Hispanic or Latino	8	7.14	3	5.8	5	8.3	0.93	1.88	0.170	0.67[b]
Not Hispanic or Latino	104	92.86	49	94.2	55	91.7				
Education level										
Associate or less	39	34.8	17	32.6	22	36.7				
Bachelor	49	43.8	24	46.2	25	41.7	0.12	5.10	0.079	0.19[a]
Master's or higher	24	21.4	11	21.2	13	21.6				
Years of nursing experience										
1–5	23	20.54	12	23.1	11	18.3				
6–10	24	21.43	13	25	11	18.3				
11–20	25	22.32	8	15.4	17	28.3	1.36	10.05	0.018	0.27[a]
>20	40	35.71	19	36.5	21	35.1				
Employer location type										
Urban	58	51.79	25	48.1	33	55				
Rural	28	25	15	28.8	13	21.7	2.61	1.45	0.485	0.11[a]
Inner-city	26	23.21	12	23.1	14	23.3				
United States geographic area										
Northeast	25	22.32	14	27	11	18.4				
Southeast	26	23.21	10	19.2	16	26.5				
Midwest	26	23.21	14	26.8	12	20.1	2.02	3.04	0.566	0.14[a]
Southwest	13	11.61	5	9.7	8	13.3				
West	22	19.64	9	17.3	13	21.7				

Notes: Pearson's chi-square (χ^2) tests and one-way analyses of variance were conducted to compare categorical variables. A p-value < 0.05 indicates statistical significance. [a]Effect sizes are reported as Cramér's V with 95% confidence intervals for variables with more than two categories. [b]Effect sizes are reported as odds ratios with 95% confidence intervals for binary variables.

Table 2. Characteristics of verbal abuse experienced by nurses

Characteristics of verbal abuse	Total		Emergency nurses		Non-emergency nurses	
	n	%	*n*	%	*n*	%
Experienced verbal abuse incidents in the last 12 months						
Yes	109	97.32	52	100	57	95
No	3	2.68	0	0	3	5
Experienced verbal abuse incidents occurred frequently						
Yes	72	64.5	34	65.4	39	65
No	40	35.5	18	34.6	21	35
Responsible persons for verbal abuse incidents						
Patient	53	47.32	29	55.8	24	40
Patient's family/visitors	18	16.07	11	21.2	7	11.7
Nurses	14	12.5	6	11.5	8	13.3
Management/supervisor	13	11.61	2	3.8	11	18.3
Physician	14	12.5	4	7.7	10	16.7
The incident could have been prevented						
Yes	71	63.4	29	55.8	42	70
No	41	36.6	23	44.2	18	30
Took time off as a result of the verbal abuse						
Yes	8	7.14	4	7.7	4	6.7
No	104	92.86	48	92.3	56	93.3
Witnessing incidents of verbal abuse in the last 12 months						
Yes	104	92.86	51	98.1	53	88.3
No	8	7.14	1	1.9	7	11.7
Worried about verbal abuse						
Yes	80	71.4	44	84.6	36	60.1
No	32	28.6	8	15.4	24	39.9
Knowing how to use procedures for reporting incidents of verbal abuse						
Yes	69	61.6	33	63.5	36	60
No	43	38.4	19	36.5	24	40
Reporting verbal abuse incidents was effective						
Yes	53	47.5	25	48.1	29	48.3
No	59	52.5	27	51.9	31	51.7
Encouragement to report verbal abuse						
Yes	35	31.25	12	23.1	23	38.3
No	77	68.75	40	76.9	37	61.7
Satisfied with the way the incidents were handled						
Highly dissatisfied	54	48.6	25	48.1	29	48.3
Highly satisfied	58	51.4	27	51.9	31	51.7
Training on how to deal with verbal abuse						
Yes	44	39.3	18	34.6	26	43.3
No	68	60.7	34	65.4	34	56.7

Table 3. Type of verbal abuse by source among emergency and non-emergency nurses

Nursing group	Type of verbal abuse	Patients' families/visitors		Patients		Physicians		Nurses	
		n	%	*n*	%	*n*	%	*n*	%
Emergency nurse	Yelled or shouted at	46	88.5	46	88.5	13	25	22	42.3
	Sworn at	46	88.5	45	86.5	12	23.1	22	42.3
	Threatened with harm	44	84.6	46	88.5	11	21.2	21	40.4
	Humiliated	37	71.2	37	71.1	12	23.1	22	42.3
Non-emergency nurse	Yelled or shouted at	26	43.3	33	55	17	28.3	19	31.7
	Sworn at	23	38.3	30	50	12	20	16	26.7
	Threatened with harm	18	30	25	41.7	9	15	13	21.7
	Humiliated	21	35	23	38.3	15	25	18	30

Note: Participants could select more than one response.

Table 4. Causes of verbal abuse reported by nurses

Causes of verbal abuse	Emergency nurses		Non-emergency nurses	
	n	%	*n*	%
Communication	14	26.9	22	36.7
Patient and family expectations	37	71.2	28	46.7
Staff nurse attitude	8	15.4	15	25
Shortage of nursing staff	17	32.7	23	38.3
Lack of effective anti-violence policies	24	46.2	24	40
Lack of penalty for perpetrators	38	73.1	34	56.7
Patients/visitors under the influence of illicit drugs	35	67.3	10	16.7
Patients/visitors under the influence of alcohol	33	63.5	11	18.3

Note: Participants could select more than one response.

(73.1% and 56.7%, respectively), followed by patient and family expectations (71.2% and 46.7%, respectively). The least commonly reported causes were staff nurse attitude in the ED (15.4%) and patients or visitors under the influence of illicit drugs in the non-ED settings (16.7%).

3.4. DIFFERENCES IN VERBAL ABUSE BASED ON NURSES' DEMOGRAPHICS

Independent samples *t*-tests and one-way ANOVA analysis were conducted to examine differences in the frequency of verbal abuse by age, gender, race, ethnicity, educational level, employer location type, geographic region, and years of experience as a licensed nurse.

As shown in Table 1, a statistically significant difference in verbal abuse frequency was observed by gender. Female nurses reported significantly higher incidents of verbal abuse (M = 15.2) compared to male nurses (M = 11.8), with $t(110) = -2.222$ and $p = 0.028$.

A statistically significant difference was also found based on years of nursing experience ($F[3,108] = 3.479$, $p = 0.018$).

Tukey post hoc analysis revealed that nurses with 1–5 years of experience reported significantly higher verbal abuse frequency (M = 17.0 ± 4.6, p = 0.019) compared to those with 11–20 years of experience (M = 12.0 ± 5.6).

3.5. TURNOVER INTENTION

There was no statistically significant difference in turnover intention scores between ED nurses (M = 21.4, SD = 5.75) and non-ED nurses (M = 20.5, SD = 5.48), with $t(110) = 0.885$ and $p = 0.378$. However, both groups had mean scores above 18, indicating elevated turnover intention.

3.6. DIFFERENCES IN TURNOVER INTENTION BASED ON NURSES' DEMOGRAPHICS

Independent samples t-tests and one-way ANOVA were conducted to examine differences in turnover intention across demographic variables, including age, gender, race, ethnicity, educational level, employer location type, geographic region, and years of experience as a licensed nurse. The results showed no statistically significant difference in turnover intention across any demographic variables (all $p > 0.05$).

4. DISCUSSION

This study provides novel insights into the growing nursing literature, highlighting that verbal abuse is prevalent in nursing in the US, with more than 97% of participants reporting exposure within the past year. These findings align with recent national and international nursing studies documenting verbal abuse as the most prevalent form of WPV across acute care settings, regardless of specialty.[5,25,27] Importantly, the consistently elevated turnover intention observed across both groups underscores verbal abuse as a workforce-wide nursing concern rather than an issue confined to traditionally high-risk units such as the ED.[19,20,23]

Consistent with prior nursing research, in this study, ED nurses reported significantly higher frequencies of verbal abuse compared to non-ED nurses. This finding reflects the unique clinical realities of emergency nursing, including high patient acuity, overcrowding, prolonged wait times, and heightened emotional distress among patients and families.[14,17,29] Research has repeatedly demonstrated that these contextual stressors increase the likelihood of hostile interactions, particularly verbal abuse, positioning ED nurses at disproportionate risk despite similar professional competencies and training.[13,28]

Despite significantly higher exposure to verbal abuse among ED nurses, the absence of a statistically significant difference in turnover intention between ED and non-ED nurses is a particularly salient finding. This pattern suggests that turnover intention among nurses may be influenced by broader systemic and organizational stressors that transcend unit type, including understaffing, workload intensity, moral distress, and burnout.[9,18,22] Nursing studies increasingly indicate that cumulative occupational strain, rather than exposure to a single risk factor, may drive nurses' intentions to leave their organizations, resulting in similarly elevated turnover intention across diverse practice settings.[20,22]

The comparable turnover intention scores observed across ED and non-ED nurses may also reflect the normalization of verbal abuse within nursing culture. Verbal abuse is often perceived as an unavoidable aspect of nursing work, leading nurses in both settings to internalize abuse as part of their professional role rather than as an unacceptable safety violation.[5,6,16] This normalization may erode job satisfaction and professional commitment uniformly across settings, contributing to elevated turnover intention even in units where abuse occurs less frequently.[19,23]

A critical contribution of this study is the high prevalence of underreporting and nurses' perceptions that reporting verbal abuse is futile. More than half of the participants indicated that incidents were not reported because they believed that reporting would not lead to meaningful action, a finding widely echoed in nursing literature.[5,6,15] Underreporting perpetuates a cycle in which verbal abuse remains invisible at the organizational level, limiting administrators' ability to implement targeted interventions and reinforcing nurses' perceptions that their safety concerns are not prioritized.[9,10]

Participants' identification of inadequate penalties for perpetrators and ineffective anti-violence policies highlights systemic organizational failures rather than individual-level shortcomings. The nursing literature consistently emphasizes that weak enforcement of zero-tolerance policies and ambiguous reporting pathways undermine trust in institutional leadership and discourage future reporting.[11,21,23] These findings suggest that verbal abuse against nurses persists not solely due to patient behavior, but also due to insufficient organizational accountability structures that fail to protect nursing staff across care settings.

These findings underscore the urgent need for healthcare organizational leaders to strengthen reporting systems, ensure visible follow-up after reported incidents, and foster a culture in which verbal abuse is explicitly defined as unacceptable.[4,25,28] Leadership training programs that emphasize trauma-informed responses, staff advocacy, and psychological safety may mitigate the downstream effects of verbal abuse on nurse retention.[5,23] Without such leadership engagement, turnover intention is likely to remain elevated across both ED and non-ED nursing environments.

Demographic variations in verbal abuse exposure also emerged. Female nurses and those with fewer years of experience as a licensed nurse reported significantly higher frequencies of abuse. Gender-based vulnerability has been observed in earlier studies, with female nurses often reporting greater exposure to verbal abuse, potentially due to gendered expectations of emotional labor in healthcare.[41] Moreover, the higher risk among early-career nurses highlights the potential protective role of experience, coping strategies, and professional authority that accumulate over time.[42] These results emphasize the importance of tailored support for younger and less experienced nurses who may lack the resilience or institutional knowledge to navigate abuse effectively.

At the policy level, the findings support calls for mandatory WPV prevention standards that specifically address verbal abuse against nurses. National nursing organizations have emphasized that voluntary guidelines are insufficient to change entrenched workplace cultures and have advocated instead for enforceable policies, standardized reporting mechanisms, and consistent data surveillance.[4,10,24] Policy interventions that integrate verbal abuse prevention into occupational safety regulations may be essential for reducing turnover intention and stabilizing the nursing workforce across all clinical settings.

Future nursing research should adopt longitudinal

designs to clarify the temporal pathways linking verbal abuse and turnover intention among ED and non-ED nurses. Additionally, intervention studies evaluating the effectiveness of reporting systems, leadership accountability frameworks, and staff support programs are urgently needed.[13,18,27] Advancing this line of inquiry will be essential to inform evidence-based strategies that aim to protect nurses from verbal abuse and sustain workforce retention in an increasingly strained health system.

5. LIMITATIONS

Several limitations of the present study should be acknowledged. First, the cross-sectional design limits the ability to draw causal or directional conclusions regarding the study variables. Second, the use of convenience sampling and self-selection via social media platforms and professional nursing associations may have introduced selection bias, potentially limiting the representativeness of the sample. Third, the sample consisted predominantly of White, female nurses practicing in the US, which restricts the generalizability of the findings to more diverse nursing populations. Fourth, the reliance on self-reported data may be subject to recall bias, particularly because participants were asked to report verbal abuse experienced over the past 12 months. Finally, the data were collected in 2019, which may not reflect current post-pandemic conditions.

6. CONCLUSION

The findings of this study reveal the widespread occurrence of verbal abuse among ED and non-ED nurses in the US. Verbal abuse was highly prevalent among the sample, and turnover intention scores were elevated across both ED and non-ED nurses. Although these findings do not establish a relationship or causal pathway, they suggest the need for further investigation into factors that may contribute to nurses' intention to leave their organizations, which could jeopardize the quality of healthcare services and patient outcomes. Future research should explore potential mechanisms underlying turnover intention, including how coping strategies employed by nurses who experience verbal abuse may influence their decision-making processes.

Developing effective management structures and enforcing occupational safety regulations can enhance workplace safety for nurses and improve the quality of patient care. Greater attention should be directed toward coping strategies and protective factors at both individual and organizational levels—such as stress management and communication training, leadership support, robust reporting mechanisms, and zero-tolerance policies for WPV. Longitudinal study designs are warranted to establish temporal relationships and to strengthen causal inferences regarding the association between exposure to verbal abuse and subsequent turnover intention. Furthermore, intervention studies should assess the effectiveness of targeted prevention and support programs in reducing verbal abuse and promoting nurse retention over time.

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CONFLICT OF INTEREST

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

AUTHOR CONTRIBUTIONS

Conceptualization: Mahmoud Mustafa Al-Qadi
Formal analysis: Mahmoud Mustafa Al-Qadi, Fares Daradkeh, Nathira Al Hmaimat
Investigation: Mahmoud Mustafa Al-Qadi
Methodology: Hadya Abel-Fattah, Omar Melhem, Fares Daradkeh
Writing–original draft: Mahmoud Mustafa Al-Qadi
Writing–review & editing: Hadya Abel-Fattah, Nathira Al Hmaimat, Omar Melhem

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

The study was approved by the University's Institutional Review Board on June 13, 2019 (Approval number: X19-089). All participants provided informed consent prior to participation in the study.

CONSENT FOR PUBLICATION

All participants provided informed consent for publication.

DATA AVAILABILITY STATEMENT

All data generated and/or analyzed during this study are included in this published article.

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