Scientific Reports in Medicine, 2025; 2(1): 8-18

Scientific Reports in Medicine

Research Article

The relationship between the mobbing situation of healthcare workers and their conflict action styles

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DOI 10.37609s/rinmed.43

Abstract

Objective: This study aims to examine whether there is a relationship between exposure to mobbing behaviors and conflict action styles among healthcare workers in Karabük Province.

Material and Method: This is a descriptive and cross-sectional study conducted with 225 healthcare workers in Karabük between May 15, 2023, and August 15, 2023. The data were collected using the Sociodemographic Information Questionnaire, the Mobbing Scale, and the Conflict Action Styles Scale.

Results: The participants' average score on the mobbing scale was found to be 82.15±44.10. Among the sub-dimensions of the mobbing scale, the highest score was obtained in the "relationships with colleagues" sub-dimension. Participants scored the highest in the "facilitating approach" sub-dimension of the Conflict Action Styles Scale. A significant difference was found between healthcare workers' exposure to mobbing and their marital status, profession, workplace, weekly working hours, job satisfaction, and smoking status. Additionally, significant differences were found between conflict action styles and gender, education, profession, weekly working hours, and job satisfaction.

Conclusion: Healthcare professionals are at risk of experiencing mobbing. This is an important issue that needs attention in terms of employee satisfaction and quality of life. Emphasizing mobbing and conflict action styles in training, implementing more comprehensive legal regulations, and improving working conditions are considered to be beneficial measures.

Keywords: Healtcare workers, Mobbing, Conflict action styles.

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Recieved: 2025-03-05
Accepted: 2025-03-24

INTRODUCTION

Mobbing is defined as psychological harassment, violence, intimidation, pressure, and similar behaviors carried out by one or more individuals in the same work environment towards an employee (1). It is described as any form of abusive, repetitive, and systematic behavior that jeopardizes an individual's dignity, physical, or mental integrity (2). The word "mobbing" is derived from the Latin term "mobile vulgus," which means an unstable crowd, originating from the root "Mob." In the dictionary, "Mob" is defined as "a disorderly crowd that engages in illegal violence" or "bullying" (3, 4).

The concept of mobbing was first scientifically introduced into the workplace context by Swedish psychiatrist Heinz Leymann in the 1980s. Leymann coined the term to describe a specific form of bullying towards employees in the workplace (5). He also used the term "psychological terrorism" in relation to mobbing in workplaces (6). Mobbing has become a recognized international workplace issue in the literature. This issue is evident in any country and culture (7). Mobbing can occur in both the private and public sectors, and every individual in the workforce is a potential victim of mobbing (8).

All employees in the healthcare sector can be subjected to mobbing behaviors. Factors contributing to mobbing in the healthcare sector include the need for various professional groups to work together, continuous work demands, stressful work environments, insufficient wages, bureaucratic barriers, lack of medical facilities, and unclear job descriptions (9). Due to the matrix organizational structure in hospitals, communication problems between employees are frequently encountered. Insufficient communication leads to misunderstandings and problems among employees (10). A study conducted internationally concluded that healthcare workers in hospitals, due to their unique structures, are exposed to mobbing behaviors 16 times more than those working in other service sectors (11). A retrospective study on 60 physician suicides in Italy over the past decade found that 20% of them were related to work problems involving mobbing (12).

Conflict is described as a situation where one person's demands, expectations, and interests are opposed, resisted, or differentiated by another group or individuals, creating the perception that reconciliation is no longer possible (13). In organizations where people come together for a common purpose, conflicts are natural due to differences in abilities, knowledge, skills, and experience among employees (14). Although conflict is often seen negatively, not all conflicts are destructive. A well-managed conflict can lead to positive outcomes, such as reviewing issues, becoming aware of problems, creating solutions, and improving relationships (15). Unresolved conflict, however, can escalate into mobbing behaviors, and as the intensity of the conflict increases, individuals may begin to experience psychological symptoms. Continuing unresolved issues negatively affect both the physical and psychological well-being of the individual (16).

Conflict styles refer to the behavioral actions that individuals resort to in order to cope with conflict situations (17). In conflict management, the styles developed by Rahim (1985) are defined as "integration," "accommodation," "compromise," "competition," and "avoidance" (14).

This study was conducted to evaluate the extent to which healthcare workers are exposed to mobbing behaviors, to examine whether there is a relationship between the level of mobbing exposure and conflict action styles based on various demographic characteristics of healthcare workers, and to raise awareness about mobbing.

MATERIALS AND METHODS

Type and Purpose of the Study: This study is a descriptive and cross-sectional study conducted to determine the relationship between healthcare workers' exposure to mobbing and their conflict action styles.

Study Location and Period: The research was carried out between May 15, 2023, and August 15, 2023, in healthcare institutions affiliated with the Ministry of Health in Karabük province, including physicians, midwives-nurses, and other healthcare professionals.

Population and Sample of the Study: The study population consisted of physicians, midwives-nurses, and other healthcare personnel (medical secretaries, technicians, laboratory staff, cleaning personnel, physiotherapists) actively working in Karabük and willing to participate in the study Eleven healthcare personnel who reported experiencing mobbing were excluded from work. Based on a study in the literature examining the relationship between psychological violence and conflict management styles among nurses, the calculated sample size (G-POWER) analysis determined that the minimum sample size required to achieve 80% power and a 95% confidence interval was 246.

Data Collection: The subject, content, and purpose of the study were explained to healthcare workers in written form, and participation was voluntary. The survey was conducted using Google Forms, with data collection tools (scales and survey forms) sent to healthcare workers via a link.

Data Collection Tools: The survey form consisted of three sections. The first section included the Sociodemographic Information Questionnaire, the second section contained the Mobbing Scale, and the third section comprised the Conflict Action Styles Scale.

The Sociodemographic Information Questionnaire included 17 questions about participants' age, gender, education level, marital status, and professional groups.

The Mobbing Scale, in the second section, was developed by Aiello, Deitinger, Nardella, and Bonafede (2008) to measure the exposure of healthcare workers to mobbing. The Turkish version of the Mobbing Scale was validated and tested for reliability by Ayşegül Laleoğlu and Prof. Dr. Emine Özmete in 2013. The Cronbach's alpha internal consistency coefficient of the survey was 0.948. In this study, the Cronbach's alpha coefficient was found to be α=0.978. The statements in the scale were scored on a seven-point Likert scale, ranging from "Strongly Agree – 7" to "Strongly Disagree – 1." A high score on the scale indicated greater exposure to mobbing behaviors, whereas a low score suggested less exposure. Factor analysis results revealed five sub-factors representing mobbing behaviors. The validity and reliability study of the Mobbing Scale by Laleoğlu and Özmete (2013) identified the sub-dimensions as "relationships with colleagues," "threat and harassment," "work and career," "interference with private life," and "commitment to work". The first subdimension consists of 17 items, the second subdimension consists of 7 items, the third subdimension consists of 8 items, the fourth subdimension consists of 4 items, and the fifth subdimension consists of 2 items. The scoring range of the scale is between 38 and 266. The Cronbach's alpha values for these factors were 0.961, 0.904, 0.902, 0.867, and 0.931, respectively.

The Conflict Action Styles Scale, in the third section, was developed by Johnson and Johnson (2008) and was first published in 1981, undergoing multiple revisions over time. The Turkish adaptation of the scale was based on the revision conducted by Prof. Dr. Engin Karadağ and Assoc. Prof. Dr. Ülkü Tosun (2014). The scale consists of 35 attitudinal statements and is divided into five subscales: avoidant, forcing, facilitating, compromising, and oppositional**.** Each subscale's reliability analysis yielded Cronbach's alpha values of 0.79, 0.76, 0.77, 0.78, and 0.72, respectively. In this study, the Cronbach's alpha values for the sub-dimensions were found to be 0.70, 0.70, 0.75, 0.72, and 0.73. Each subscale was assessed separately, and no total score was calculated. The scores for each subscale ranged from 5 to 35, with higher scores indicating a greater tendency to adopt that particular conflict action style. The scale was designed based on a five-point Likert format, with response options ranging from (1) "I never behave this way" to (5) "I mostly behave this way."

Data Analysis: Statistical analyses were performed using the SPSS 27.0 statistical software. Descriptive statistics such as frequency, percentage, mean, and standard deviation were used. The reliability of the data was assessed using Cronbach's alpha coefficient. The Kolmogorov-Smirnov test was used to determine whether the data followed a normal distribution (n≥30). Since the Mobbing Scale did not show normal distribution, the Mann-Whitney U test (U-table value) was used to compare the measurement values of two independent groups, and the Kruskal-Wallis test (H-table value) was used for comparisons among three or more groups. Dunnett's test was applied as a post-hoc analysis to determine differences between groups. Since the Conflict Action Styles Scale showed normal distribution, the independent t-test (t-table value) was used to compare two independent groups, and One-Way ANOVA (F-table value) was applied for comparisons among three or more groups. Bonferroni's test was used as a post-hoc analysis to identify group differences. The relationships between the scales were determined using Spearman correlation analysis. All comparisons were evaluated at a 95% confidence interval, with statistical significance set at $p<0.05$.

Ethical Approval: Research permission was obtained by applying to the Karabuk University Non-Interventional Clinical Research Ethics Committee, and ethical approval was granted on 08.05.2023 with decision number 2023/1343. Before participating in the study, healthcare workers provided both verbal and written informed consent.

RESULTS

The average age of the 225 healthcare workers who agreed to participate in the study is 32.37 years (30.00±6.839). According to Table 1, 47.5% of the 225 participating healthcare workers are in the 20-29 age group, 65.8% are female, 57.3% are married, and 55.1% have a bachelor's degree. Among the participants, 51.1% are midwives-nurses, while 90.7% work in a training and research hospital. In the study, 69.3% of the participants work in a mixed day-night shift system, 54.2% work 40-47 hours per week, 72.9% are satisfied with their unit, and 59.1% do not regularly smoke (Table 1).

In our study, the total mean score of the healthcare workers on the mobbing scale was determined as 82.15±44.10 (Min: 38; Max: 264). The highest score among the subdimensions of the mobbing scale was found in the "relationships with colleagues" subdimension, with a mean score of 38.99±22.62 (Min: 17; Max: 118).

Table 1: Sociodemographic Characteristics of Healthcare Workers

		(n=225)	(%=100)
Age	20-29	107	47.5
	30-39	72	32.0
	40-49	42	18.7
	50 and above	4	1.8
Gender	Female	148	65.8
	Male	77	34.2
Marital Status	Married	129	57.3
	Single	90	40
	Divorced	6	2.7
Education Level	Associate Degree	40	17.8
	Bachelor's Degree	124	55.1
	Postgraduate	61	27.1

Table 1: Sociodemographic Characteristics of Healthcare Workers			
Profession	Midwife-Nurse	115	51.1
	Doctor	51	22.7
	Other Healthcare Worker*	59	26.2
Institution of Employment	Training and Research Hospital	204	90.7
	Family and Community Health Centers	21	9.3
Work Type	Daytime	69	30.7
	Night-Day Mixed	156	69.3
Weekly Working Hours	40-47 hours	122	54.2
	47 hours and above	103	45.8
Satisfaction Status	Satisfied	164	72.9
	Not Satisfied	61	27.1
Smoking Status	Smoker	92	40.9
	Non-Smoker	133	59.1
***medical secretary, technician, laboratory technician, cleaning staff, physiotherapist**			

Table 2: Relationship between health workers' perceptions of mobbing and sociodemographic variables						
Variables	**Mobbing Scale**	**Relationships with Colleagues Subdimension**	**Threat and Harassment Subdimension**	**Work and Career Obstructions Subdimension**	**Interference with Private Life Subdimension**	**Commitment to Work Subdimension**
	***X* ± SS**	***X* ± SS**	***X* ± SS**	***X* ± SS**	***X* ± SS**	***X* ± SS**
Marital Status						
Married	80.000±44.007	38.178±22.065	11.232±7.899	18.697±11.503	7.317±5.069	4.573±3.166
Single	87.000±45.002	41.155±23.740	12.066±7.403	20.711±11.855	8.522±5.649	4.544±2.907
Divorced	55.666±11.325	24.166±7.808	7.000±0.000	14.000±7.694	4.166±0.408	3.166±2.206
Test statistics	H=5.171	H=4.727	H=9.256	H=4.001	H=9.979	H=0.781
p value	p=0.075	p=0.094	**p=0.010**	p=0.135	**p=0.007**	p=677
Education Level						
Associate Degree	85.352±50.326	40.725±25.827	12.470±8.882	19.352±12.542	7.941±6.290	4.862±3.492
Bachelor's Degree	79.373±42.850	38.617±22.475	10.060±6.980	19.373±12.345	7.173±5.019	4.147±2.896
Postgraduate	84.796±41.086	38.237±20.118	13.288±7.251	19.406±9.186	8.576±4.832	5.288±3.023
Test statistics	H=3.132	H=0.460	H=24.158	H=1.716	H=12.108	H=10.35
p value	p=0.209	p=0.795	**p=<0.001**	p=0.424	**p=0.002**	**p=0.006**
Institution of Employment						
Training and Research Hospital	83.725±43.420	40.004±22.530	11.524±7.414	19.740±11.604	7.852±5.259	4.602±3.080
Family and Community Health Centers	66.857±48.757	29.195±21.611	10.761±9.627	15.857±11.208	6.381±5.607	4.666±3.351
Test statistics	U=1220.000	U=1167.500	U=1603.000	U=1567.500	U=1415.000	U=2106.500
p value	U=1220.000	**p=<0.001**	**p=0.047**	**p=0.041**	**p=0.008**	p=0.897

Table 2: Relationship between health workers' perceptions of mobbing and sociodemographic variables						
Variables	**Mobbing Scale**	**Relationships with Colleagues Subdimension**	**Threat and Harassment Subdimension**	**Work and Career Obstructions Subdimension**	**Interference with Private Life Subdimension**	**Commitment to Work Subdimension**
	***X* ± SD**	***X* ± SD**	***X* ± SD**	***X* ± SD**	***X* ± SD**	***X* ± SD**
Work Type						
Daytime	76.695±46.568	34.869±22.173	11.173±8.571	18.115±11.380	7.318±5.561	5.217±3.705
Night-Day Mixed	84.564±42.900	40.820±22.645	11.576±7.193	19.935±11.686	7.891±5.185	4.339±2.760
Test statistics	U=4353.000	U=4143.500	U=4644.500	U=4730.000	U=4514.000	U=4762.500
p value	**p=0.022**	**p=0.006**	p=0.087	p=0.144	**p=0.046**	p=0.156
Weekly Working Hours						
40-47 hours	75.303±41.243	34.875±19.872	10.877±7.631	17.352±10.228	7.319±5.029	4.877±3.402
Over 47 hours	90.262±46.164	43.873±24.715	12.135±7.597	21.776±12.673	8.184±5.586	4.291±2.677
Test statistics	U=4840.500	U=4791.500	U=5229.500	U=4946.500	U=5539.500	U=5816.500
p value	**p=0.003**	**p=0.002**	**p=0.024**	**p=0.006**	p=0.113	p=0.322
Satisfaction Status						
Satisfied	71.250±33.964	32.993±16.409	10.573±6.241	16.286±9.105	6.908±4.150	4.487±2.985
Not Satisfied	111.459±54.125	55.131±28.558	13.819±10.169	27.688±13.441	9.885±7.169	4.934±3.390
Test statistics	U=2348.500	U=2452.000	U=3962.000	U=2161.000	U=3828.500	U=4808.500
p value	**p=<0.001**	**p=<0.001**	**p=0.012**	**p=<0.001**	**p=0.005**	p=0.645
Smoking Status						
Smoker	85.272±48.175	40.021±23.247	12.858±8.887	19.510±12.081	8.108±5.389	4.771±3.298
Non-Smoker	79.992±41.100	38.285±22.236	10.481±6.472	19.285±11.298	7.443±5.235	4.496±2.960
Test statistics	U=5489.500	U=5646.000	U=4716.000	U=6057.000	U=5201.500	U=5886.000
p value	**p=0.190**	p=0.325	**p=0.002**	p=0.898	**p=0.048**	p=0.618

***The group that creates a significant difference between the groups, Kruskal Wallis Test=H, Mann Whitney U Test=U.**
X: Mean, SD: Standard deviation

A significant difference was found between the marital status of healthcare workers and the subdimensions of threat and harassment (p=0.010) and interference with private life (p=0.007). According to the advanced analysis performed to determine the difference, healthcare workers in the divorced group had significantly higher mean scores on the interference with private life subdimension compared to the married or single groups (p<0.001). A significant difference was also found between the professional variable and the subdimensions of threat and harassment (p=<0.001), interference with private life (p=0.002), and work commitment (p=0.006). Regarding the institution worked at, a significant difference was found between the total score of the mobbing scale (p=0.001), the relationships with coworkers subdimension (p=<0.001), threat and harassment subdimension (p=0.047), job and career-related obstacles subdimension (p=0.041), and interference with private life subdimension (p=0.008). Additionally, a significant difference was found between satisfaction status and the total score of the mobbing scale (p=<0.001), relationships with coworkers subdimension (p=<0.001), threat and harassment subdimension (p=0.012), job and career-related obstacles subdimension (p=<0.001), and interference with private life subdimension (p=0.005) (Table 2).

There is no significant difference between healthcare workers' age, gender, and educational status and their perception of mobbing.

Table 3: The Relationship Between Healthcare Workers' Conflict Action Styles and Sociodemographic Variables					
Variables	**Avoidant Style Subdimension**	**Forcing Style Subdimension**	**Facilitating Style Subdimension**	**Compromising Style Subdimension**	**Oppositional Style Subdimension**
	***X* ± SS**	***X* ± SS**	***X* ± SS**	***X* ± SS**	***X* ± SS**
Gender					
Female	19.121±4.583	22.594±4.782	24.939±4.776	16.358±5.921	21.459±3.928
Male*	21.285±4.895	24.220±5.662	25.831±5.222	17.818±7.677	22.675±4.705
Test statistics	t=-3.282	t=-2.270	t=-1.287	t=-2.201	t=-2.056
p value	**p=0.001**	**p=0.024**	p=0.200	**p=0.029**	**p=0.041**
Education Level					
Associate Degree	21.350±5.051	25.075±5.562	27.450±4.684	17.575±7.605	22.825±4.031
Bachelor's Degree	19.556±4.899	22.701±5.002	24.766±5.035	16.451±6.042	21.524±4.381
Postgraduate	19.508±4.264	22.803±4.945	24.770±4.576	17.213±7.007	21.967±4.041
Test statistics	F=2.374	F=3.483	F=5.022	F=0.558	F=1.449
p value	p=0.095	**p=0.032**	**p=0.007**	p=0.573	p=0.237
Profession					
Doctor	19.352±4.279	21.882±4.563	24.549±4.553	17.607±7.526	21.686±3.916
Midwife-Nurse	18.791±4.978	22.843±5.449	24.782±5.418	16.173±6.309	21.513±4.696
Other Healthcare Workes	22.389±3.904	24.847±4.630	26.745±3.941	17.542±6.243	22.745±3.432
Test statistics	F=12.530	F=5.144	F=3.826	F=4.183	F=1.725
p value	**p=<0.001**	**p=0.007**	**p=0.023**	**p=0.009**	p=0.181
Weekly Working Hours					
40-47 hours	20.352±4.695	23.795±5.269	25.967±4.709	16.139±6.409	22.327±4.168
Over 47 hours	19.281±4.865	22.388±4.913	24.388±5.091	17.708±6.739	21.339±4.280
Test statistics	F=0.158	F=0.605	F=0.326	F=1.680	F=0.200
p value	p=0.095	**p=0.041**	**p=0.017**	p=0.075	p=0.082
Satisfaction Status					
Satisfied*	20.390±4.689	23.573±5.163	25.939±4.442	15.402±5.375	22.378±3.885
Not Satisfied	18.442±4.818	22.016±4.964	23.377±5.713	20.770±7.906	20.524±4.853
Test statistics	t=2.749	t=2.031	t=3.165	t=3.776	t=2.965
p value	**p=0.006**	**p=0.043**	**p=0.002**	**p=<0.001**	**p=0.003**
***The group that creates a significant difference between groups, t = t-test / F = Variance analysis (ANOVA) test**					

No significant difference was found between the gender variable of healthcare workers and the facilitator style subdimension, while significant differences were found in the other subdimensions. A significant difference was found between the education level of healthcare workers and the facilitator subdimension (p=0.007) and the coercive subdimension (p=0.032). In advanced analysis, the mean scores of the facilitator subdimension were found to be significantly higher among healthcare workers with an associate degree compared to those with a bachelor's degree.No significant difference was found in the resistive style subdimension based on the professional variable, but significant differences were found in the other subdimensions. In the advanced analysis, the mean scores of the avoidant subdimension were significantly lower between doctors (p=0.002) and midwives-nurses (p<0.001) compared to other healthcare workers. According to post-hoc analysis, the mean scores of the coercive

subdimension were significantly lower between other healthcare workers and doctors (p=0.007). A significant difference was found between the weekly working hours of healthcare workers and the facilitator subdimension (p=0.017) and the coercive subdimension (p=0.041). Significant differences were found between all subdimensions and satisfaction status (Table 3).

DISCUSSION

In this study, it was observed that sociodemographic characteristics such as marital status, profession, workplace, work schedule, weekly working hours, job satisfaction, and smoking status influenced perceptions of mobbing behaviors. Participants' marital status affected their perceptions of experiencing mobbing in the "threat and harassment sub-dimension" and the "intervention in private life sub-dimension." Advanced analysis to determine the difference revealed that the mean scores for the intervention in private life sub-dimension were significantly higher in the divorced group compared to the married and single groups. Unlike our study, Akca and colleagues conducted a study on women's perceptions of mobbing in the healthcare sector and found a significant difference in the mobbing experiences of single healthcare workers (18). Similarly, a study conducted between 2016 and 2017 in a state and university hospital in Konya found a significant difference in the levels of mobbing behavior based on marital status, with single healthcare workers experiencing mobbing at a higher rate (19). Differences in findings may be due to factors such as the number of participants, the cultural characteristics of the geographical region, gender distribution, and the type of institution where they work. The higher levels of mobbing behavior experienced by divorced individuals in our study could be related to societal attitudes toward divorce. The perception that divorced healthcare workers may be required to work more shifts due to workload distribution in institutions may have influenced their mobbing experiences.

In this study, a significant difference was found between the professional variable and the threat and harassment sub-dimension, the intervention in private life sub-dimension, and the commitment to work sub-dimension. However, advanced analysis did not reveal any significant differences among specific groups. A study conducted in a state hospital in the Black Sea region among healthcare workers from different departments found that the reputational attack sub-dimension of the mobbing behavior scale varied based on occupational status, with nurses and emergency medical technicians (EMTs) experiencing mobbing more frequently than other employees (20). Another study by Kırılmaz and colleagues in 2015 at Bolu Training and Research Hospital found that risk factors related to mobbing behaviors were higher among physicians (83.3%), nurses (46.9%), and health officers (80%) based on their job titles (21). These differences may be attributed to variations in the number of respondents and sample size. Healthcare workers are considered a high-risk group compared to employees in other service sectors. Issues such as unclear job descriptions, working with insufficient healthcare personnel, heavy workload, stressful environments, and challenging working conditions may contribute to negative behaviors among healthcare professionals.

Our research found a significant difference between the institution where healthcare workers were employed and the mobbing scale, the relationships with colleagues sub-dimension, the threat and harassment sub-dimension, the work and career obstruction sub-dimension, and the intervention in private life sub-dimension, particularly in favor of Training and Research Hospitals. A study conducted by Uysal and colleagues in 2018 at Bolu Izzet Baysal Training and Research Hospital found a significant difference in the level of mobbing experienced by healthcare workers based on their employment affiliation, with those employed under the Ministry of Health experiencing mobbing at a higher rate (22). The similarities between our findings may be due to factors such as the characteristics of inpatient

treatment institutions, bed capacity, insufficient healthcare personnel, high patient volume, and increased workload.

A significant difference was observed between job satisfaction and the total mobbing scale score, the relationships with colleagues sub-dimension, the threat and harassment sub-dimension, the work and career obstruction sub-dimension, and the intervention in private life sub-dimension. In parallel with our study, a study conducted by Yıldırım and Daşbaş on female social workers employed in the public sector found that participants who were dissatisfied with their institutions had higher mobbing behavior scores (23). Similarities in findings may be attributed to factors such as the work environment, workload, team dynamics, working hours, excessive workload, assignments, and biases.

In this study, it was observed that sociodemographic characteristics such as gender, education level, professional status, weekly working hours, job satisfaction with the unit of employment, and the presence of chronic illness influenced conflict action styles.

It was determined that there was a significant difference in favor of men between the gender variable and the avoiding sub-dimension, the forcing sub-dimension, the compromising sub-dimension, and the resisting sub-dimension. Similar to our study, a study conducted by İkiz and Çatal on teacher candidates found that the forcing sub-dimension of conflict action styles differed significantly in favor of men (24). However, in contrast to our findings, a study conducted by Akpolat and Oğuz in the 2020-2021 academic year in Istanbul with school administrators observed that female administrators used the facilitating, forcing, and avoiding action styles more frequently than male administrators (25). The way men are raised may cause them to exhibit more forceful or resistant behavior when faced with conflicts.

In our study, a significant difference was found between participants' education level and the facilitating and forcing sub-dimensions. In Yılmaz's study, it was found that among nurses, those in the associate degree and vocational high school groups were more likely to choose the avoidance style in peer conflicts compared to those in the bachelor's and postgraduate groups (26). However, in Özkaya's study on school administrators and teachers in Denizli, no differences were observed in conflict action styles based on education level (27). The differences in research findings may stem from the fact that some studies focus on specific professional groups. Differences in educational level may lead individuals to use various conflict action styles in conflict management.

Our research findings revealed a significant difference in conflict action styles based on professional variables among healthcare workers, specifically in the avoiding, forcing, facilitating, and compromising sub-dimensions. It was found that doctors and midwives/nurses used the avoiding style more frequently than other healthcare workers. Additionally, doctors used the forcing sub-dimension more than other healthcare professionals. A study conducted by Delak and Sirok in 2018 on physicians and nurses in primary healthcare services in Slovenia found that nurses preferred the avoidance style, while physicians preferred the compromising style (28). Similarly, in Akpolat and Oğuz's study on school administrators in Istanbul, assistant principals were found to use the avoiding approach more frequently than school principals (25). These findings are consistent with our results. Professional differences may influence individuals' preferred conflict management styles when dealing with conflicts.

A significant difference was observed in all sub-dimensions of conflict action styles in favor of those who were satisfied with their current situation. Parallel to our findings, a study conducted by Bozkurt and Beydağ in 2023 on nurses working in a private hospital found that 61.2% of participants were satisfied with their workplace, and the resisting and facilitating sub-dimension score averages were high. It is believed that factors such as team motivation, communication among employees,

a high-paced work environment, and personal and cultural differences play a role in the conflict resolution methods used by healthcare workers.

Limitations

The limitations of this study include the fact that it was conducted only with healthcare workers working in the city center of Karabük. Therefore, the findings of this study cannot be generalized to the entire population.

CONCLUSION

In the study, significant statistical results were obtained between some sociodemographic characteristics and various sub-dimensions of both the mobbing perception scale and the conflict action styles scale. It was observed that healthcare workers scored the highest in the "relationships with colleagues" sub-dimension of the mobbing scale, while they scored the highest in the "facilitating approach" sub-dimension of the conflict action styles scale.

It was found that healthcare workers are at significant risk for mobbing, and to prevent this, it is recommended to increase awareness training on mobbing in in-service training programs. Additionally, supportive work environments, management support, fair practices among employees, and the establishment of a mobbing reporting hotline can play an important role in combating mobbing. In general, more comprehensive legal protections should be developed to prevent mobbing behaviors.

Acknowledgement

Peer-Review

Double blind both externally and Internally Peer Reviewed

Conflict of Interest

The authors declare that they have no conflict of interests regarding content of this article.

Financial Support

The Authors report no financial support regarding content of this article.

Ethical Declaration

Ethical approval was obtained from Karabuk University Non-Interventional Clinical Research Ethical Committee with date 08.05.2023 and number 2023/1343., and Helsinki Declaration rules were followed to conduct this study.
Before participating in the study, healthcare workers provided both verbal and written informed consent.

Authorship Contributions

Concept: NS, Design: NS, MV, Supervising: EN, AAA, Financing and equipment: -, Data collection and entry: ME, EH, Analysis and interpretation: EN, Literature search: AAA, Writing: ME, NS, Critical review: NS

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