Analyzing the Effects of Workplace Bullying on Psychological Wellbeing of Nursing Professionals

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1 Introduction

Workplace bullying represents a significant occupational hazard within healthcare settings, particularly affecting nursing professionals who operate in high-stress environments characterized by hierarchical structures and intense interpersonal dynamics. The nursing profession, fundamental to healthcare delivery systems worldwide, faces unprecedented challenges regarding workforce retention and mental health preservation. While previous research has established correlations between workplace bullying and various negative outcomes, the precise mechanisms through which bullying affects psychological wellbeing remain inadequately explored. This study addresses critical gaps in the existing literature by examining not only the direct effects of bullying but also the mediating and moderating variables that influence this relationship.

The novelty of our approach lies in the development of a comprehensive theoretical framework that integrates elements from organizational psychology, trauma theory, and resilience research. We move beyond traditional bullying assessment methods by creating multidimensional measurement tools that capture the complexity of bullying experiences in healthcare contexts. Furthermore, our longitudinal design enables us to track the temporal dynamics of bullying effects, revealing how psychological impacts evolve over time and identifying critical intervention points.

Our research addresses three primary questions that have received limited attention in previous studies: How do different forms of workplace bullying vary in their psychological impact on nursing professionals? What individual and organizational factors moderate the relationship between bullying experiences and psychological outcomes? At what threshold does workplace bullying begin to produce clinically significant psychological distress? By answering these questions, we contribute both theoretically and practically to the understanding and mitigation of workplace bullying in healthcare environments.

2 Methodology

2.1 Research Design

This study employed an innovative sequential explanatory mixed-methods design conducted over an 18-month period from January 2022 to June 2023. The quantitative phase involved longitudinal survey administration at three time points (baseline, 9 months, and 18 months), while the qualitative phase consisted of in-depth phenomenological interviews with a purposively selected subsample of participants. This design enabled both statistical generalization and rich contextual understanding of bullying experiences.

2.2 Participants

Our sample comprised 347 nursing professionals recruited from six healthcare institutions representing diverse organizational contexts including academic medical centers, community hospitals, and specialized care facilities. Participants included registered nurses (68%), licensed practical nurses (19%), and nurse practitioners (13%) with experience ranging from 1 to 35 years (M=12.4, SD=8.7). The sample was predominantly female (87%), reflecting the gender distribution within the nursing profession.

2.3 Measures

We developed and validated several innovative instruments specifically for this study. The Workplace Bullying Severity Index (WBSI) measures bullying experiences across four dimensions: frequency (5-point scale from never to daily), intensity (7-point distress scale), duration (months experienced), and psychological impact (10-item subscale). Psychological wellbeing was assessed using a composite measure incorporating the Depression Anxiety Stress Scales (DASS-21), the Professional Quality of Life Scale (ProQOL), and the Psychological Wellbeing Scale (PWS). Additionally, we measured potential moderating variables including social support, resilience, organizational climate, and professional self-efficacy using validated instruments adapted for healthcare contexts.

2.4 Data Analysis

Quantitative data analysis employed advanced statistical techniques including hierarchical linear modeling to account for nested data structures, structural equation modeling to test our theoretical framework, and survival analysis to identify critical thresholds in bullying experiences. Qualitative data underwent phenomenological analysis using Colaizzi's seven-step method to identify essential themes and structures of the bullying experience. Integration of quantitative and qualitative findings followed a complementary approach where qualitative data helped explain and contextualize statistical relationships.

3 Results

3.1 Prevalence and Forms of Workplace Bullying

Our findings revealed that 67% of nursing professionals experienced at least one form of workplace bullying during the study period, with verbal aggression being most prevalent (52%), followed by professional undermining (41%), exclusionary behaviors (33%), and work-

related bullying (28%). The Workplace Bullying Severity Index demonstrated excellent psychometric properties (Cronbach's =.92) and revealed significant variations in bullying experiences across different healthcare settings and nursing specialties.

A particularly novel finding emerged regarding the cumulative threshold effect. Nursing professionals who experienced bullying behaviors at or above the 75th percentile on the WBSI showed a 3.7 times greater likelihood of developing clinically significant psychological distress compared to those below this threshold. This nonlinear relationship suggests that bullying impacts accelerate beyond certain intensity or frequency levels, providing important insights for intervention targeting.

3.2 Psychological Impact Analysis

Structural equation modeling revealed that workplace bullying accounted for 42% of the variance in psychological distress scores, with direct effects (=.58, p¡.001) and indirect effects mediated by professional self-efficacy (=.34, p¡.001) and organizational support (=.29, p¡.001). The bystander amplification effect emerged as a significant finding, with nurses who witnessed bullying but were not direct targets showing psychological distress levels 82% as severe as direct targets, highlighting the pervasive psychological contamination of bullying environments.

Longitudinal analysis demonstrated that psychological impacts evolved through distinct phases: initial reaction (first 3 months), adaptation/resistance (3-9 months), and consolidation (9+ months). Nurses who developed effective coping strategies during the adaptation phase showed significantly better long-term outcomes, suggesting critical windows for intervention.

3.3 Moderating and Mediating Factors

Our analysis identified several significant moderators of the bullying-psychological wellbeing relationship. Social support from colleagues emerged as the strongest protective factor (mod-

eration effect: =-.41, p¡.001), followed by organizational justice perceptions (=-.33, p¡.001) and professional resilience (=-.28, p¡.001). Interestingly, individual demographic factors including age, gender, and years of experience showed minimal moderating effects, suggesting that organizational and interpersonal factors play more crucial roles in determining psychological outcomes.

The qualitative findings provided rich contextual understanding of these statistical relationships. Participants described how supportive unit cultures and effective leadership buffered against bullying impacts, while hierarchical structures and tolerance of bullying behaviors exacerbated psychological harm. The phenomenological analysis revealed that the meaning nurses attributed to bullying experiences significantly influenced psychological outcomes, with experiences interpreted as professional challenges rather than personal attacks associated with better adaptation.

4 Conclusion

This study makes several original contributions to the understanding of workplace bullying's effects on nursing professionals' psychological wellbeing. The development and validation of the Workplace Bullying Severity Index provides researchers and practitioners with a comprehensive tool for assessing bullying experiences beyond simple frequency counts. The identification of the cumulative threshold effect offers important insights for targeted interventions, suggesting that resources should prioritize individuals experiencing bullying above critical severity levels.

The bystander amplification effect represents a previously underappreciated dimension of workplace bullying, indicating that anti-bullying initiatives must address environmental contamination in addition to direct victimization. Our findings regarding the temporal evolution of psychological impacts provide guidance for timing interventions, with the adaptation phase emerging as particularly crucial for developing effective coping strategies.

From a practical perspective, our research suggests several evidence-based interventions for healthcare organizations. Developing supportive unit cultures, enhancing organizational justice, and building professional resilience represent promising approaches for mitigating bullying impacts. Training programs should address both potential targets and bystanders, given the significant psychological effects on witnesses. Organizational policies must move beyond simple anti-bullying statements to create structures that support reporting, intervention, and cultural change.

Future research should explore the specific mechanisms through which organizational factors moderate bullying impacts and investigate the long-term career consequences of workplace bullying. Additionally, intervention studies testing the effectiveness of strategies targeting the identified moderating factors would advance both theoretical understanding and practical application. The nursing profession's sustainability depends on addressing workplace bullying systematically, and this study provides important foundations for such efforts.

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