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Işıl Karatuna, Sandra Jönsson & Tuija Muhonen

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Işıl Karatuna[1*], Sandra Jönsson[2], Tuija Muhonen[1]
[1)] Centre for Work Life and Evaluation Studies/School Development and Leadership, Malmö University, Sweden
[2)] Department of Sociology, Lund University, Sweden

Abstract

Background: Workplace bullying is a severe and widespread occupational problem that negatively affects individuals, organizations, and societies. Studies have shown that national culture influences the way bullying is understood and experienced across different countries. However, our understanding of the cross-cultural variations in workplace bullying is still lacking. This study aimed to compare nurses' experiences of workplace bullying in two culturally distinct countries: Turkey and Sweden.

Methods: Using a qualitative design, semi-structured interviews were conducted with nurses (21 Turkish, 16 Swedish) who identified themselves as targets and/or bystanders of workplace bullying. Data were collected during 2019/2020 and analyzed using the deductive content analysis method.

Results: There were many similarities between the Turkish and Swedish nurses in their reports of the most common types, antecedents, effects of, and target responses to workplace bullying. Differences were observed between countries concerning the source of bullying and in bystander responses.

Conclusion: The findings emphasize that workplace bullying is a serious problem in the nursing profession across cultures and attention should be paid to cultural factors in understanding the varying bullying-related experiences of nurses. Healthcare organizations should therefore consider developing tailor-made interventions that fit their local cultural contexts to deal with workplace bullying in a more effective way.

Keywords: Workplace bullying, nursing, cross-cultural comparison, deductive content analysis, Turkey, Sweden

ISBN: 978-91-7877-614-6

DOI: 10.24834/isbn.9789178776146

Malmö University
2025-01-31

1. Introduction

Workplace bullying is a severe and widespread occupational problem that negatively affects individuals, organizations, and societies. It is defined as a form of aggression at work characterized by frequent (e.g., weekly) and consistent (e.g., over 6 months) negative behaviors directed at a person by one or more perpetrators who have power over the targeted party (Einarsen et al., 2020). Bullying can originate from a superior, colleague, or subordinate of the targeted individual(s) and be classified as work-related (e.g., unrealistic goals, withholding information), personal (e.g., isolation, humiliation) and physical/threatening (e.g., threats of violence) (Bartlett and Bartlett, 2011).

The occurrence of workplace bullying has been linked to organizational and work environmental risk factors (e.g., organizational culture, leadership, role ambiguity) (Blomberg et al., 2024; Salin and Hoel, 2020), individual factors such as the perpetrator's characteristics (e.g., unstable self-esteem, lack of social competencies), the target's characteristics (e.g., being different from the rest of the work group, low self-esteem) (Zapf and Einarsen, 2020), and societal factors such as national culture (Ahmad, et al., 2021).

Exposure to workplace bullying is associated with physical and psychological health complaints (Mikkelsen et al., 2020) and work-related attitudes such as absenteeism and turnover intention (Boudrias et al., 2021) and lower organizational commitment and job satisfaction (Nielsen and Einarsen, 2012). Negative consequences related to workplace bullying are not limited to targeted individuals but also extend to bystanders who witness bullying. Previous evidence indicates that witnessing bullying is likely to have negative effects on mental health and employee attitudes such as work engagement, job satisfaction, and intention to quit (Nielsen et al., 2024; Salin and Notelaers, 2020).

The way the target reacts to bullying behaviors can influence the escalation or de-escalation of a bullying process. Targets may engage in active responses (e.g., confronting the bully, reporting) to end bullying (Nielsen et al., 2020). However, active actions may not always be helpful or accessible for some targets. Thus, targets may engage in passive behaviors (e.g., avoiding the perpetrator, talking to a family member or friend), or exit responses, such as leaving the organization (D'Cruz and Noronha, 2010). Bystanders can also affect the course of a bullying situation by enacting behaviors such as defending the target (active constructive), doing nothing (passive destructive), supporting the bully (active destructive), or listening to the target's complaints and concerns without offering assistance (passive constructive) (Jönsson and Muhonen, 2022; Paull et al., 2012).

Nursing is one of the occupations most prone to workplace bullying (Lever et al., 2019). Previous research has shown that nurses who are exposed to workplace bullying experience both physical and psychological consequences (João et al., 2023; Johnson, 2021) and are more likely to report dissatisfaction with their jobs (Holm et al., 2023), as well as high turnover intention and decreased organizational commitment (Xia et al., 2024).

Some evidence suggests that there are differences in the ways nurses experience bullying at work across national cultures (Brunetto et al., 2016; Karatuna et al., 2020; Lee et al., 2022). However, current understanding of cross-cultural variation in workplace bullying in nursing is still lacking. Thus, the current study aimed to contribute to the literature by comparing nurses' experiences of workplace bullying in two culturally distinct countries: Turkey and Sweden.

This study utilized the Global Leadership and Organizational Behavior Effectiveness (GLOBE) study (House et al., 2004) to examine Turkish and Swedish nurses' experiences of workplace bullying in a cross-cultural context. The GLOBE study provided data on cultural values and practices in 62 countries and in the present study, three of the GLOBE practices, namely power distance, in-group collectivism, and assertiveness were used because previous research showed that these dimensions are relevant in explanations of variance in perceptions of workplace bullying across cultures (Jacobson et al., 2014; Karatuna et al., 2020; Salin 2021).

Compared with Sweden, Turkey is a high power-distance culture (House et al., 2004), meaning that people in Turkey tend to accept the unequal distribution of power in institutions and organizations (Hofstede, 1980). Previous cross-cultural research has indicated that perceptions of workplace bullying vary depending on the power distance characteristics of a given culture. For example, D'Cruz et al. (2016) showed that the source of bullying was most often a superior in high power distance cultures (Turkey, India), but was either a superior or a colleague in a lower power distance culture (Australia). Similarly, Escartin et al. (2011) found that workplace bullying was mainly defined as a hierarchical phenomenon in high power distance countries (e.g., Southern European and Central American countries).

Additionally, Loh et al. (2010) found that employees in Singapore (high power distance culture) were less sensitive to negative outcomes of bullying (e.g., decreased job satisfaction) compared with employees in Australia (low power distance culture). Furthermore, Samnani (2013) hypothesized that employees in high power distance cultures are less likely to engage in resistance-based responses toward subtle acts of bullying than employees in low power distance cultures. In line with this assumption, Guneri-Cangarli et al. (2013) found that, in Australia (low power distance culture), bystanders were more likely to intervene in response to workplace bullying compared with those in Turkey (high power distance culture).

In contrast to Swedish society, Turkish society is characterized by high in-group collectivism practices (i.e., the degree to which individuals express pride, loyalty and cohesiveness in their organizations or families) (House et al., 2004). Previous research indicated that societies high in in-group collectivism practices (e.g., Gulf countries) tend to accept the social exclusion of employees who are different in terms of gender, religion, or country of origin (Salin, 2018). Moreover, a recent review conducted among nurses (Karatuna et al., 2020) showed that individual factors (e.g., being different from the rest of the work group) were more likely to be reported as an antecedent of workplace bullying in studies conducted in high in-group collectivist cultures such as Middle East countries, than in studies conducted in low in-group collectivist cultures such as Anglo countries.

Furthermore, Turkish society, compared with Swedish society, rated higher on assertiveness practices (i.e., the degree to which individuals in organizations and societies are assertive, confrontational, and aggressive in social relationships) (House et al., 2004). In low assertiveness cultures, people are expected to manifest covert rather than overt bullying (Jacobson et al., 2014; Salin, 2021).

In consideration of the abovementioned cross-cultural findings on workplace bullying and cultural differences between Turkey and Sweden, we aimed to compare Turkish and Swedish nurses' experiences of workplace bullying by addressing the following research questions: (1) Who is the source of bullying in nursing? (2) Which types of bullying behaviors are common in nursing? (3) What are the antecedent factors of bullying in nursing? (4) What are the perceived effects of workplace bullying among nurses? (5) How do targeted nurses respond to workplace bullying? (6) How do bystander nurses respond to workplace bullying?

2. Materials and methods

A qualitative methodology with semi-structured interviews was applied to describe how Turkish and Swedish nurses differ or are similar in their perceptions of the source, types, antecedents, effects of and responses to workplace bullying. The Standards for Reporting Qualitative Research (SRQR checklist) was used to enhance the quality and transparency of the study (O'Brien et al., 2014).

2.1. Sampling and recruitment

The sample consisted of 37 nurses working in various medical settings in Turkey (n = 21) and Sweden (n = 16). The inclusion criteria for participation in the study included perceiving oneself as a target or/and a bystander of workplace bullying. The participants' characteristics are presented in Table 1.

Table 1. Participant characteristics.

Characteristic	Turkey (n=21)	Sweden (n=16)
Gender, n (%)		
Women	20 (95.3)	15 (93.8)
Men	1 (4.7)	1 (6.2)
Nursing position, n (%)		
Assistant nurse	2 (9.5)	2 (12.5)
Staff nurse	18 (85.7)	14 (87.5)
Head nurse	1 (4.8)	0 (0)
Age (years)		
Mean (*SD*)	33.19 (8.11)	46.33 (10.27)
Range	19-51	28-60
Target and/or bystander, n (%)		
Target	8 (38.1)	4 (25)
Bystander	6 (28.6)	4 (25)
Target and bystander	7 (33.3)	8 (50)

The first author was responsible for collecting data in Turkey. Participants in Turkey were recruited by "snowball sampling" (Parker et al., 2019) distributing the study information sheet first to individuals that the author knew to meet the inclusion criteria. Then, these initial participants were subsequently asked to distribute the study information sheets to other individuals whom they knew would meet the criteria. Snowball sampling is often used to recruit individuals that are not easily accessible to researchers (Noy, 2008).

The second and third authors were responsible for the data collection process in Sweden. The Swedish participants were recruited from a previous questionnaire study (Holm, Jönsson and Muhonen, 2023) in which they had announced their interest to participate in an interview study. The researchers contacted (by phone or email) the volunteers and informed them about the details of the study. Thereafter, interviews were booked with those who were still interested in participating. All participants were employed at a large organization providing public healthcare in Sweden.

2.2. Data collection

All participants were interviewed using a semi-structured interview guide that was developed by the authors and consisted of questions about the participants' background and their experiences of being a target and/or a bystander of workplace bullying. Specifically, participants were asked questions regarding the source, types, antecedents, and effects of bullying, and how they had acted as targets or bystanders in bullying situations.

The interviews were conducted between January 2019 and January 2020 in Turkey and between March 2019 and September 2020 in Sweden. The interviews had a duration of between 40 and 95 minutes, and were conducted face to face or via Zoom, Teams, or telephone.

Participation was voluntary and all interviews were conducted after informed consent was provided. The interviewers had no prior relationship with the study participants. All interviews were conducted in the native tongue of the participant and audio-recoded. Before starting the interviews, each participant was informed about the objectives of the study, audio-recording of the interview, and their right to refuse to answer questions and withdraw at any time. The participants were also informed about how the interview data will be reported and how their confidentiality will be assured and maintained throughout. To protect the anonymity and privacy of the participants, no real names or employer information were used in the study and all data were stored in a secure way preventing the access of the third parties.

2.3. Data Analyses

The recorded narratives were transcribed verbatim in the original languages, whereas quotations were translated into English by the authors. To maintain accuracy, the Turkish translation of the quotations were reviewed and approved by an expert in the field of work psychology who is fluent in English and Turkish.

Data were analyzed using deductive qualitative content analysis. This method is suitable when the structure of analysis is operationalized based on previous knowledge (Elo & Kyngäs, 2008). In the present study, previous workplace bullying research presenting data on the source, antecedents, types, effects of and responses to workplace bullying (Bartlett & Bartlett, 2011; D'Cruz & Noronha, 2010; Einarsen et al., 2020; Karatuna et al., 2020; Paull et al., 2012) was employed as a theoretical framework for conceptualizing nurses' experiences of workplace bullying in Sweden and Turkey. Hence, using the previous data, a structured categorization matrix was developed.

Next, the verbatim transcripts as unit of analysis, were read repeatedly, and the data were coded in English for correspondence with the categories identified in the structured categorization matrix. Authors in Sweden (SJ, TM) independently coded the transcripts and Turkish transcripts were coded by the author (IK) and reviewed by an expert in the field of work psychology who is fluent in English and Turkish. Only manifest content, which describes the visible and obvious in the text, was analyzed (Granheim and Lundman, 2004).

After coding the transcripts independently, several meetings were held among the authors to discuss the content of the coded categories and sub-categories. Accordingly, codes were compared to each other and sorted into sub-categories and categories defined in the structured categorization matrix. Discussions continued until consensus was obtained regarding the final identification of categories and sub-categories. No inconsistencies existed and a shared understanding was reached to strengthen the internal validity (Patton, 2015).

The authors then quantified the codes using frequency counts and calculated the code counts within each category. Categorization matrix used to analyze the interviews including number of mentions for each sub-category in Turkey and Sweden are presented in Table 2. Finally, representative quotes for each category were discussed and selected by the authors.

In interpreting the differences and similarities between the two countries, we relied on their GLOBE cultural practices scores for power distance, assertiveness, and in-group collectivism. Consultation between the authors was essential throughout the whole process of analysis and interpretations.

2.4. Ensuring trustworthiness

To enhance the trustworthiness of the findings, the four Lincoln and Guba (1985) criteria were used: credibility, dependability, conformability, and transferability. Credibility was ensured by gathering data from a respectable number of nurses, the detailed descriptions of data collection and analysis, and the continuous discussion between the researchers during the analysis. All interviews followed the same interview guide, and all authors were involved in the analyses of the interviews to establish dependability. Conformability was ensured through having multiple researchers and using direct quotations from the transcripts within the presentation of findings. Detailed descriptions of the participants were provided for transferability purposes.

2.5. Ethical considerations

The Swedish Ethical Review Board approved the study in Sweden (2018-00228). For the interviews conducted in Turkey, no ethical approval from an ethical review board was required at the time of the interviews. The authors declare that all investigations were carried out in conformity with the ethical standards of the Swedish Research Council (2017). All interviews were conducted after informed consent was provided. Confidentiality was assured and maintained throughout. To protect the anonymity and privacy of the participants, no real names or employer information were used in the study and all data were stored in a secure way preventing the access of the third parties. Researchers informed the participants about the objectives of the study and their right to refuse to answer questions and withdraw at any time. Participants were informed about how they could receive the results of the study.

Table 2. Categorization matrix used to analyze the interviews including number of mentions for each sub-category in Turkey and Sweden

Source of workplace bullying (RQ1)	Superior (12/3)	Peer (5/5)	Sub-ordinate (0/8)	Other (doctor) (8/3)
Types of workplace bullying behaviors (RQ2)	Work-related (66/25)	Person-related (15/20)	Physically intimidating (3/0)	Verbal abuse (33/7)
Antecedents of workplace bullying (RQ3)	Target characteristics (18/1)	Perpetrator characteristics (14/20)	Organizational characteristics (30/24)	
Effects of workplace bullying (RQ4)	Effects on targets' health (25/19)	Effects on targets' work (24/7)	Effects on bystanders (5/8)	
Target responses to workplace bullying (RQ5)	Active response (26/18)	Passive response (22/16)	Exit response (10/2)	
Bystander responses to workplace bullying (RQ6)	Active constructive (9/12)	Active destructive (0/0)	Passive constructive (8/7)	Passive destructive (12/7)

NOTE. Each participant may have mentioned more than one response for the related category. Thus, frequencies do not tally with the number of participants.

3. Results

3.1. Source of workplace bullying

This category included participants' comments about the source of workplace bullying in nursing. Some sources, such as superiors, peers and doctors were mentioned by nurses in both countries. However, there were differences in the frequency of mentions between the two groups. For example, participants from Turkey most often reported superiors (e.g., head nurse) and doctors as the source of bullying in nursing.

> *Head nurses bully staff nurses most frequently. Doctors also often bully nurses. (TUR 6: target, female, age 44, staff nurse)*

In contrast, superiors and doctors were described as the least frequent sources of workplace bullying in Sweden. Bullying from subordinates was only reported in Sweden and was the most often identified source of bullying among Swedish nurses.

It is often the assistant nurses [who bully]. They group together, control the whole ward and create a toxic atmosphere. SE 14: target/bystander, female, 38, staff nurse

3.2. Types of workplace bullying behaviors

This category included nurses' comments about the types of bullying behaviors encountered at work in Turkey and Sweden. In both countries, work-related behaviors were described by nurses as being the most common type of bullying behaviors. For example, assigning tasks outside of a person's job description, questioning competence, and assigning too many shifts were among the most frequent work-related bullying behaviors reported in the Turkish sample, while refusing to collaborate/help was the highest among the Swedish sample.

Nurses are required to do many non-nursing duties, such as clerical tasks. (TUR 3: target, female, age 51, staff nurse)

It was at an intensive care unit, where you must get help, if the patient is getting worse. You have to get help quickly. And it happened at some point, that she [assistant nurse] denied help when a patient became very ill. (SE 9: target, female, age 55, staff nurse)

Person-related behaviors such as gossiping, spreading rumors, ignoring, not talking to the target, and social exclusion were mentioned as the bullying behaviors that nurses encounter in both cultures, although these were more frequently reported by Swedish nurses than Turkish nurses.

When she talks to them, they ignore her totally and walk away. Making somebody invisible like that (and I have witnessed that myself) is awful – and this is our manager that they are making invisible. (SE 11: bystander, female, age 43, staff nurse)

Nurses in both countries described experiences of verbal abuse such as yelling, ridiculing in front of people, and insulting; however, all these behaviors were more often encountered by Turkish nurses compared with Swedish nurses.

One time I gave my opinion on a topic that I have experience with…she [the doctor] said; Who are you to tell me what to do? (TUR 2: target and bystander, female, age 32, staff nurse)

In contrast, physically intimidating behaviors such as hitting the table and invasion of personal space were only described by Turkish nurses.

He [the doctor] asked me to suture a wound. This is something I can do, but frankly it is not my job. When I told him this, he walked up to me and started yelling. (TUR 12: target, female, age 29, head nurse)

3.3. Antecedents of workplace bullying

This category represented the differences and similarities in nurses' reports of the antecedents of bullying in nursing in Turkey and Sweden. Organizational factors were described as the most common triggers of workplace bullying in both cultures. Being seen as subordinate to doctors and having unclear job descriptions were the most often mentioned organizational

antecedents in the Turkish sample, while Swedish nurses most frequently described organizational antecedents related to leadership issues.

> *The doctor wants you to do something and while you are doing it, the head nurse calls you and tells you to go the third floor; then another doctor wants you to do another thing and when you say you can't, she [the doctor] says; You are never available! You feel like saying it is not my job to do that, but the job description of nurses is not clear. (TUR 18: bystander, female, age 25, staff nurse).*

> *So, the manager quit, and then we got a new manager who we thought was good, someone who could handle these people [group of bullies]; but she couldn't, so she quit. Then we got a new manager, but she also quit. So now the whole organization is breaking up. (SE 9: target and bystander, female, age 55, staff nurse).*

Perpetrators' characteristics (e.g., being manipulative, being friends with the manager) were reported as a trigger of bullying in both cultures. However, these antecedents were more frequently mentioned among Swedish nurses.

> *I thought my manager listened to me, was understanding and on my side, but afterwards, I realized that she really did not care because she was friends with them [the bullies]. (SE 4: bystander/target, female, age 31, staff nurse)*

In contrast, target characteristics such as being different from the rest of the work group was only mentioned by Turkish nurses.

> *She was bullied because she had a sickness! Because of her sickness, she was exempted from working overtime. Others were upset about her situation because this meant extra work for them. So, she became a target of bullying. (TUR 8: target and bystander, female, age 33, staff nurse)*

3.4. Effects of workplace bullying

This category included Swedish and Turkish nurses' reports of the effects of workplace bullying. Negative effects of workplace bullying on targets' psychological and physiological health were commonly reported in both countries. Accordingly, nurses reported decreased well-being, emotional exhaustion, depression, sleep problems, crying attacks, fatigue, vertigo, tachycardia, and feelings of anger, self-blame, and self-doubt.

> *I start my day thinking about how I will endure her presence. It is tiring. I feel exhausted. (TUR 2: target and bystander, female, age 32, staff nurse)*

> *I am normally not weepy, but I just totally collapsed in her [manager's] office and said: I can't take this anymore, it is horrible. (SE 15: target and bystander, female, staff nurse)*

In both countries, nurses also described how workplace bullying negatively affected targets' work. For example, reduced job satisfaction was a common outcome of bullying across the two cultures. However, compared with their counterparts in Sweden, Turkish nurses were more likely to report negative work-related attitudes such as decreased motivation, increased errors, decreased organizational commitment, unwillingness to go to work, and disaffection with the job. Further, a few Swedish nurses described how they had to take sick leave.

I could not enter the room while he was there. I was waiting for him to leave the room. This certainly was increasing the possibility of making mistakes in my work. (TUR7: target, female, age 28, staff nurse)

During one period it really affected me a lot. I felt lousy and I took sick leave a couple of times, for a week. /.../ I was totally exhausted. (SE 8: target, female, age 49, staff nurse)

Both Turkish and Swedish nurses described negative effects of being bystanders of workplace bullying. For example, becoming desensitized and normalization of bullying behavior were mentioned in both samples. However, Swedish participants also discussed how bystanders were emotionally affected, became targets, and resigned.

After a long time, I felt that I had to quit the job; I felt that I would not survive otherwise. I couldn't stay and continue feeling this bad. (SE 5: target, female, age 50, staff nurse)

3.5. Target responses to workplace bullying

This category represented targets' responses to workplace bullying. Some active responses such as confronting the bully, talking to the head nurse/manager, filing a formal complaint to the management, and asking for support from a trade union were mentioned by nurses in both cultures.

I got support from the trade union and learnt about my legal rights. Then I filed a formal complaint with the management. (TUR 8: target and bystander, female, age 33, staff nurse)

I am professional in my work and I was not impolite towards her [the bully] but I confronted her and she couldn't take that. (SE 9: Target and bystander, Female, Age 55, Staff nurse)

In contrast, active responses such as filing a legal complaint against the bully and fighting back against the bully were only mentioned by Turkish nurses.

After all, I was an experienced nurse. I had the courage to fight back against him. When he yelled at me, I yelled back. (TUR 12: target, female, age 29, head nurse)

Talking with colleagues, talking with friends/family, working harder, seeing a psychiatrist/psychologist and enduring were the passive target responses reported in both countries. Some targets in Turkey also described how they tried to avoid the bully.
In both countries, some participants ended up choosing an exit response (resigning, transferring to another unit), although these responses were more frequently described by Turkish nurses than Swedish nurses. Additionally, both Swedish and Turkish targets mentioned how they had to shift their strategies from active to passive responses when their attempts to break the bullying cycle were not successful.

First, I wanted to solve the problem by talking with her. Then I understood that it was not possible, because she was not even listening. Then I asked for a change of unit, but no change has been made yet. /.../ I am still enduring it. (TUR 9: target and bystander, female, age 25, staff nurse)

We were a group of five or six colleagues who went spontaneously to our manager to make a complaint about the bullies. However, she was almost angry with us, and never followed

up, so we just carried on working as usual. (SE 9: target and bystander, female, age 55, staff nurse)

3.6. Bystander responses to workplace bullying

This category included participants' comments on bystander responses to workplace bullying. Passive constructive bystander responses, such as listening to the target, were commonly mentioned in both cultures. However, there were clear differences in terms of the most common bystander responses reported in Turkey and Sweden. For example, compared with their counterparts in Sweden, Turkish bystanders mentioned more often using passive destructive responses such as avoiding taking action against workplace bullying.

My colleagues did not intervene. They knew they would be bullied if they said something. (TUR 3: target, female, age 51, staff nurse)

In contrast, among Swedish nurses several active constructive bystander responses were mentioned, such as talking to the manager. However, the managers often did not take any action to change the situation.

The bosses were quite absent and difficult to get hold of. When we made complaints, they did not act. (SE2: bystander, female, age 28, staff nurse)

4. Discussion

The objective of this study was to compare nurses' experiences of workplace bullying in two culturally distinct countries: Turkey and Sweden. The results yielded evidence for both differences and similarities between the two countries. The source of bullying was one of the differences observed between the reports of Turkish and Swedish nurses. In accordance with previous research (D'Cruz et al., 2016; Escartin et al., 2011; Karatuna et al., 2020; Salin et al., 2018), power distance accounted for this variation, e.g., downwards bullying was most common in Turkey (high power distance culture), whereas horizontal bullying was more often mentioned in Sweden (relatively low power distance culture).

Furthermore, in contrast to Turkey, upwards bullying was common among Swedish nurses. Consistent with this finding, bullying of managers by subordinates has been previously reported by studies conducted in relatively low power distance countries such as Australia (Branch et al., 2007; Tuckey et al., 2024) and Sweden (Björklund et al., 2019). Additionally, in a study conducted in Norway (low power distance country), Nielsen et al. (2024) found that leaders have the same risk of being bullied as non-leaders. However, inconsistent with our findings, there have also been some reports of upwards bullying in high power distance countries. For example, D'Cruz and Rayner (2013) found that even though downwards bullying was most frequent, the level of upwards bullying was also relatively high in India. Nevertheless, this was found to be related to the presence of cross-level co-bullying in which subordinates who bullied their superiors were rarely alone but acted with another superior in most cases.

Furthermore, in the current study, doctors were reported as a more common source of bullying in Turkey, compared with Sweden. This may be related to the traditional hierarchy of doctors over nurses (Filizli and Önler, 2020), which in turn supports the view that downwards bullying is most common in high power distance cultures.

The predominant type of bullying behavior was work-related in both samples consistent with previous research conducted among nurses (Johnson, 2021). However, overt behaviors such as verbal abuse were more common in Turkey than in Sweden. This finding may be attributed to the highly assertive characteristics of Turkish society (House et al., 2014), supporting the assumption that in low assertiveness cultures, people are more likely to manifest covert rather than overt bullying (Jacobson et al., 2014).

In line with previous nursing research (Johnson, 2021), organizational factors were the most commonly reported antecedents of bullying in both countries. Nevertheless, Turkish nurses referred to target's characteristics (e.g., being different from the rest of the work group) more often than their counterparts in Sweden. Turkey's high in-group collectivist culture, in which individuals tend to make a higher distinction between in-group and out-group members might account for this finding (Karatuna et al., 2020).

Targets in Turkey and Sweden shared similarities in their responses to workplace bullying and used a combination of active and passive responses. Nevertheless, we found evidence indicating that Turkish nurses more frequently chose exit responses than their peers in Sweden. This difference could be caused by the age difference between the Turkish participants (who were younger) and Swedish participants, in accordance with evidence showing that younger nurses are more likely to leave their job (Adams et al., 2021). Moreover, both Swedish and Turkish participants who ended up quitting, also reported that they initially used active coping strategies but had to change their strategies to avoidance and/or exit responses when their attempts did not prove successful. Similar findings were reported in previous studies that investigated the escalating process of workplace bullying (Karatuna, 2015; Krishna et al., 2023).

The current study revealed cross-cultural differences in bystander responses to workplace bullying between the two groups. While active constructive bystander responses (e.g., talking to the manager) were most frequently reported among Swedish nurses, Turkish bystanders most often avoided taking action in response to workplace bullying. This finding was in line with prior research which indicated that bystanders in low power distance cultures are more likely to intervene in workplace bullying compared with those in high power distance cultures (Guneri-Cangarli et al., 2013; Jungert and Holm, 2022). Nevertheless, although it was less common compared with nurses in Turkey, some bystanders in the Swedish sample remained silent, and fear of being the next target was evident in the narratives of both Turkish and Swedish interviewees. This finding was consistent with D'Cruz et al.'s findings (2016), in which fear of being targeted was identified as a mutual underlying reason for the passive stance of bystanders across culturally distinct countries.

Negative effects of workplace bullying among targets' health were similar in Turkey and Sweden, indicating that bullying is detrimental for nurses' health regardless of cultural differences. This finding was in line with prior research conducted among nurses. For example, a systematic review and meta-analysis that included studies from Korea Republic, China, Italy and Israel showed that workplace bullying was associated with higher job stress and a worse professional quality of life for nurses (Galanis et al., 2024). Furthermore, in a qualitative systematic review that included 27 studies from different countries (i.e., United States, Australia, Italy, Iran, Pakistan, South Africa), Shorey and Wang (2021) reported that workplace bullying affected nurses physically, emotionally and psychologically.

However, negative work-related attitudes were more often mentioned in Turkey than in Sweden. This finding was not in accordance with previous studies which showed that employees in low power distance cultures are more negatively affected by workplace bullying and incivility compared with employees in high power distance cultures (Loh et al., 2009; 2021). Therefore, one should be cautious in drawing conclusions based on this finding because the differences in work attitudes of Swedish and Turkish nurses may also be a result of differences in situational dispositions to work life rather than a result of differences in power distance characteristics (Hauf and Richter, 2015). For example, Turkish nurses often complained about their status in society (being seen as subordinate to doctors) and unclear job description. It might be the case that workplace bullying might affect nurses' work attitudes more negatively in the presence of such working conditions.

Furthermore, negative effects of bullying on bystanders (e.g., being emotionally affected, becoming the next target, resigning) were more common among nurses from Sweden. This may be related to Swedish nurses' frequent reports of active intervening in bullying situations than their counterparts in Turkey. However, in contrast to this assumption, Rosander and Nielsen (2023) found no increased risk of becoming the next target for Swedish respondents who had actively intervened in bullying situations when witnessing bullying of others. Therefore, further research is needed to better understand the consequences of intervening against workplace bullying.

Some limitations of this study should be mentioned. First, almost all participants included in the interviews were female. Some evidence indicates that male nurses are at higher risk of experiencing workplace bullying in a female-dominant profession (Eriksen and Einarsen, 2004). Hence, future research should also include male participants to examine gender-related effects on nurses' experiences of workplace bullying across different cultures. Second, the current findings provide insight into how nurses in this sample experience workplace bullying, which cannot be generalized to the whole population. A third limitation was the use of a snowball sampling method for data collection in Turkey. Although snowball sampling method is used in investigating difficult-to-access groups such as targets and bystanders of workplace bullying (e.g., Björklund et al., 2019; Johnson et al., 2015, Mishra et al., 2018), it might generate potential selection bias. We tried to reduce this bias by ensuring that Turkish participants came from different healthcare units.

Fourth, this study investigated nurses' experiences of workplace bullying in the light GLOBE cultural practices. Although GLOBE study is still one of the most important and often used framework in the workplace bullying and harassment research (Karatuna, 2020; Otterbach et al., 2021; Power et al., 2013; Salin, 2018, 2020; Stankov et al., 2022; Striebling, 2022), one must be critical in making assumptions based on the differences across national cultures as given in the GLOBE scores. Considering that it has been more than two decades since the publication of the GLOBE cultural data set, it is very likely that social, economic, and political changes may affect societal cultures (Pagda et al., 2021). Further research in different countries is necessary to be able to make meaningful inferences regarding the role of cultural practices in nurses' experiences of workplace bullying.

Finally, we only focused on three cultural practices of the GLOBE study (power distance, in-group collectivism, and assertiveness) in explaining the differences between Turkish and Swedish nurses' experiences of workplace bullying. Future research should consider other cultural practices (e.g., gender egalitarism, performance orientation) and other contextual factors such as the healthcare system and socio-economic status to strengthen our understanding in relation to varying bullying experiences across different countries.

The present findings have some implications for nursing management and healthcare organizations. The differences revealed in Swedish and Turkish nurses' reports suggest that cultural factors may influence the perceptions and experiences of workplace bullying. For instance, in high power distance cultures, bystanders might be less likely to intervene in bullying situations, or in high in-group collectivist cultures being different from the rest of the work group might be an important trigger of bullying, or in highly assertive cultures verbal abuse might be considered as normal, thus can be tolerated. Thus, from a practical point of view, healthcare organizations should consider developing tailor-made interventions that fit their local cultural contexts, rather than one-size-fits all solutions. Nevertheless, considering the similarities between Turkish and Swedish nurses' reports, it is also important for healthcare organizations and nursing managers to implement training programs aiming to raise awareness about workplace bullying and its detrimental consequences on targets, bystanders, and healthcare organizations.

Moreover, considering the globalization of healthcare that has led to increased mobility of nurses and internationalization of the nursing workforce, we believe that our findings can help managers in understanding possible varying perceptions of bullying in a culturally diverse workforce, and thereby developing more effective intervention strategies to counteract workplace bullying in globalized healthcare organizations.

5. Conclusions

This study contributed to workplace bullying research by exploring the similarities and differences in nurses' experiences of workplace bullying from a cross-cultural perspective. Our findings show that nurses in different countries might perceive and experience workplace bullying differently, and cultural factors play an important role in understanding different bullying experiences across countries. However, although culture may have an influence on

nurses' bullying-related experiences, it should be noted that we also found many similarities across countries, especially when it comes to the negative impacts of workplace bullying. Consequently, workplace bullying is a serious problem in the nursing profession across cultures. Drawing attention to cultural factors can help healthcare organizations and nursing managers to deal with bullying in a more effective way.

Author contributions

IK, SJ, and TM contributed to the conception and design of the study and analyzed the data. All authors listed performed the interviews and organized the data. IK wrote the first draft of the paper. All authors contributed to manuscript revision, read, and approved the submitted version.

Funding statement

This research was funded by the Swedish Research Council for Health, Working Life and Welfare (FORTE), Grant Number 2018-00228 and Grant Number 2016-07220.

Conflict of interest

The authors declare that there is no conflict of interest.

Acknowledgments

We thank Prof. Oğuz Başol, PhD. for reviewing the analysis and quotations of the Turkish data.

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