

Workplace bullying and its association with secondary traumatic stress and turnover intention among emergency and critical care nurses



Original article

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Abstract: Objective: This study aims to identify the prevalence of bullying in the workplace and to examine its association with turnover (TO) intention and secondary traumatic stress (STS) among Jordanian nurses employed in Emergency Departments (EDs) and critical care units (CCUs). Nurses employed in the EDs and CCUs are exposed to high levels of bullying behaviors that may contribute to STS, leading to high rates of TO.

Methods: A descriptive cross-sectional design was used. A sample of 150 Jordanian nurses working in CCUs and EDs completed the study. Data collection was performed using the Demographical Questionnaire, the Negative Acts Questionnaire-Revised (NAQ-R), ProQOL scale, and TO scale. The IBM SPSS software was used to analyze data.

Results: About 10.7% and 89.3% were categorized as "occasionally bullied" and "victims of workplace bullying" subsequently. Workplace bullying was positively associated with TO intention ($r = 0.46, P < 0.001$) and STS ($r = 0.36, P < 0.001$). TO was positively associated with STS ($r = 0.36, P < 0.001$). Bullying was a unique significant predictor of TO intention ($t = 4.59, B = 0.34, P < 0.001$) and STS ($t = 4.15, B = 0.34, P < 0.001$).

Conclusions: Bullying behavior has negative adversarial effects on TO and the experience of STS. The prevalence of bullying behavior in the EDs and CCUs remains high despite the increasing awareness of its negative impacts. Healthcare organizations should put systems in place to ensure that zero-tolerance policy are monitored in terms of the effectiveness of its implementation.

Keywords: critical care units • emergency department • STS • turnover intention • workplace bullying

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1. Introduction

Bullying is referred to as repeated unwanted harmful actions that lead to feelings of humiliation and low self-confidence.¹ Bullying action includes, but is not limited to physical and verbal attacks, threats, and withholding of support. Bullying in the nursing profession is a widespread problem that begins in nursing schools and continues throughout the nursing profession.²

Bullying can reduce nurses' morale and their desire to stay in the profession.^{3,4} Bullying is also associated with increased job dissatisfaction and is considered a main cause of headache, depression, recurring illness, fear of going to work, absenteeism, and decreased productivity.⁵ Exposure to bullying at the workplace could lead to secondary traumatic stress (STS). STS is a negative feeling associated with work-related trauma. It is about work-related secondary exposure to extremely or traumatically stressful events at the workplace.⁶

1.1. Literature review

Bullying is more likely to occur in high-pressure environments with heavy workloads and low independence areas. Nurses in Emergency Departments (EDs) and critical care units (CCUs) are particularly vulnerable to bullying by patient relatives and their colleagues.⁷ Unfortunately, many nurses employed in the CCUs have reported that no action was taken regarding bullying incidents.⁸

Nurses are among the most important human resources in the health system. The healthcare organization must provide a high-quality professional environment that retains nurses and improves their professional quality of life.^{9,10} Assessment of nurses' intention to remain in the profession and the associated factors is necessary to develop policies related to staff retention. ED nurses are more vulnerable to a violent work environment due to the high level of patient-nurse contact. Most people who are bullied choose to leave their jobs rather than face bullying.¹¹

The literature highlighted the role of organizational and personal factors associated with bullying. Some organizational and personal variables, such as age, gender, educational level, working shifts, and experience, could contribute to bullying.¹² However, limited studies have identified the consequences of bullying in terms of turnover (TO) and STS in Jordanian EDs and CCUs.

The current study is among the novel studies in Jordan that link bullying with TO and STS in EDs and CCUs. This topic is significant as the absence of clear policies in reporting bullying incidents and the lack of training programs to deal with bullying in Jordanian hospitals are taken into consideration.⁷ The results of

the current study could pay more attention to the importance of having strict policies that protect nurses from the negative consequences of bullying.¹³

1.2. Purpose

This study examines the relationships between bullying in the workplace, TO, and STS among Jordanian nurses employed in EDs and CCUs. These are the questions of the study:

1. What is the prevalence of bullying among ED and CCU Jordanian nurses?
2. What are the levels of STS among ED and CCU Jordanian nurses?
3. What are the scores of TO intentions among ER and CCU Jordanian nurses?
4. What are the relationships between bullying, TO, and STS among ED and CCU Jordanian nurses, controlling for personal and organizational factors?

2. Methods

2.1. Design

A descriptive cross-sectional design was used.

2.2. Sample

This study was conducted in one government, one teaching, and one private hospital. The government hospital is considered the largest hospital in the country, with a capacity of 1101 beds and various EDs and CCUs including medical-surgical CCU, pediatric CCU, and neonatal CCU. The teaching hospital has a capacity of 436 beds and includes ED, medical-surgical CCU, and neonatal CCU. The private hospital has a capacity of 436 beds, ED, CCU for male, medical-surgical CCU for female, Neuro-CCU, neonatal CCU, and ED. The total number of nurses working in EDs and CCUs in the 3 hospitals is 280, of them 180 are employed in the government hospital.

The target population in this study was the Jordanian nurses employed in CCUs and EDs. The accessible population was nurses who worked in CCUs and EDs in the 3 selected hospitals. A convenience sampling technique was used. The sample size was estimated by using the G Power program version 3.1.9.4. The sample was calculated based on multiple regression; with 10 possible predictors, alpha error = 0.05, power = 0.80, and medium effect size. The required sample size was 147 participants. This number was increased to 170 to overcome the possibility of having missing or incomplete data.

2.3. Inclusion/exclusion criteria

2.3.1. The inclusion criteria

Registered nurses, both genders, working at the bedside, have at least one year experience in EDs or in CCUs, and a minimum of a bachelors' degree.

2.3.2. The exclusion criteria

Associate nurses, nurse managers, and nursing mandate from other hospitals.

2.4. Measurement

Data were collected using the demographic questionnaire, the negative act questionnaire-revised, the ProQOL scale, and the TO intention scale.

2.4.1. The demographic questionnaire

This questionnaire inquires about the demographic characteristics of the participants (e.g., gender, age, place of work, experience, marital status, monthly salary).

2.4.2. Negative act questionnaire-revised NAQ-R

The English version of the negative act questionnaire-revised (NAQ-R)¹⁴ was used to assess workplace bullying. The NAQ-R consists of 22 questions: 12 on personal bullying,^{2-7,10-13,15-17} 7 on work-related bullying,^{1,3,14,18-21} and 3 on intimidation-related bullying.^{8,9,22} These items are scored as follows: (5) daily, (4) weekly, (3) monthly, (2) occasionally, and (1) never, to show the frequency of exposure to bullying. Cronbach's alpha for the 22 items in the NAQ-R was 0.90, indicating excellent internal consistency reliability. Criterion validity was confirmed by relating the scores on the NAQ-R to a single-item measure and showing a high correlation with the total score of bullying and 3 factors.¹⁴ The total score ranges from 22 to 110 points, scores <33 indicate no bullying, scores 33–45 indicate occasional bullying, and scores >45 indicate severe bullying.¹⁴

2.4.3. ProQOL

ProQOL tool was developed by Stamm.⁶ It consists of 30 questions measuring compassion satisfaction (10 items), burnout (10 items), and STS (10 items). The scale is rated on a 5-point scale as follows: (1) Never, (2) Rarely, (3) Sometime, (4) Often, and (5) Very Often. In this study, only STS was measured. Cronbach alpha for STS is 81. The scale has good construct validity with over 200 published papers and more than 100,000 articles.⁶

2.4.4. TO intention scale

Turnover intention scale was developed and validated by Bothma and Roodt.¹⁵ It consists of 15 questions, rated on a 5-point scale. The midpoint of the scale is 18. Scores below 18 indicates a desire to stay, while scores above 18 indicates a desire to leave the organization. Cronbach alpha for TO intention scale is 0.80. The construct validity was established by the tool developer and consultants.¹⁵

2.5. Pilot study

Pilot testing was conducted with 15 staff nurses from different CCUs and EDs to ensure the tools' clarity, feasibility, reliability, and the time needed to complete the questionnaire for each participant. The participants reported that the questionnaires were clear with no need for modifications. To assess internal consistency, the Cronbach's alpha was computed. The Cronbach's alpha was 0.847 for NAQ-R, 0.721 for STS, and 0.859 for TO intention scale.

2.6. Data collection

A paper-based questionnaire was used for data collection; the researcher met the head nurse of each ED and CCU and explained the purpose of the study and its significance. The purpose of the study and relevant information were explained to the head nurses and nurse participants. The cover letter included detailed information explaining the purpose and significance of the study. The questionnaires were distributed by the researcher in collaboration with head nurses. The researcher confirmed that all participants met the inclusion criteria and signed the consent form. Nurses spent approximately 20 min to complete the questionnaires. The number of invited participants was 170, of them 150 agreed to participate and returned completed questionnaires. Data collection started at the end of July, 2022 and ended at the end of August, 2022.

2.7. Ethical considerations

The researcher obtained the IRB from the Ministry of Health for the government hospital and hospital administration for other selected hospitals. Anonymity was also provided to participants and the researcher referred to the participants by using numerical identifiers. Participation in the study was voluntary. All potential participants had the right to withdraw from the study at any time without any negative repercussions. The researcher provided all participants with information about the

study including its purpose, significance, procedure, study risks and benefits, and time needed to complete the study.

2.8. Data management and analysis

Data were analyzed using the IBM SPSS (SPSS) version 26 (IBM Corporation, Armonk, New York, United States). Descriptive statistics were used to describe the characteristics of the study participants. Descriptive statistics were also employed to identify the scores of the main variables in the study including bullying, TO, and STS. An independent *t*-test was used to examine the difference in continuous variables based on the dichotomous variables. To examine the difference in continuous variables based on variables with >2 categories, one-way ANOVA test was used. Pearson correlation coefficient test also was used to examine the relationships between the continuous variables (bullying, STS, TO intention, experience, and age). Multiple regression analyses were used to examine the unique role of bullying in predicting STS and TO intention.

3. Results

3.1. Sociodemographic characteristics

A total of 150 nurses participated in the study. The mean age was 28 years (SD = 4). The sample is almost equally split into male (*n* = 73, 48.7%) and female (*n* = 77, 51.3%) participants, and more than half were single (*n* = 78, 52.0%). In terms of educational level, the majority had an undergraduate degree (*n* = 135, 90.0%).

As for the workplaces, more than half of the participants were employed by the government hospital (*n* = 80, 53.3%) followed by the teaching hospital (*n* = 40, 26.7%) and the private hospital (*n* = 30, 20.0%). The majority of the participants worked in the EDs (*n* = 61, 40.7%) while the rest worked in CCUs namely medical-surgical CCU (*n* = 43, 28.7%), neonatal CCU (*n* = 19, 12.7%) and pediatric CCU (*n* = 27, 18.0%). The mean length working experience as a nurse was 5.6 years (SD = 3.4) while the mean length of working in the current department was 3.4 years (SD = 2.6 years). The average number of patients taken care of on a daily basis was 14 (SD = 20) patients. Last, in terms

Items	Mean	SD	Frequency (n)	Percentage (%)
<i>Age (years)</i>	28	4		
<i>Years of experience</i>	5.6	3.4		
<i>Years employed in current department</i>	3.4	2.6		
<i>Number of patients cared for</i>	14	20		
<i>Monthly salary</i>	508.7	87.3		
<i>Gender</i>				
Male			73	48.7
Female			77	51.3
<i>Marital status</i>				
Single			78	52
Married			72	48
<i>Educational attainment</i>				
Bachelor (undergraduate)			135	90
Master's or PhD (postgraduate)			15	10
<i>Hospital</i>				
Government hospital			80	53.3
Teaching hospital			40	26.7
Private hospital			30	20
<i>Area of work</i>				
Emergency			61	40.7
Critical care			89	59.3
Medical-surgical CCU			43	28.7
Neonatal CCU			19	12.7
Pediatric CCU			27	18

Table 1. Sociodemographic characteristics.

of monthly salary, the mean pay was 508.7 Jordanian Dinar (JD) (SD = 87.3 JD). Table 1 shows the sociodemographic characteristics of participants.

3.2. Bullying behavior, TO intention, and STS among the participants

Table 2 shows the M, SD, range, frequencies, and percentages of experiencing bullying. The mean scores for overall bullying behavior was 62.1 (SD = 11.6) which meant that participants had overall severe experiences/victim of bullying in their workplaces. In addition, it was found that about 10.7% and 89.3% were categorized as “occasionally bullied” and “victims of workplace bullying” subsequently. The mean scores for STS were 29.7 (SD = 5.8), suggesting moderate levels of STS among participants. The overall mean scores of TO intention were 52.0 (SD = 7.3), indicating high TO intention and a desire to leave the organization among the nurse participants.

3.3. Relationships between bullying behavior, TO intention, and STS

Bullying behavior had a significant moderate positive relationship with TO intention ($r = 0.46$, $P < 0.001$), which meant that nurses who had higher levels of bullying experience demonstrated higher intention to leave the organization. Results are similar to that of bullying behavior and STS, as nurses who had higher levels of bullying experience reported higher scores on STS ($r = 0.36$, $P < 0.001$). Finally, a significant moderate positive relationship was found between TO intention and STS, with nurses expressing lesser desire to stay in the organization being those who reported higher levels of STS ($r = 0.36$, $P < 0.001$).

3.4. Inferences on sociodemographic characteristics

Inferential tests were performed to determine whether significant differences or relationships existed among

bullying behavior, TO intention and STS of emergency and critical care nurses based on their sociodemographic characteristics (Table 3). In terms of bullying, significant differences were found based on the hospital and department participants were working in. Nurses working in the government hospital had significantly higher levels of bullying experience than nurses working in the private hospital ($P < 0.001$). In addition, nurses working in the EDs had significantly higher levels of bullying experience than nurses working in the medical-surgical CCUs ($P < 0.001$) and pediatric CCUs ($P < 0.05$). Moreover, a significant weak positive relationship was found between the average number of patients taken care of in a shift and overall bullying behavior, which meant that nurses who had higher patient load also reported higher levels of bullying experience ($r = 0.23$, $P < 0.05$). No other significant differences or relationships were found based on other sociodemographic characteristics.

On the other hand, there was a significant weak negative relationship between TO intention and the nurses' age ($r = -0.18$, $P < 0.05$), length of experience working as a registered nurse ($r = -0.18$, $P < 0.05$), and length of experience working in the current department ($r = -0.21$, $P < 0.05$). These results suggested that nurses who were younger and had shorter years of experience working as a registered nurse and working in their current departments expressed a higher desire to leave the organization. In addition, nurses working in the government hospital had significantly higher levels of TO intention than nurses working in the private hospital ($P < 0.001$). No other significant differences or relationships were found based on other sociodemographic characteristics.

When looking at STS, significant differences on scores were only found based on the workplace. No other significant differences or relationships were found based on other sociodemographic characteristics. Nurses working in the teaching hospital had significantly higher levels of STS compared to nurses working in the private hospital ($P < 0.05$).

Items	Mean	SD	Possible range	Interpretation	N (%)
Total score of NAQ-R	62.1	11.6	20–32	Not bullied	0 (0.0)
			33–44	Sometimes bullied	16 (10.7)
			>45	A victim of workplace bullying	134 (89.3)
Work-related	14.8	2.8			
Personal-related	13.6	2.9			
Physically intimidating	14.3	3.8			

Table 2. The score of NAQ-R and its interpretation.

Variety and category	B	TO	STS
<i>Gender</i>			
Male	61.2 (11.4)	51.6 (6.3)	30.0 (5.3)
Female	62.9 (11.7)	52.4 (8.2)	29.5 (6.1)
<i>t</i>	−0.87	−0.64	0.49
<i>P</i> -value	0.685	0.067	0.390
<i>Age</i>			
<i>r</i>	−0.09	−0.18	0.05
<i>P</i> -value	0.286	0.033*	0.565
<i>Marital status</i>			
Single	63.3 (12.4)	52.7 (7.5)	29.6 (5.8)
Married	60.7 (10.5)	51.2 (7.1)	29.8 (5.8)
<i>t</i>	1.37	1.18	−0.23
<i>P</i> -value	0.168	0.860	0.819
<i>Educational attainment</i>			
Bachelor's	62.5 (11.5)	52.1 (7.2)	29.8 (5.6)
Master's	58.7 (12.0)	51.3 (8.3)	28.7 (6.8)
<i>t</i>	1.21	0.40	0.75
<i>P</i> -value	0.844	0.233	0.562
<i>Hospital**</i>			
The government hospital	64.26 (11.68)	54.35 (6.10)	29.86 (5.87)
Teaching hospital	64.0 (5.63)	52.35 (5.34)	31.05 (3.58)
Private hospital	62.08 (13.43)	45.16 (8.42)	27.566 (7.17)
<i>F</i>	11.22	22.16	3.29
<i>P</i> -value	0.000*	0.000*	0.040*
<i>Department**</i>			
ED	65.67(9.68)	52.15 (7.48)	28.5 (7.18)
Medical-surgical CCU	58.06 (11.91)	51.15 (6.57)	32.1 (8.41)
NCCU	63.94 (12.78)	53.8 (7.12)	34.10 (7.13)
Pediatric CCU	59.03 (11.71)	51.29 (8.31)	29.22 (7.70)
<i>F</i>	4.83	0.60	0.68
<i>P</i> -value	0.003*	0.616	0.563
<i>Years of experience as a registered nurse</i>			
<i>r</i>	−0.07	−0.18	0.03
<i>P</i> -value	0.367	0.025*	0.756
<i>Years employed in the current department</i>			
<i>r</i>	−0.01	−0.21	0
<i>P</i> -value	0.909	0.009*	0.980
<i>Patient load per shift</i>			
<i>r</i>	0.23	0.06	0
<i>P</i> -value	0.005*	0.459	0.952
<i>Monthly income</i>			
<i>r</i>	−0.10	−0.12	−0.12
<i>P</i> -value	0.222	0.144	0.158

Note: ** $P < 0.01$; * $P < 0.05$; B, bullying; STS, secondary traumatic stress; TO, turnover intention; NCCU: Neurocritical care unit.

Table 3. Sociodemographic characteristics, bullying behavior, TO intention and STS, M (SD).

3.5. The unique role of bullying in STS and TO intention

Hierarchical multiple linear regression was performed to determine the unique role of bullying in STS and TO intention of EDs and critical care nurses, controlling for demographic characteristics (Tables 4 and 5). Private workplace was significantly associated with STS in bivariate analysis. Therefore, it was entered into the first step of regression analysis while bullying was entered into the second model. Both models were significant ($P < 0.001$). Private workplace accounted for only 3.5% of the variance and bullying for about 10.1% of the variance. However, in the second model, only bullying was significantly associated with STS ($t = 4.146$, $B = 0.341$, $P < 0.001$).

To assess the role of bullying in TO intention, the demographic variables associated with TO were entered in the first model, while bullying was entered in the second model. Both models were significant ($P < 0.001$).

Demographic variables accounted for 25.1% of the variance and bullying accounted for about 9.6% of the variance in TO intention. However, in the second model, only private workplace ($t = 4.52$, $B = 0.33$, $P < 0.001$) and bullying ($t = 4.59$, $B = 0.34$, $P < 0.001$) were significantly associated with TO intention.

4. Discussion

The results showed high levels of bullying behavior experienced by the participants across all hospital sites. In this study, levels of bullying behavior were higher compared to the levels measured by a previous research that investigated bullying behavior in other healthcare environments in Jordan.¹⁶ The results of this study suggest that some EDs and CCUs had nursing staff members reporting worse experiences of being victimized by bullies compared to others. Despite the number of studies conducted in this area and the several recommendations to put policies and plans in place

Roll	B	Std. error	Beta	<i>t</i>	<i>P</i> -value
<i>Roll 1</i>					
(Constant)	24.875	2.134		11.658	0
Private hospital	2.692	1.157	0.188	2.326	0.021
<i>Roll 2</i>					
(Constant)	17.533	2.691		6.516	0
Private hospital	0.912	1.179	0.064	0.774	0.440
Bullying	0.170	0.041	0.341	4.146	0

Note: R1 square change = 0.035; R2 square change = 0.101; STS, secondary traumatic stress.

Table 4. The unique role of bullying in STS.

Roll	B	Std. error	Beta	<i>t</i>	<i>P</i> -value
<i>Roll 1</i>					
(Constant)	35.68	5.21		6.84	0
Age	0.15	0.19	0.09	0.78	0.436
Private hospital	8.27	1.32	0.46	6.26	0
Experience in the nursing	-0.32	0.28	-0.15	-1.14	0.257
Experience in department	-0.29	0.29	-0.11	-1.03	0.303
<i>Roll 2</i>					
(Constant)	26.07	5.31	0	4.91	0
Age	0.16	0.18	0.10	0.93	0.357
Private hospital	6.02	1.33	0.33	4.52	0
Experience in the nursing	-0.23	0.26	-0.11	-0.88	0.383
Experience in department	-0.42	0.27	-0.15	-1.57	0.119
Bullying	0.21	0.05	0.34	4.59	0

Note: R1 square change = 25; R2 square change = 9.6; TO, turnover.

Table 5. The unique role of bullying in TO intention.

that will not tolerate, reduce, and eliminate incidences of bullying, bullying behaviors remain prevalent in some Jordanian hospitals.^{17,19,20}

The results of the study showed high levels of TO intention among the nurse participants across all hospital sites, which meant that they had lesser desire to stay within the organization. High TO intention has the potential to significantly affect the adequacy of the nursing workforce, especially when viewed within the context of existing staff shortages and poor skill mix allocations. AS healthcare organizations struggle to recruit to meet vacancy requirements, the strategy would be to employ subsequent interventions to increase staff retention and lessen the number of resignations. However, high TO rates disrupt staffing numbers because nurses leave instead of staying in their current job roles.^{21,22} It should be noted, though, that TO intention only pertains to the desire or intent to leave the organization but does not necessarily translate to actual TO rates.²³ This implies that there is a possibility to significantly reduce actual TO rates by early implementation of interventions to curb TO intention.²³

The results of the study showed moderate levels of STS among emergency and critical care nurses. Internationally, scores are higher among the participants compared to other nursing groups who scored lower STS scores.²⁴ Locally, there is a scarcity of studies that recently investigated STS among Jordanian nurses. Measuring STS is necessary because it provides insight into how nurses feel regarding the way they carry out their job roles and responsibilities, especially when considering that Jordanian emergency and critical care nurses scored higher in this aspect compared to their peers.¹⁸

Participants who reported high scores on bullying behavior and TO intention had high scores of STS. In addition, workplace bullying was a unique predictor of TO intention and secondary of traumatic stress in the critical care nurses and ED nurses. The results of the study are similar to those of other studies that investigated the negative effects of bullying and other hostile behaviors.^{25,26} Moreover, the results validated that the debilitating impact of bullying behaviors similarly affects ED and CCU nurses working in Jordanian healthcare settings. The results should demonstrate the need for nurse managers and hospital administrators to take action against bullying behaviors, and ensure that its occurrence is not only reduced but all the more eliminated in the workplace. In addition, clear and effectively implemented interventions to reduce workplace bullying will improve the quality of work for nurses.²⁷

The results of the study showed that years of experience and the workplace are the variables that

significantly predicted TO intention. While years of experience is an individual- and personal-level variable, it is inexorably tied to the workplace. Therefore, it is not unexpected that nurses with shorter years of experience had higher scores for TO intention because once they realized that the workplace did not meet their expectations, they would not possess the desire to stay in the organization.²⁸ It is worth noting that workplace in this context did not only refer to the physical infrastructure but to the totality of the healthcare organization, including all tangible (e.g., workforce, staffing, resources, policies, guidelines, pathways, supplies, equipment, etc.) and intangible (e.g., interpersonal relationships, organizational culture, patient safety climate, leadership, managerial support, job satisfaction, etc.) elements of the hospital and department sites.²⁹ The existence of any adversarial behavior that can negatively impact the physical and mental health and well-being of nurses is under the umbrella of the workplace. As such, nurse managers and hospital administrators must consider the significant contribution of the quality of the workplace to the intention of nurses on whether to stay or leave their current job posts.³⁰ Interventions that can improve the quality of the nursing work environment should be explored and implemented.²⁷

4.1. Recommendations

Healthcare organizations must implement a zero-tolerance policy regarding bullying behaviors. However, the results of the previous studies showed the persistent prevalence of bullying suggesting that the existence of policies may not be enough as a preventive measure. As such, the implementation of policies must be monitored through regular audits and continuous quality improvement efforts. Nurse managers and hospital administrators must monitor whether policies are strictly followed as demonstrated by timely reporting observed or experienced bullying events, disciplinary actions for perpetrators, adequate managerial support for victims, resolution of the bullying event, and evidence of learning and sharing based on the event. Managers and hospital administrators must take advantage of the possibility of reversing TO intention and perform targeted approaches that can enjoin staff nurses to remain and continue working for the organization.

The results revealed that workplace was the most significant factor associated with TO intention apart from lesser years of experience suggesting that the quality of the healthcare environment encountered by new members of staff largely dictated their desire on whether to remain or leave the organization. As such, healthcare organizations should ensure that their workplaces are

safe and healthy for nurses and other members of staff to grow personally and professionally, and that support systems are available to manage any issues or concerns that nurses encounter during the performance of their daily duties and responsibilities.

Nurse educators should develop and formulate educational and training programs on how to recognize, report, and deal with any observed or experienced traumatic behaviors. Literature has shown that some of the reasons why negative behaviors exist are because nurses don't have the skills to recognize them when it happens, and don't have the self-efficacy to report said behaviors for fear of repercussions from the perpetrators. Therefore, there is value in implementing educational and training programs that can equip nurses with the ability to recognize, report, and act on any witnessed or experienced events of bullying regardless of who the perpetrator is.

Future research should center on investigating why bullying persists among nurses in healthcare environments that are supposed to champion positive behaviors such as caring, compassion, kindness, and respect. Nurse researchers should also aim to examine what interventions might prove effective in reducing, and eventually eliminating, bullying behaviors, taking into account sociodemographic and professional characteristics that allow the persistence of negative behaviors. Moreover, while healthcare organizations claim to possess policies that prevent and discourage bullying behavior, very little research has been done to measure the effect of actual policy implementation on the elimination of bullying behaviors. Future research has the potential to address these concerns.

4.2. Strengths and limitations

Theoretically, the primary strength of the study is its contribution to the body of knowledge that can help planners, managers, and future researchers to better understand the phenomenon of bullying and its consequences on ED and CCU nurses. Methodically, the primary strength of the study is its adequate sample size and use of valid and reliable tools to measure the variables of interest. On the other hand, the study has some limitations. First, the study is cross-sectional in nature, which means that variables were only measured at one point in time. Therefore, there are no data available as a trend, and nurse managers and administrators do not have any idea about changes on the levels of bullying behavior, TO intention, CS, and STS over a period of time. Second, the study was limited to emergency and

critical care nurses who are already exposed to highly stressful and emotionally laden environments.

5. Conclusions

Bullying behavior has negative, adversarial effects on TO intention and the experience of STS. However, despite the increasing awareness of the effects of bullying behaviors and the need to have such eliminated within healthcare organizations, emergency and critical care nurses still reported experiencing high levels of hostile and uncivil acts within the workplace. The persistence of bullying, the high TO intention, and STS can have significant implications on clinical practice, policy and nursing research. Healthcare organizations should put systems in place to ensure that zero tolerance policies are not only in place but are also monitored in terms of the extent and effectiveness of its implementation. Nurse managers and hospital administrators should also formulate and carry out plans that will reduce TO intention and eliminate STS to promote the physical and mental health and well-being of nurses and encourage them to stay and grow professionally within the organization.

Bullying behavior should be eliminated as much as possible because it creates an atmosphere that is non-favorable for nurses to care for their patients in a safe, secure and accurate manner. Moreover, with higher TO intention and STS in environments where bullying is prevalent, nurses will intend to eventually leave their jobs, and this scenario exacerbates stressed-out healthcare organizations that are already struggling with staff shortages and poor skill mix allocations.

If nurses had a high desire to leave the organization because of increased levels of negative psychological reactions as a result of being bullied or negatively treated by other members of staff, healthcare organizations will struggle to prevent staff from resigning their posts, and will, in turn, find it difficult to recruit and fill in the vacancies.

Ethical approval

The researcher obtained the IRB from the Ministry of Health for the government hospital and from the hospital administration for other selected hospitals.

Conflicts of interest

All contributing authors declare no conflicts of interest.

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