



Resilience Relationship with Moral and Power Harassment in Iranian Critical Care Nurses

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Abstract

Background: The escalating prevalence of moral harassment in the high-stress environment of the intensive care unit is impacting the overall health of nurses, ultimately putting patient health, safety, and even lives at risk. This issue is becoming increasingly significant. One common form of moral harassment is the misuse of authority within the treatment system. This study aims to determine the relationship between resilience and moral and power harassment in critical care nurses.

Methods: This cross-sectional study was conducted in 2022-23. The study included a sample size of 106 critical care nurses in hospitals affiliated with Tehran University of Medical Sciences in Tehran, Iran. Sampling was carried out using a stratified random method. Data collection involved demographic, moral harassment, power harassment and resilience questionnaires. Analysis was performed using SPSS software version 19, with descriptive statistics and the Pearson correlation test.

Results: The study revealed that the mean±SD resilience score for nurses overall was 89.01±19.50, with mean±SD for moral harassment at 16.99±14.54 and power harassment at 66.9±9.31. Spearman's correlation coefficient test showed a significant and poor relationship between power harassment and moral harassment among nurses ($p<0.001$, $r=0.647$), as well as a significant and negative relationship between power harassment and resilience ($p<0.001$, $r=-0.357$), and moral harassment and resilience ($p<0.001$, $r=-0.387$).

Conclusion: Resilience plays a crucial role in mitigating the negative effects of power and moral harassment in the workplace, impacting the perceived health of individuals. Resilience helps explain the distress caused by power harassment and moral harassment in the workplace.

Keywords: Critical care, Intensive care units, Iran, Morals, Prevalence, Psychological, Resilience, Sample size, Workplace

Introduction

Workplace violence is a leading cause of job dissatisfaction among nurses, resulting in absenteeism and department transfers (1). If nurses remain in their roles, they may suffer emotional damage from workplace violence, leading to conditions such as post-traumatic stress disorder, burnout, anxiety, depression, and an inability to provide quality patient care (2).

Psychological violence, also known as workplace bullying, is a significant form of workplace violence, with some considering harassment of power as a type of workplace bullying. This term was first introduced by Japanese workers in 1995, describing situations where individuals in positions of power misuse their authority through behavior, words, or actions to harass others. Reports of power harassment in Japan increased from 6.4 in 2002 to 20.3% in 2012, suggesting a significant rise in such incidents over the years (3).

This harassment can manifest in various forms, including physical attacks, humiliation, verbal insults, and interference with an individual's personal life. It may also be accompanied by other forms of harassment, such as sexual harassment (4). Superiors inflicting such behavior on subordinates can cause physical pain and emotional distress (5).

Experts often equate harassment of power with bullying, with the term "pawa hara" being used in Japan as an alternative to workplace bullying. The Labor Policy Council of Japan distinguishes this harassment as occurring specifically between managers and subordinates, emphasizing the power dynamics at play and the severity of resulting psychological and physical damage (6).

Moral harassment, a common form of harassment of power, involves intentional actions aimed at destabilizing an individual through repeated and severe attacks unrelated to factors like gender, age, or performance (7). It can be classified based on the direction of the harassment, including downward, upward, horizontal, or mixed forms (8). Key elements of moral harassment include temporality, duration, intentionality, direction, frequency, location, and deliberate disruption of working conditions through psychological attacks (9). According to Lyman, moral harassment is a dynamic process that begins

with critical injuries and sudden changes in personal relationships, involving direct or indirect attacks. Moral harassment then escalates with frequent aggressive and humiliating behaviors, labeling the victim. This is followed by guilt, emotional reactions, and psychosomatic symptoms. If human resources management takes decisive action and a multidisciplinary team follows up, this process can be disrupted. Otherwise, the victim may leave the workplace through voluntary resignation, dismissal, sick leave, or early retirement. In severe cases, suicide attempts have been observed in victims (10).

Moral harassment can easily occur in organizations with defined hierarchies and rigid procedures, especially in sectors like medicine and education, where duties are not clearly defined (9). The hospital environment is one such place where nurses may be exposed to moral harassment (11), particularly those working in critical care and emergency departments. Studies have shown that critical care nurses have a 3% weekly or daily prevalence of moral harassment and 30% experience it occasionally (12), leading to poor mental health, absenteeism, and job burnout (13).

Researchers have found that in the face of adversities in the work environment, nurses experience burnout and resilience as two opposite ends of a continuum. Strengthening resilience can help reduce burnout in nurses (14). Resilience refers to the ability to cope successfully with adverse conditions (15) and includes characteristics like social support, self-efficacy, work-life balance/self-care, humor, optimism, and realism (16). Developing resilience enables nurses to respond effectively to challenging situations and adapt to stress in the workplace (17).

Previous studies have highlighted the impact of moral harassment and harassment of power on nurses' performance and ethical behavior, as well as their positive and negative consequences.

In this study, researchers aimed to investigate the relationship between resilience, harassment of power, and moral harassment among nurses working in the intensive care unit to deepen understanding of factors related to nurses' ethical challenges.

Material and Methods

Research design

This cross-sectional study was conducted in 2022 in critical care units (ICU, CCU, and dialysis) of hospitals affiliated with Tehran University of Medical Sciences in Tehran, Iran. The research population consisted of all nurses working in the critical care department, with a sample size of 106 individuals at a confidence level of 95%.

Participants and research context

The criteria for participation included having at least a bachelor's degree in nursing, a minimum of 6 months of work experience in the intensive care unit, and no history of acute or known mental illness, drug harassment, or use of antidepressants and anxiety medications. Exclusion criteria involved the recent death of a first-degree relative and failure to complete at least 90% of the questionnaire items.

Sampling was done using the stratified random sampling method and a random numbers table. Data was collected through demographic profile questionnaires, the Connor and Davidson 2003 resilience questionnaire, the Inarsen and Rockens 2017 moral harassment questionnaire, and the power harassment questionnaire. The demographic profile questionnaire included information on gender, age, education level, work experience, shift work, marital status, work unit, and organizational position.

The resilience questionnaire comprised 25 statements scored on a Likert scale ranging from zero (completely false) to five (always true). It measured factors such as individual competence, trust in instincts, tolerance of negative emotions, and acceptance of change, safe relationships, control, and spiritual influences. Scores ranged from 25 to 125, with levels categorized as low, average, or high (18). The reliability of the resilience questionnaire was evaluated by Mohammadi *et al* in Iran, yielding a reliability coefficient of 0.93 (19).

The moral harassment questionnaire contained 22 statements scored on a Likert scale from 1 to 5, measuring exposure to negative and offensive behaviors in the last six months (20). The power harassment questionnaire consisted of 15 statements scored from 0 to 5, assessing behavioral situations related to harassment of power. Reliability coefficients for both questionnaires were measured in the Iranian context and found to be 0.74 and 0.81, respectively.

Data analysis

After obtaining written informed consent, questionnaires were distributed to nurses, who were given two weeks to complete and return them. Data was analyzed using SPSS version 19 software, with descriptive statistics and Pearson's correlation coefficient used to explore relationships between resilience, moral harassment, and power harassment. Research objectives and questions included examining the resilience, moral and power harassment experienced by nurses in critical care units of Tehran University of Medical Sciences in 2022. The study aimed to determine the relationships between resilience and moral harassment, as well as resilience and power harassment among critical care nurses.

Ethical approval

Ethical considerations were taken into account, with approval from the Ethics Committee of Tehran University of Medical Sciences (IR.TUMS.FNM.REC.1402.086) obtained prior to data collection. Participants were informed of the research objectives and the confidentiality of their information, and written informed consent was obtained.

Results

This study was conducted with the participation of 106 nurses working in intensive care units in selected medical sciences hospitals in Tehran. The average age of the subjects was 35.75 ± 7.49 years, ranging from 23 to 60 years old. Their average work experience was 9.35 ± 6.18 years, ranging from 1 to 30 years. Other demographic characteristics are shown in table 1.

According to the Kolmogorov-Smirnov test, the data distribution of the resilience variable was normal ($p=0.099$), but the moral harassment and power harassment variables were not normal ($p<0.001$ and $p<0.001$). The findings of the study showed that the average resilience score of nurses was 89.01 ± 19.50 , with a minimum score of 25 and a maximum score of 125. The classification of nurses' resilience scores showed that 3.8% (4 people) were at a low level, 31.1% (33 people) were at a medium level, and 65.1% (69 people) were at a good level. The average moral harassment score of nurses was 16.99 ± 14.54 , with a minimum score of 0 and a maximum score of 80. The classification of moral harassment scores of

Table 1. Demographic information of nurses participating in this study

Variables		N(%)
Age	<30	37(9.34)
	30-40	33(1.31)
	40-50	31(2.29)
	>50	5(7.4)
Sex	Male	39(8.36)
	Female	67(2.63)
Marital Statuses	Single	45(5.42)
	Married	61(5.57)
Educational level	Bachelor	78(6.73)
	Master	25(6.23)
	PhD	3(8.2)
Organizational position	Nurse	99(4.93)
	Head nurse	3(8.2)
	Supervisor	4(8.3)
Work experience/year	<5	37(9.34)
	5-10	33(1.31)
	10-20	31(2.29)
	>20	5(7.4)
Critical Care Unit	G-ICU	9(5.8)
	CCU	2(9.1)
	Dialysis	72(9.67)
	Cancer ICU	2(9.1)
	Emergency ICU	12(3.11)
	Open heart ICU	9(5.8)

nurses showed that 69.8% (74 people) were at a low level, 25.5% (27 people) were at a medium level, and 4.7% (5 people) were at a high level. The average power harassment score of nurses was 10.66 ± 9.31 , with a minimum score of 0 and a maximum score of 47. The classification of nurses' power harassment scores showed that 73.6% (28 people) were at a low level, 19.8% (21 people) were at a medium level, and 6.6% (7 people) were at a high level. There was no statistically significant relationship between all the demographic variables investigated in the study and the variables of resilience, harassment of power, and moral harassment ($p > 0.05$) (Table 2).

Using Spearman's correlation coefficient test, it was observed that there is a significant and direct relationship between power and moral harassment in working nurses; as the power harassment variable increases, moral harassment increases and *vice versa* ($p < 0.001$ and $r = 0.647$).

There is a significant and inverse relationship between harassment of power and resilience in working nurses; as the harassment of power variable increases, resilience decreases and *vice versa* ($p < 0.001$ and $r = -0.357$). There is also a significant and inverse relationship between moral harassment and resilience in working nurses; as the moral harassment variable increases, resilience decreases and *vice versa* ($p < 0.001$ and $r = 0.387$) (Table 3).

The simultaneous effect of the independent variables investigated in the study on the resilience variable was examined using a multiple regression model. The independent variables were entered into the regression equation step by step in the order of their importance in

Table 2. Relationship of variables of resilience, abuse of power and moral harassment of critical care nurses with demographic characteristics

	Number	Resilience		Moral harassment		Power harassment	
		Mean \pm SD	p-value	Mean \pm SD	p-value	Mean \pm SD	p-value
Age	>30	29	41.72 \pm 22.89	0.553	86.17 \pm 10.16	0.758	92.27 \pm 9.10
	30-40	51	97.33 \pm 16.90		27.00 \pm 17.18		15.07 \pm 12.11
	40-50	21	91.71 \pm 22.83		69.57 \pm 11.14		92.80 \pm 8.9
	>50	5	45.80 \pm 6.93		27.60 \pm 15.21		15.20 \pm 9.12
Sex	Male	39	88.15 \pm 24.90	0.650	61.46 \pm 14.15	0.254	92.56 \pm 9.10
	Female	67	73.35 \pm 15.88		53.88 \pm 14.17		03.71 \pm 8/10

Contd. table 2.

Marital status	Single	45	62.77±22.89	0.733	68.40±16.17	0.796	75.91±11.10	0.853
	Married	61	02.45±17.88		86.68±12.16		06.47±11.10	
Education level	Bachelor	78	57.00±19.87	0.192	16.92±14.16	0.950	96.32±10.10	0.975
	Master	25	88.16±18.94		39.28±16.17		93.96±12.11	
	PhD	3	61.66±17.98		22.33±12.16		09.66±7.8	
Organizational position	Nurse	99	91.69±19.88	0.816	63.52±14.17	0.559	49.09±10.11	0.204
	Head Nurse	3	94.50±4.83		09.50±16.17		12.50±5.5	
	Supervisor	4	98.00±10.94		61.25±6.6		03.00±4.5	
Work experience/ year	5<	37	16.35±19.89	0.496	91.56±13.17	0.088	03.51±10.11	0.478
	5-10	33	95.24±20.84		53.24±16.19		92.93±10.12	
	10-20	31	73.96±18.92		49.64±13.14		73.96±6.7	
	20>	5	04.60±14.93		80.40±11.12		92.00±5.6	
Critical Care Unit (CCU)	G-ICU	9	42.00±11.91	0.103	66.44±19.19	0.317	47.77±13.14	0.110
	CCU	2	41.00±1.99		41.00±11.17		12.50±2.13	
	Dialysis	72	80.86±18.88		84.81±13.16		75.54±8.10	
	Cancer ICU	2	06.50±16.80		55.00±15.29		48.00±8.24	
	Emergency ICU	12	78.50±25.93		91.41±12.13		44.58±4.9	
	Open heart ICU	9	74.66±14.88		66.77±10.15		36.66±9.10	

Table 3. The relationship between variables of resilience, harassment of power and moral harassment critical care nurse

	Resilience	Moral harassment	Power harassment
Resilience	1	-	-
Moral harassment	-0.387**	1	-
Power harassment	-0.357**	0.647**	1

explaining the dependent variable. In this regression model, only two variables, harassment of power ($T=-4.28$, $p<0.001$) and education ($T=2$, $p=0.037$), were entered into the model. The final model had a good fit ($F=22.17$, $p<0.001$). Additionally, the two variables (power and education) were able to explain and predict 18% of the changes in the resilience variable, while the rest of the changes in the resilience variable were explained by other variables that were not investigated in the study ($r\text{-square} = 0.18$) (Table 4).

Table 4. The simultaneous effect of the independent variables examined in the study on the variable of resilience by means of multiple regression model

Variables	Not standardized coefficients		Standardized coefficients	t-test	p-value
	(β)	Std. Error	Beta		
Constant	81.86	93.4	-	60.17	>0.001
Power harassment	-0.66	15.0	-0.383	-4.28	>0.001
Education	15.7	38.3	189.0	12.2	0.037

Discussion

The results of this study revealed a significant and direct relationship between harassment of power and moral harassment among working nurses. As the variable of harassment of power increases, moral harassment also increases, and *vice versa*. Additionally, the study found a significant and inverse relationship between harassment of power, moral harassment, and resilience in working nurses. As harassment of power and moral harassment increase, resilience decreases, and *vice versa*. Previous studies examining the relationship between resilience and workplace harassment are scarce, but those that have been conducted show negative relationships between these variables, as well as between resilience and mental and physical health (21).

This study, being one of the first in the field of moral harassment and resilience among nurses, utilized a researcher-made questionnaire. Due to the limited comparison opportunities, results from studies most similar to this one were used for comparison. For example, Hajjibabae *et al*'s study on bullying in the work environment of nurses revealed an inverse and significant relationship with the dimensions of assurance and quality assurance of nursing services in critical care and emergency departments. Although this study indicated a low level of bullying among nurses, it is crucial to implement detailed planning to recognize, prevent, and manage this phenomenon. Given the importance of the relationship between workplace bullying and the quality of nursing services, hospitals must ensure accurate and continuous fulfillment of promises. The study also highlighted that lower levels of workplace bullying are associated with higher quality nursing services. Therefore, further research should be conducted on the impact of workplace bullying on patient care and its quality in hospitals and healthcare centers (22).

The results of Morra *et al*'s study aimed at determining the psychological reactions of Lebanese nurses to workplace violence in intensive care units showed a positive and significant correlation between exposure to workplace violence and anxiety, especially among patients and their families. Although verbal harassment is more common among intensive care nurses in Lebanon compared to physical and sexual violence, the severity of the situation and its impact

on nurses' mental health and well-being cannot be ignored (23).

A study by Einarsen *et al* in a sample of 460 male industrial workers, supervisors, and managers in a Norwegian marine engineering industry showed that aggression and harassment are important problems in this organizational environment. On a weekly basis, 7% of men reported at least one of the following behaviors from co-workers or supervisors: teasing and insults, verbal harassment, rumors spread about themselves, insulting remarks, frequent reminders of mistakes, hostility, or silence when entering into a conversation or making an effort worthless. About 22% reported that they were subjected to one or more of these practices at least monthly. Although such practices and behaviors are now common and experienced by most organizational members, they may significantly impair mental health and well-being, as well as overall job satisfaction, occurring consistently and regularly. A significant correlation was found between exposure to harassment and job satisfaction and mental health and well-being. A strong correlation was found between exposure to harassment and dissatisfaction with coworker interactions (24).

Also, the results of another study by Einarsen *et al* aimed at bullying and harassment in the workplace and their relationship with the quality of the work environment: an exploratory study shows that the occurrence of bullying and harassment has a significant correlation with all seven measures of the work environment used in the study. Low satisfaction with leadership, work control, social climate, and especially the experience of role conflict are most associated with bullying. Additionally, the results show that different working conditions are related to bullying in different organizational environments. Only role conflict showed a consistent correlation with bullying in all subsamples. Working conditions accounted for 10% of the variance in bullying, which ranged from 7 to 24% in different sub-samples. The results indicate that both bullying victims and bullying observers report a poor quality work environment (25).

The results of Nielsen *et al*'s study with the aim of examining harassment of power in the workplace - a systematic review and meta-analysis of individual

health and well-being outcomes show a significant relationship between harassment of power and consequences such as mental health issues, job dissatisfaction, and the intention to leave the job (26). The results of the study by Meseguer *et al* aimed at determining the role of resilience between harassment of power in the workplace and health through mediation analysis show that exposure to bullying behaviors is linked to poorer health, and resilience plays a mediating role in the relationship between harassment of power in the workplace and employee health. According to this study, perceived power harassment disrupts the bio-psycho-social-spiritual balance in the workplace, and employees with lower levels of resilience experience a greater decline in their health when faced with power harassment, while those with higher resilience scores adapt better and succeed (27).

Moreover, the results of Maidaniuc-Chirilă *et al*'s study, aimed at determining the mediating role of resilience in the relationship between harassment of power in the workplace and pressure on Romanian employees, show that resilience influences the perceived health of workers when they experience situations of harassment of power in the workplace. Resilience helps to explain the symptoms of discomfort caused by harassment of power in the workplace (28). Fabri *et al*'s study aimed at determining the relationship between violence in the workplace and the quality of professional life in nurses revealed that the prevalence of workplace violence in the last 12 months was 65.3% verbal, 29.7% moral harassment, 17.8% physical, 1% sexual harassment, and 1% racial discrimination (29).

Sexual harassment was associated with racial discrimination, but there was no relationship between types of violence and job burnout. However, there was a relationship between workplace violence and quality of professional life (29). Sousa *et al*'s study, entitled "Predictors of Moral Harassment in Nurses Working in Intensive Care Units in Brazil", showed that 33% of participants were harassed at work, with 3% feeling harassed several times a week or almost daily. Predictors of moral harassment in this study included young nurses (under 30 years old), type of contract employment, working in intensive care or emergency departments, and work experience (less

than 5 years) or long tenure in the department (over 10 years) (12).

The results of Oletto *et al*'s study, aimed at determining the role of resilience in creating meaningful work for young Brazilian workers who have experienced moral harassment, showed that behavioral changes such as isolation, silence, introversion, and not taking moral harassment seriously can be signs of moral harassment in affected youth. The study also noted that young people often exhibit flexibility to maintain their jobs, either out of necessity or gratitude for the harassment they have endured. The findings suggest that moral harassment has a significant impact on the personal and professional lives of young people, leading to demotivation, impaired work performance, loss of work enjoyment, low self-confidence, and psychological issues (30).

Liu *et al*'s study, aimed at determining the relationship between workplace violence, job satisfaction, burnout of nurses, and patient safety, found that 28% of nurses had been verbally harassed by patients or their families repeatedly in the past 12 months, with a smaller percentage experiencing physical harassment from patients or families (93-96%) or from other employees. About a quarter of nurses reported moderate burnout, with half of them expressing satisfaction with their jobs. Approximately 7% of nurses rated patient safety in their units as poor. Workplace violence was associated with burnout, lower job satisfaction, poor patient safety, and increased adverse events. Nurse burnout and job satisfaction were found to be significant factors mediating overall patient safety and adverse events (31).

Sun *et al*'s study, aimed at determining the incidence of workplace violence among doctors and its relationship with mental stress, sleep quality, and mental health, found that verbal harassment had the highest prevalence (76.2%), followed by disruptive behavior (58.3%), humiliation (40.8%), mob behavior (40.2%), instilling fear and terror (27.6%), physical violence (24.1%), and sexual harassment (7.8%). Exposure to workplace violence significantly impacted the mental stress, sleep quality, and mental health of doctors (32).

Based on the results of this study and the reviewed studies, moral and power harassment in work environments, especially in the hospital environment

and among health care workers, are more prevalent. This can negatively affect their personal and social lives, leading to job burnout, reduced job satisfaction, and ultimately causing them to quit their jobs. Therefore, it is important to develop and implement measures against workplace violence and create a healthy environment for nurses.

Limitation

The study has certain limitations that should be noted. This study was one of the limited studies conducted in Iran. In order to generalize its results, this issue should be considered, and more extensive studies should be conducted on other working nurses in different provinces. It is also possible that nurses did not provide accurate information about power and moral harassment due to fear of disclosing their information to their superiors. Future studies could compare these findings with other outcomes such as job satisfaction, participation, or absenteeism. Additionally, more research is needed to determine if resilience can act as a moderating variable and under what conditions.

Future research should analyze the effects of resilience in the relationship between power harassment and moral harassment in the workplace, differentiating based on professional level, and considering additional variables as mediators to clarify the mediation process.

Conclusion

The results of this study indicate a significant and direct relationship between harassment of power and moral harassment in working nurses. As the variable of harassment of power increases, moral harassment

also increases, and *vice versa*. Furthermore, there is a significant and inverse relationship between harassment of power and moral harassment with resilience in working nurses. As the variables of harassment of power and moral harassment increase, resilience decreases, and *vice versa*. Resilience plays a role in the perceived health of individuals experiencing power and moral harassment in the workplace. Nursing managers and officials are recommended to provide full information to nurses about power and moral harassment, and to address these cases without bias towards the harassment individuals.

Ethics approval

This study was initiated after receiving ethical approval from the Ethics Committee of the Tehran University of Medical Sciences, Tehran, Iran and approved by Exceptional Talent Development Center. The study conformed to the principles of the Helsinki Declaration. All participating patients received verbal and written information on the study and provided informed consent to participate. They were guaranteed anonymity in the findings report and research analysis.

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Conflict of Interest

There are no conflicts of interest.

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