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Griffith UNIVERSITY
Queensland, Australia

From workplace microaggression to workplace injury: reducing risk

Participant workbook



PIEF
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Workplace Microaggression
Closing the Gap of Concept and Practice

The data included in workbook is based on findings from:
Ferguson, S., Pretty, D., Davison. S., and Buys. N. (2025) Workplace Microaggression: A Systematic Review. RISE Research Unit. Griffith University, commissioned by EML.

Workplace microaggression

Defined

What is workplace microaggression (WM)?

WM refers to a combination of lower-level behaviours – including incivility, verbal abuse, and microaggressions – that may appear minor when viewed individually but, collectively, erode trust, morale, and psychological safety.

Key behaviour types:

Incivility

A spectrum of rude, disrepectful, exclusionary, or hostile behaviours that violate professional norms and undermine psychological safety.

Verbal abuse

A more overt and direct form of aggression, involving hostile or demeaning language that can cause immediate psychological harm. It occurs in both internal (leaders, supervisors, coworkers) and external (customers, patients, clients) interactions.

Microaggression

Microaggressions are subtle behaviours or comments that reflect underlying biases or stereotypes. While each instance may appear minor or isolated, they often target aspects of identity such as race, gender, age, or ability.

Notes



Prevalence

How widespread the behaviour is, typically measured as the proportion of works who have experienced these behaviours within a set timeframe.

Frequency

How often the behaviour occurs, typically measured as the number of incidents reported by individuals over a defined period of time.

Barriers to reporting

- Fear of consequences
- Workplace culture
- Minimisation/normalisation of behaviours
- Lack of faith in reporting systems/processes

Prevalence and/or frequency rates

Internal sources

Emergency medical services incivility experiences:

10.1% Daily
31.7% Weekly
61% Monthly

Rates were higher among females.

Verbal aggression was experienced by:

31.5% Healthcare workers
31.2% Nurses
13% Physicians

The impact of role and hierarchy

42% Physician to nurse aggression
11% Superior to physician aggression

External sources

82% of postal services employees reported at least some incivility in the last 12 months.

49.8% Healthcare workers point prevalence of insults and offence (reported incidents in real time).

Sometimes/rarely Emergency services (police) frequency of incivility behaviours.

Verbal aggression was experienced by:

51.9% Young workers in hospitality
47.4% Young workers in arts entertainment
55.9% Healthcare workers

Internal and external sources

62% Point prevalence of incivility in retail workers
(Survey: Is there incivility in your workplace right now?)

Impacts

Organisational

Employee attitudes and engagement

- Turnover intentions
- Reduced job satisfaction
- Lower commitment
- Perceived job security

Productivity and performance

- Decreased productivity
- Decreased work quality
- Presenteeism and absenteeism
- Work withdrawal

Disruptive workplace behaviours

- Counterproductive work behaviours
- Retaliatory behaviours

Workplace relationships and culture

- Impacted workplace relationships
- Negative work culture and atmosphere

Emotional and psychological

Emotional distress and disorders

- Psychological and emotional distress
- Psychological symptoms or disorders (Depression, anxiety, PTSD)

Cognitive and stress responses

- Rumination and stress

Wellbeing and life impacts

- Decreased wellbeing and resilience
- Impacted personal life

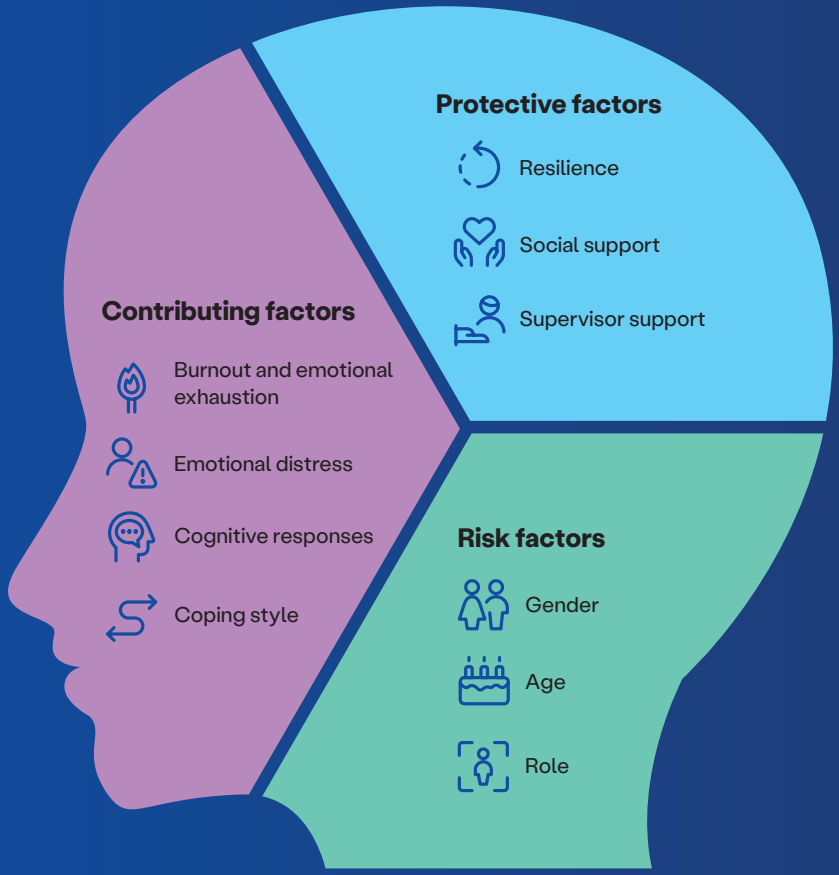
Work-related psychological impacts

- Decreased motivation and self-efficacy (confidence, competence, efficacy)
- Burnout and emotional exhaustion
- Depersonalisation
- Social alienation

Physical and functional symptoms

- Fatigue
- Physical symptoms
- Sleep disturbance

Mediating and moderating factors



Intervention targets

- Address underlying processes
- Mitigate the adverse effects of WM

Mediators Refer to variables that explain the process through which microaggressions affect outcomes. Mediators help to uncover how or why WM leads to certain effects. For example, experiencing WM might increase anger, which then leads to retaliation. Here, anger is the mediator explaining why microaggression affects improper worker behaviour.

Moderators Refer to factors that influence the strength or direction of the relationship between microaggressions and outcomes. Moderators help to identify when or for whom microaggressions are more or less harmful. For example, employees who have strong support from colleagues may feel less affected by WM, while those with little support may experience stronger negative or more detrimental effects

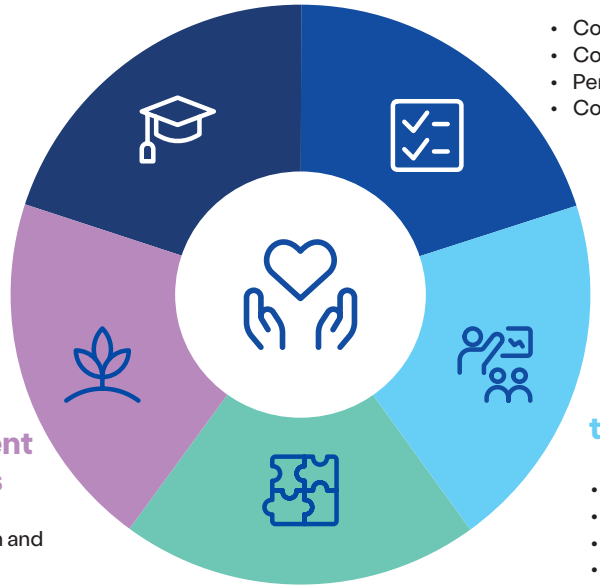
Best practice interventions

Education

- Behaviour
- Policy and procedures
- Reporting
- Impacts

Range of skills and strategy

- Communication skills
- Cognitive appraisal
- Perspective taking
- Conflict management



Stress management techniques

- Improve health and wellbeing
- Reducing stress
- Increase stress management techniques

Specialised and multi-tiered training

- Industry
- Staff
- Supervisors
- Leadership

Various training components

eg. roleplay, cognitive rehearsal, reflective practice

Consider: The broader implication is to combine interventions that cover individual capability with system-level policies, procedures, reporting and leadership action.

Which intervention is most feasible in your context, and what would make it effective?

Translating research into practice

What do you think WM's are ?

- Have you personally observed WM's?
- What are the cues you noticed?
- How is this information currently captured, documented or communicated, if at all?
- How could you pass insights back to the workplace in a way that is safe, constructive and focused on improvement rather than blame?

Where do you believe they appear in your workplace?

WORKSHOP ACTIVTY 1

1. What counts as a "small behaviour" that can still create risk of workplace microagagression?
2. Which "cues" are easiest to dismiss because they seem "too small" to report?

Where to look	What to notice
Communication	
Meetings/ collaborative work	
Customer/client interactions	
Leadership/ team culture	

WORKSHOP ACTIVITY 2

KEY RESEARCH FINDING:
WM is underreported. When experiences are not captured, organisations can underestimate both the harm and the need for preventive action.

Four barriers identified in the review:

1. Fear of consequences
2. Workplace culture and normalisation
3. Minimisation of the behaviour
4. Lack of faith in reporting systems

When someone says: "We don't see that here?" or "It's just part of the job", what might the organisation actually be missing?

Where might information be travelling instead: informal conversations, absenteeism, claims, case management, turnover?

Notes

Becoming an agent for change

- What are the impacts of not intervening, implanting change, giving support?
- What's the 'cost' of small things going unaddressed?
- When people say 'we don't see that' what might we be missing? (is it normalised, unreported, channelled through informal networks?)
- What would it look like to treat WM as an 'early warning indicator for broader psychosocial risk and how could we do that? (i.e. How can claim teams, mobile case managers and employers collaborate more effectively to address issues earlier)?
- Where are the current barriers, and what small shifts could make a meaningful difference?

Notes

WORKSHOP ACTIVITY 3

"The review identified adverse employee and organisational outcomes, with effects occurring through direct and indirect pathways".

Use the prompts below to map how repeated behaviours could escalate in a real workplace context.

Outcomes	Cost of small things going unaddressed
What happens?	
Immediate Effects - What changes for the person, team or work design?	
Accumulation - What happens if repeated or left unresolved?	
System impact - Where this may surface: performance, absence, health claim, recovery or return to work?	

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