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Experiences, Beliefs and Perceptions of Emergency Department Nurses in Mental Resilience and Positive Emotions as Protective Factors Against Mobbing. A Qualitative Study

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Abstract: *Mobbing is a complex and multifaceted phenomenon frequently observed in Emergency Department (ED) settings, with profound implications for the mental health and professional performance of nurses. On a daily basis, nurses are confronted with highly demanding and often unpredictable situations, which expose them to ethical dilemmas, interpersonal tensions, and various forms of harassment. The present study seeks to explore the perspectives, experiences, and perceptions of healthcare professionals on mobbing, with particular attention to the role of psychological resilience and positive emotions as protective factors. Specifically, the research focused on: (a) the level of knowledge and awareness regarding mobbing, (b) the different forms of mobbing and their relation to psychological resilience, (c) the experience of positive emotions and coping strategies in the face of mobbing, and (d) preventive measures and proposed management strategies. This qualitative study was conducted with a purposive sample of 40 nurses employed across four Greek public hospitals. Data were gathered through 40 semi-structured interviews, structured around four central thematic axes comprising a total of 12 guiding questions. The findings suggest that mobbing is a tangible and ongoing problem within public healthcare institutions. Participants described workplace mobbing as a form of psychological abuse, most commonly manifested through verbal and behavioral expressions. It was further highlighted that such behaviors may stem not only from colleagues and supervisors but also from patients' relatives or caregivers. To prevent such incidents within healthcare environments, hospital administrations should embrace a more human-centered approach. Department heads need to be sufficiently trained and sensitized to identify and address instances of workplace harassment*

effectively. In addition, the introduction of educational and awareness-raising seminars, peer-support groups, and structured support programs for the recovery and reintegration of mobbing victims is strongly recommended.

Keywords: mobbing, emergency department, nurses, psychological resilience, positive emotions, workplace violence, qualitative research

INTRODUCTION

Mobbing, also referred to as moral harassment, is a pervasive occupational risk in healthcare, particularly for nurses who form the frontline of patient care. It is defined by repeated hostile actions, verbal intimidation, and systematic efforts to undermine professional competence, all of which have damaging consequences for individuals as well as healthcare systems. Within nursing, moral harassment is of particular concern as it negatively impacts job performance, motivation, productivity, the nurse–patient relationship, and overall psychological well-being (Einarsen et al. 2011; Arnetz et al. 2018). Nurses working in Emergency Departments (EDs) are especially vulnerable due to the high-intensity nature of their environment, which is characterized by overcrowding, limited resources, and emotionally charged encounters (Kowalenko et al. 2012; Koutsofta, Nteou, Ioannou, Georgiou, 2025). Healthcare professionals (HCPs) in EDs frequently confront excessive workloads, emotional exhaustion, and a lack of organizational support, factors that substantially heighten the risk of moral harassment (Dall'Ora, Ball, Reinius, Griffiths, 2020). Empirical evidence shows that such hostile work environments foster burnout, anxiety, depression, and turnover intentions, ultimately jeopardizing workforce stability and patient safety (Al-Quadi, Maruca, Beck, Walsh, 2022).

Iftikhar and Qureshi demonstrated that mobbing behaviors are closely linked to reduced work performance and increased depressive symptoms among nurses (Iftikhar, Qureshi, 2014). Similarly, Zhang et al. conducted a large-scale study in China that examined workplace violence among nurses. Out of 4,125 questionnaires distributed in 14 cities, 3,004 were returned. Findings revealed that 25.77% of respondents had experienced physical violence, 63.65% verbal abuse, and 2.76% sexual harassment. The study further indicated that less experienced nurses, part-time staff, and those working in emergency and pediatric departments displayed lower stress tolerance and were more likely to encounter mobbing (Zhang, Wang, Xie, Zhou, Li, Yang, Zhang, 2017).

In Greece, the phenomenon has also been documented. Research highlights that moral harassment is present across a variety of work contexts, including healthcare settings (Serafeimidou, Dimou, 2016; Pantazis, Intas, 2016; Fountouki, Pediaditaki, Theofanidis, 2011; Rodriguez-Carballeira, Escartib, Zapf, Arrieta, 2010; Koinis, Velonakis, Kalafati, Tziaferi, 2019; Koinis, Tziaferi, 2014; Karatza, Zyga, Tziaferi, Prezerakos, 2016; Karakioulafi, 2003; Konstantinidis, 2011; Spiridakis, 2009). Contributing factors include organizational shortcomings, management practices, and dysfunctional team dynamics (Leymann, 1996; Zapf, Knorz, Kulla, 1996). The consequences extend beyond the individual to affect families, institutional efficiency, and productivity (Chappel, Martino, 2001; Papalexandris, Galanaki, 2011; Ege, 2002; Ferrari, 2004). Victims of workplace harassment often report difficulties in collaboration, reduced stress resilience, and even somatic symptoms (Dikmetas, Top, Ergin, 2011).

Studies investigating the effects of moral harassment on nurses have consistently shown that exposure to mobbing results in fatigue, anxiety, insomnia, impaired concentration, restlessness, and a sense of failure (Yildirim, 2009; Cinar, Kormaz, Yilmaz, 2016). Such psychological strain undermines the effective implementation of the nursing process and compromises the delivery of high-quality patient care (Patsia, Polychronopoulou, Sakaretsanou, 2017). In Greece, qualitative research has provided further insights into these experiences. Patsia et al. (2017) found that although most nurses had not been falsely accused or silenced from expressing their opinions, many reported being subjected to negative criticism or verbal aggression from superiors (Patsia, Polychronopoulou, Sakaretsanou, 2017). Similarly, Najafi et al. in Iran identified risk factors for workplace violence such as unrealistic expectations from patients and their families, inadequate administrative handling of bullying, poor professional communication, and both personal and colleague-related issues. Their findings linked workplace violence to a deterioration in care quality and a more negative outlook toward the nursing profession (Najafi, Fallahi-Khoshknab et al., 2017).

Amid such challenges, psychological resilience has emerged as a critical protective factor. Defined as the dynamic capacity to adapt positively to adversity, resilience enables ED nurses to regulate stress, preserve their professional identity, and derive meaning from demanding circumstances (Liu, Zhang et al., 2023; Jiang, Liu et al., 2024). Qualitative studies suggest that resilience should not be understood solely as an individual trait but also as an interpersonal and organizational resource, strengthened through peer support, effective leadership, and a culture of collective efficacy (Riley, Kokab et al., 2021). Resilience works in tandem with positive emotions, which, according to Fredrickson's broaden-and-build theory, enhance cognitive flexibility, foster stronger interpersonal connections, and generate long-term psychological resources (Fredrickson, 2004). For ED nurses, experiences of professional pride, gratitude, and fulfillment have been shown to buffer the adverse impact of mobbing and sustain engagement in the face of ongoing adversity (Gillespie, Berry Gates, Kowalenko, Chapman, 2023).

The experience of positive emotions is also strongly connected to quality of life (QoL), which acts as a mediator between workplace stressors and health outcomes. QoL—encompassing physical, psychological, and social dimensions of well-being—has been recognized as a central determinant of how nurses respond to occupational stressors (WHO, 1997). A higher QoL enables healthcare professionals to maintain psychological balance, resist the corrosive impact of mobbing, and remain committed to clinical practice (Kalliath, Morris, 2002). Emotional well-being, positive relationships, and professional satisfaction together form a protective shield that preserves psychological resources and sustains engagement despite workplace challenges (WHO, 1997; Kalliath, Morris, 2002). Positive emotions, in turn, reinforce self-efficacy and strengthen workplace relationships, thereby contributing to a more resilient professional identity (Fredrickson, 2004).

Taken together, resilience, positive affect, and quality of life operate as interconnected protective factors that mitigate the harmful consequences of moral harassment in ED settings. Interventions that strengthen these dimensions—such as peer support systems, leadership recognition, and organizational policies that promote psychological safety—are essential for safeguarding nurse well-being and improving the quality of patient care (Liu, Zhang et al., 2023; Riley, Kokab et al., 2021). Thus, the interplay between resilience, positive affect, and quality of life emerges as a multidimensional protective mechanism that not only helps nurses cope with mobbing but also provides critical guidance for healthcare organizations in designing interventions that promote sustainable well-being and professional commitment.

Qualitative Studies on Workplace Violence, Moral Harassment, and Protective Factors in Emergency Departments

Several qualitative investigations have examined workplace violence and moral harassment in Emergency Departments (EDs), consistently underscoring the role of resilience, positive emotions, quality of life, and organizational support as pivotal protective factors. Davey et al., through semi-structured interviews with 63 physicians, nurses, and paramedics across seven EDs in India, reported that violence was predominantly triggered by patient companions, extended waiting times, and heavy workloads. Identified protective mechanisms—effective communication, structured staff training, and public awareness campaigns—were shown to mitigate adverse psychological outcomes and support staff well-being (Davey, Ravishankar, et al., 2020).

Lyver et al., in 52 in-depth interviews conducted in two academic urban EDs, revealed key themes such as "Violence as part of the job," "Leadership dynamics," and "Inconsistencies in team response." Their findings emphasized that supportive leadership, standardized procedures, targeted training, and collaborative team culture function as resilience-enhancing resources, improving both workplace climate and individual coping capacities (Lyver, Singh, et al., 2025).

Similarly, Querin et al. (2022) examined narratives from resident physicians and ED staff, documenting frequent incidents of verbal and physical abuse, often underreported. Collegial debriefing and organizational support following such events emerged as critical psychological safeguards, highlighting the necessity of institutional protocols and systematic training in addressing workplace violence (Querin, Beck, Dallaghan, Shenvi, 2022).

Building on this, Liu et al., through a meta-synthesis of 12 qualitative studies, identified four central themes of resilience in emergency and critical care nurses: social support from colleagues and family, self-regulation and active learning, a strong sense of professional meaning and accomplishment, and leadership/unit culture. These factors were directly linked to positive emotions, personal growth, and enhanced quality of life (Liu, Zhang et al., 2023).

Billings et al., investigating protective factors among UK junior doctors, pointed to the importance of peer networks, team cohesion, high-quality supervision, equitable workload distribution, and opportunities for recovery during shifts. Although not limited to ED contexts, these insights are readily transferable to emergency care environments (Riley, Kokab et al., 2021).

Finally, Stjerna Doohan et al. (2024) explored threats and violence in prehospital EMS settings, demonstrating that aggression management training, clear operational protocols, interagency collaboration, and peer support constitute effective protective mechanisms also applicable to ED staff (Stjerna Doohan, Davidsson, Danielsson, Aléx, 2024).

Collectively, these studies converge on the conclusion that organizational support, collegial relationships, professional meaning, and resilience-enhancing strategies are indispensable in buffering the psychological and professional toll of workplace violence and moral harassment. Synthesizing these findings provides an evidence base for the design of interventions aimed at safeguarding nurse well-being, fostering resilient workplace cultures, and ultimately improving patient care outcomes.

The purpose of the research

This study forms part of a broader research initiative examining how mental resilience and the experience of positive emotions enable Emergency Department (ED) nurses to cope with mobbing in

Greek public hospitals. The qualitative component specifically investigates ED nurses' perceptions and lived experiences, focusing on resilience and positive emotions as protective resources against harassment. The aim is twofold: first, to explore how these factors shape coping mechanisms, and second, to identify prevention and intervention strategies that can strengthen psychological well-being and enhance workplace safety. By doing so, the study addresses existing gaps in the literature, offering new insights into the conceptualization and manifestation of mobbing, while simultaneously raising awareness among healthcare professionals of its impact and significance.

The main research questions:

Research Questions

1. What is the level of knowledge and awareness among ED nurses regarding mobbing in the workplace?

2. What forms of mobbing do ED nurses commonly experience or observe?

3. How do ED nurses respond to incidents of mobbing, and what coping strategies do they use?

4. How do mental resilience and positive emotions influence nurses' ability to manage and withstand mobbing?

5. What positive emotions do nurses experience at work, and how do these affect their psychological well-being?

6. What preventive measures and organizational strategies are perceived as effective in addressing mobbing?

Scope and Aims of the Research

This study represents the qualitative component of a broader mixed-methods research project examining the experiences, beliefs, and perceptions of Emergency Department (ED) nurses regarding mental resilience and positive emotions as protective factors against mobbing in Greek public hospitals. Its primary objective is to explore how resilience and positive emotional experiences shape coping strategies and strengthen nurses' capacity to endure workplace moral harassment. A further aim is to identify preventive measures and organizational strategies that may promote psychological well-being and foster safer, more supportive work environments for nursing staff. Understanding these psychosocial dimensions is critical for designing targeted interventions that alleviate the psychological burden of mobbing and contribute to improved occupational health outcomes (Braun, Clarke, 2006; Patton, 2002; Pope, Mays, 2006).

Significance and Importance of the Study

This qualitative study addresses a critical gap in understanding the complex interplay between mental resilience, positive emotions, and the experience of moral harassment (mobbing) among Emergency Department (ED) nurses in Greek public hospitals. Mobbing within healthcare has been consistently associated with heightened psychological distress, burnout, diminished job satisfaction, and compromised quality of patient care (Einarsen et al. 2011; Laschinger, Grau, Finegan, Wilk, 2010). By examining the subjective experiences, beliefs, and perceptions of ED nurses, the study provides

nuanced insights into how protective psychological resources may buffer the negative consequences of workplace harassment.

The focus on resilience and positive emotions as coping mechanisms is particularly salient within the high-intensity context of emergency care, where nurses are regularly exposed to ethical dilemmas, emotional strain, and interpersonal conflict (McAllister, McKinnon, 2009). Understanding the role of these protective factors is essential for informing targeted interventions that not only enhance psychological well-being but also sustain professional commitment in the face of adversity.

Beyond individual coping, this study contributes to the broader discourse on occupational health by underscoring the need for organizational and policy-level initiatives that confront mobbing and cultivate supportive workplace cultures (Johnson, 2009). Findings derived from the thematic analysis offer actionable recommendations for hospital administrations, including preventive frameworks and structured management strategies designed to strengthen staff morale and improve patient care outcomes.

Moreover, the study's conclusions resonate with global priorities advocating for mental health support and workplace safety in healthcare professions (WHO, 2020). In doing so, it reinforces the importance of integrating evidence-based practices into organizational policy, thereby advancing healthier and more sustainable work environments for frontline healthcare professionals.

METHODOLOGY

Study Design

This study adopts a qualitative research design, employing semi-structured, in-depth interviews to generate rich and contextually grounded data. Qualitative content analysis, complemented by thematic analysis based on Braun and Clarke's framework (Elo, Kyngäs, 2008) was used to systematically identify, code, and organize themes emerging from the interview transcripts. This analytic approach enabled a deeper exploration of participants' subjective experiences and the meanings they attributed to mental resilience and moral harassment within the emergency healthcare environment.

The chosen methodology reflects best practices for investigating complex psychosocial phenomena that are not readily captured through quantitative methods (Creswell, Poth, 2018). Semi-structured interviews were conducted with nurses working in the Emergency Departments of all four participating hospitals, facilitated via videoconferencing to ensure accessibility and consistent researcher–participant engagement.

Place of Conduct

The study was conducted in four (4) selected Greek public hospitals: The University General Hospital of Larissa, the General Hospital of Karditsa, the General Hospital of Trikala and the General Hospital of Volos "Achillopoulio". These sites were chosen due to their representative roles in regional emergency healthcare delivery and prior approval from hospital administrations (Protocol Nos. 6641/8-2-2024, 5236/28-3-2024, 5744/10/26-2-2024) to support research involving nursing staff.

Study sample

The study sample consisted of 40 nursing professionals (25 females, 15 males) employed in the Emergency Departments (EDs) of four public hospitals in the Thessaly region of Greece. Participants

were recruited using purposive sampling to capture individuals with direct experiences of moral harassment, as well as variation across age, family status, educational background, and years of professional practice. This strategy ensured the collection of diverse, information-rich data aligned with the study objectives (Patton, 2002; Creswell, Poth, 2018).

Among the female participants (n = 25, 62.5%), three age groups were represented: 24–40 years (n = 10), 40–50 years (n = 10), and 50–55 years (n = 5). Family status included married (n = 18), single (n = 4), divorced (n = 2), and widowed (n = 1). Educational qualifications ranged across Technological Education diplomas, University degrees, and Vocational Training diplomas, distributed as follows: 4, 1, and 5 in the youngest group; 5, 1, and 4 in the middle group; and 3, 1, and 1 in the oldest group. Years of professional experience varied from approximately 2 to more than 11 years.

Male participants (n = 15, 37.5%) were also distributed across three age groups: 24–40 years (n = 4), 40–50 years (n = 8), and 50–55 years (n = 3). Their family status included single (n = 2), married (n = 11), and divorced (n = 2). Most male nurses held Technological Education diplomas or Vocational Training diplomas, with a smaller proportion holding University degrees. Professional experience similarly ranged from 2 years to over 11 years.

This demographic stratification ensured representation across variables with potential influence on experiences and perceptions of moral harassment, resilience, and positive emotions in the workplace (Guest, Bunce, Johnson, 2006; Elo, Kyngäs,2008). Participants' demographic and professional characteristics are summarized in Table 1.

Inclusion Criteria

Participants were eligible if they met the following conditions:

Full-time employment in an ED at one of the participating hospitals;

Licensed nursing personnel, including registered nurses and nurse assistants (Zhang, Punnett, Nannini, 2016);

A minimum of six months' continuous service in their current ED role, ensuring sufficient exposure to the work environment (Bowling, 2005);

Proficiency in Greek sufficient to comprehend and complete the study materials;

Provision of informed written consent to participate.

Exclusion Criteria

Participants were excluded if they met any of the following conditions:

- On temporary leave, extended absence, or probationary contracts during data collection;
- Occupying administrative or exclusively supervisory roles with minimal direct patient contact;
- Less than six months of ED experience;
- Declined or failed to provide informed consent;
- Prior participation in a similar survey within the preceding year, to minimize survey fatigue and response bias (Yildirim & Yildirim, 2007)

Table 1. Sample of qualitative study: Demographic and personal data

Nursing Personnel (All Qualification Levels)	n-total	Age Group	Sex	Number of nurses	Family Status	Education Level (Nurse with Technological Education/ Nurse with a University degree / Nurse with a Vocational Training diploma	Years of work Experience
Female Nurses	n=25 (62.5%)	24–40	Female	12	8 married 4 single	7 / 2 / 3	Approx. 2–5 years
		40–50	Female	10	10 married	5 / 1 / 4	Approx. 6–10+ years
		50–55	Female	3	2 divorced 1 widowed	3 / 1 / 1	Approx. 11+ years
Male Nurses	n=15 (37.5%)	24–40	Male	4	2 single 2 married	1 / 0 / 3	Approx. 2–5 years
		40–50	Male	8	6 married 2 divorced	5 / 1 / 2	Approx. 6–10+ years
		50–55	Male	3	3 married	3 / 0 / 0	Approx. 11+ years

Note: The sample comprised 40 nursing professionals employed in Emergency Departments across four public hospitals in Thessaly, Greece. Purposive sampling was employed to ensure representation across varied age groups, gender, marital status, educational qualifications (Technological Education, University degree, Vocational Training diploma), and professional experience ranging from 2 to over 11 years.

Ethical Approval and Research Ethics

This qualitative study, conducted as part of a broader mixed-methods research project, received formal approval from the administrations of the University General Hospital of Larissa (Protocol No. 6641/8-2-2024), the General Hospital of Karditsa (Protocol No. 5236/28-3-2024), and the General Hospital of Trikala (Decision No. 162, Protocol No. 5744/10/26-2-2024). The research was carried out in strict accordance with ethical principles governing human subjects research, including voluntary participation, anonymity, confidentiality, and the right to withdraw at any stage without penalty.

Data collection was conducted through semi-structured videoconference interviews, each lasting 30–40 minutes. Prior to participation, written informed consent was obtained, following a clear explanation of the study objectives, confidentiality safeguards, and participant rights. Given the sensitive nature of the topic and the vulnerability of the nursing population, additional measures were adopted to preserve participants' dignity and well-being (WHO, 2013; Liamputtong, 2020). While no direct psychological intervention was provided, participants were informed of available mental health support services. The research team received training to recognize potential signs of participant distress; no such cases occurred during data collection.

The ethical procedures complied fully with both national and international guidelines for research involving human subjects (Emanuel, Wendler, Grady, 2000; Israel, Eng, Schulz, Parker, 2005).

Participants were explicitly informed of their rights, including data protection and pseudonymization, the option to decline responses to specific questions, and the opportunity to seek clarifications during the interview process (Patton, 2002; Pope, Mays, 2006). The study aims to inform policy and practice by contributing to interventions that alleviate psychological burden and foster emotional well-being among emergency nurses.

Data Collection and Analysis

This qualitative study was carried out through individual semi-structured, in-depth interviews with healthcare professionals from selected hospitals, forming the qualitative strand of a larger mixed-methods project. Written informed consent was obtained from all participants prior to data collection. Participation was entirely voluntary, with no incentives offered and no adverse consequences for refusal.

The interview guide was structured around four thematic axes, each comprising three open-ended questions, resulting in a total of twelve prompts designed to elicit participants' experiences, perceptions, and coping strategies related to mobbing, mental resilience, and positive emotions (see Table 2). Interviews, lasting approximately 30–40 minutes, were conducted via videoconference to ensure accessibility. Each participant was assigned a unique identifier (e.g., N.S.1), where "N" denotes nursing, "S" staff, and the number corresponds to the order of participation.

Data analysis employed a combination of qualitative content analysis (Patton, 1990; Bowling, 2002; Silverman, 2001) and thematic analysis based on Braun and Clarke's six-phase framework (Braun & Clarke, 2006). Content analysis entailed systematic coding and categorization of textual data to facilitate an organized understanding of participants' narratives. Thematic analysis followed a sequential process involving transcript familiarization, initial code generation, theme identification, iterative review, theme definition, and final reporting. This approach allowed for both structured data organization and an in-depth exploration of latent patterns, ultimately capturing the complexity and richness of nurses' perspectives. The main themes emerging from the analysis are summarized in Table 3.

Table 2. Semi-stuctured interviewing axes

Thematic Axis	Interview Question No.	Interview Question
Axis 1: Experience of Positive Emotions in the Workplace	Q1	Are there moments in your work when you feel positive emotions? If yes, when does this occur?
	Q2	How do you think positive emotions help you cope with situations of mobbing?
	Q3	Are there specific practices that help you maintain a positive mood in the workplace?

Axis 2: Quality of Life and Working Conditions	Q4	How would you assess your overall quality of life as a healthcare professional in the ED?
	Q5	Which factors in your workplace enhance or reduce your quality of life?
	Q6	How do you believe working conditions affect your resilience to mobbing?
Axis 3: Mental Resilience and Coping with Mobbing	Q7	What does mental resilience mean to you?
	Q8	What strategies do you use to strengthen your mental resilience at work?
	Q9	Do you believe mental resilience is enough to cope with mobbing?
Axis 4: Prevention Measures and Interventions	Q10	What measures do you think could be taken to reduce mobbing?
	Q11	How can management contribute to preventing mobbing?
	Q12	How could collaboration among colleagues be strengthened to avoid such phenomena?

Note: The interview guide consisted of four thematic axes, each containing three open-ended questions, for a total of twelve questions. The structure was designed to elicit information on emergency department nurses' experiences, beliefs, and perceptions regarding positive emotions, mental resilience, and measures to prevent or address mobbing.

Table 3. Thematic Analysis of Interview Data

Axis	Theme	Indicative Participant Responses
1. Experience of Positive Emotions	Theme 1.1: Moments eliciting positive emotions (Expression of gratitude by patients)	"I feel good when my patients thank me."
	Theme 1.2: The role of positive emotions in coping with negative situations (Effective team collaboration)	"When we collaborate effectively during a difficult case, I feel very positive."
	Theme 1.3: Strategies for maintaining a positive mood (Use of short breaks)	"A short break at work helps me maintain my composure."
2. Quality of Life and Work Conditions	Theme 2.1: Impact of work conditions on quality of life (Challenges due to workload)	"The job is very demanding, especially during shifts with limited staff."
	Theme 2.2: Factors enhancing or diminishing quality of life (Support from colleagues)	"Support from colleagues is important, especially when I feel pressured."
	Theme 2.3: Influence of quality of life on resilience (Work-life balance)	"I try to maintain a balance, but it is difficult with the job's demands."
3. Mental Resilience and Coping with Mobbing	Theme 3.1: Definition and significance of psychological resilience (Resilience as strength)	"Resilience means being able to keep going despite difficulties."
	Theme 3.2: Strategies to strengthen resilience (Family support)	"My family helps me cope with work-related stress."
	Theme 3.3: Adequacy of resilience as a protective factor (Self-care strategies)	"I try to relax after work with activities I enjoy, like reading."
4. Preventive Measures and Interventions	Theme 4.1: Suggestions for reducing mobbing (Training on recognizing moral harassment)	"It would be helpful to know how to recognize and address harassment."
	Theme 4.2: Role of management (Support from administration)	"Management needs to show that they stand by us in such incidents."
	Theme 4.3: Enhancing cooperation among colleagues (Strengthening teamwork)	"Activities outside work could help us get to know each other better and improve cooperation."

Note: This table summarizes the main themes from interview data, illustrating key participant perspectives with representative quotes across four thematic axes.

RESULTS/FINDINGS

Results/Findings of Thematic Analysis of Nurses' Interviews

The interviews were conducted with 25 female and 15 male nurses, yielding significant findings and observable trends, which are presented below according to the main thematic axes of analysis. Of the 40 participants, twenty-nine (29) were married, six (6) single, four (4) divorced, and one (1) widowed. In terms of professional experience, sixteen (16) reported 2–5 years, eighteen (18) had up to 10 years, and six (6) possessed more than 10 years of work experience.

The majority of the themes identified through the analysis fell within the following domains: *Experience of Positive Emotions in the Workplace; Quality of Life and Working Conditions; Mental Resilience and Coping with Mobbing; and Prevention Measures and Interventions.*

Illustrative quotations from participants are included below to support the thematic findings. All excerpts from health professionals were originally provided in Greek and have been translated into English for reporting purposes.

Analysis-Main Findings-Observations

Experience of Positive and Negative Emotions in the Workplace

The majority of participants reported positive emotional experiences in the workplace, with 18 of 25 female nurses and 11 of 15 male nurses expressing feelings of satisfaction and gratitude. Female nurses primarily emphasized the sense of fulfillment and gratitude derived from patient recovery, whereas male nurses more frequently associated positive emotions with recognition of their work and collegial support. Age also influenced the emphasis placed on emotional experiences: younger female nurses (24–40 years) highlighted satisfaction arising from teamwork and collaboration, while older nurses (40–55 years) placed greater value on personal recognition and the sense of making a meaningful contribution to patients' lives.

In contrast, negative emotions were predominantly linked to workload and psychological stress across both genders. Participants frequently described feelings of exhaustion and frustration, attributing these largely to inadequate support and insufficient recognition of their efforts. Older female nurses (50–55 years) further disclosed that personal challenges, such as divorce or widowhood, negatively affected their workplace mood, with many reporting loneliness and social isolation. These findings underscore the dual nature of emotional experiences in nursing, shaped by both organizational conditions and personal life circumstances.

All 40 participants indicated that they employed strategies to sustain a positive emotional state during shifts. Short breaks were consistently identified as an effective coping mechanism, enabling nurses to regain composure, relieve stress, and return to their duties with renewed focus. During these breaks, participants typically engaged in simple restorative activities such as hydrating, stepping outside for fresh air, or engaging in light conversations with colleagues. The availability of such opportunities was widely perceived as essential for maintaining mental clarity and emotional balance in the demanding environment of emergency care (Table 4).

A nurse substantiated: "*Yes, I feel satisfied when a patient expresses gratitude for the care I provide. I also feel positive when I work well with my team to treat emergencies*. (Female nurse, 34 years old, 8 years of experience)

A nurse elucidated: "*Unfortunately, these moments are very rare. I often feel that stress and fatigue dominate. Sometimes, when we manage to help a patient and see them recover, I feel like I'm doing something good. But, in general, the positive moments are few and far between and quickly forgotten due to the constant pressures*". (Female nurse, 40 years old, 12 years of experience, Ass. Nurse)

One nurse conveyed: "*Yes, there are many moments when I feel satisfaction from my work, especially when I see the immediate relief or improvement of our patients. Also, when working with my team to address difficult situations, the sense of collaboration fills me with positivity".* (Male nurse, 49 years old, 22 years of experience)

When asked, "How do you believe that positive emotions help you cope with situations of mobbing?" nurses working in Emergency Departments (Eds), described both constructive and limiting aspects of relying on positive emotions as a coping strategy.

One nurse underscored: *«Maintaining a sense of optimism allows me to focus on my professional duties without being consumed by the hostility. It helps me to preserve my mental stability and continue providing high-quality patient care despite the tension."* (Female nurse, 46 years old, 15 years of experience)

A nurse corroborated: *«Positive emotions, such as compassion and empathy, enable me to respond to harassment without aggression, which often prevents escalation and maintains a safer environment for both staff and patients."* (Male nurse, 30 years old, 6 years of experience)

A participant expounded: *«While I try to stay positive, relying solely on optimism sometimes delays my decision to report the problem. It can make me tolerate behaviors that should not be acceptable."* (Female nurse, 54 years old, 28 years of experience)

A nurse affirmed the view that: *"In the high-stress environment of the Emergency Department, positive thinking can be protective in the short term, but if the harassment persists, it may lead to emotional exhaustion because I avoid confronting the situation directly."* (Male nurse, 48 years old, 12 years of experience)

In response to the question, *"Are there specific practices that help you maintain a positive disposition in the workplace?"* nurses employed in Emergency Departments reported a variety of strategies. These ranged from patient-centered focus and collegian communication to personal organization and external social support.

One nurse provided insight into: *«I try to maintain a positive attitude by focusing on the patients and the help I provide them. When I feel that my work is stressful, I communicate with my colleagues, share my concerns, and find ways to relax after work. Support from my family is also very important for sustaining a positive outlook."* (Female nurse, 42 years old, 14 years of experience)

A participant characterized: *«I make time to talk to colleagues whenever possible. If I have a short break, I use it to regroup and restore my mental balance."* (Male nurse, 35 years old, 5 years of experience)
One participant emphasized: *«Usually, I do not have time to implement specific practices.*

Occasionally, I try to talk with colleagues, but the stress and pressure of the Emergency Department leave little room to maintain a positive mood." (Female nurse, 52 years old, 27 years of experience, Ass.Nurse)

One nurse observed that: *"I always try to see the positive side of things, even during difficult periods. For me, organization and planning are essential. Communication with colleagues is also important; when relationships are good, teamwork becomes easier, and maintaining positive energy is more achievable."* (Male nurse, 408 years old, 11 years of experience)

Table 4. Positive and Negative Emotional Experiences Among Nurses and Associated Strategies

Category	Female Nurses	Male Nurses	Age-Related Trends	Common Negative Emotions	Coping Strategies
Positive Emotions	18/25 reported satisfaction and gratitude	11/15 reported satisfaction	Younger females (24–40): satisfaction from teamwork and collaboration Older nurses (40–55): personal recognition, meaningful impact	–	Short breaks, simple restorative activities
Sources of Positive Emotions	Patient recovery	Recognition of work, support from colleagues	–	–	Hydration, stepping outside, light conversations
Negative Emotions	Work overload, psychological stress	Work overload, psychological stress	Older females (50–55): personal challenges such as divorce or widowhood increased feelings of loneliness/social isolation	Exhaustion, frustration, lack of support, insufficient recognition	–
Coping Strategies Used	100% participants reported strategies	100% participants reported strategies	All age groups: short breaks crucial for regaining focus and emotional balance	–	Short breaks, hydrating, fresh air, colleague interaction

Note: The table summarizes nurses' reported emotional experiences, distinguishing between positive and negative affect, associated contributing factors, and employed coping strategies, with attention to age and gender variations.

Quality of Life, Work Conditions and Its Influence on Resilience among Emergency Department Nurses

The majority of participants indicated that their overall quality of life was strongly shaped by workload, working conditions—most notably staff shortages—and irregular schedules. Specifically, 88% of female nurses (22/25) and 80% of male nurses (12/15) identified these factors as central determinants of their well-being.

Age-related differences also emerged. Nurses aged 24–40 years (4 females, 2 males) and those aged 40–50 years (8 females, 6 males) emphasized the detrimental effects of continuous shift work and restricted free time on family life. Such working patterns were commonly associated with work–family conflict, fatigue, and decreased life satisfaction.

Positive interpersonal relationships, and particularly effective teamwork with colleagues, were identified as important contributors to quality of life. This was acknowledged by 60% of male nurses and 50% of female nurses. Nevertheless, limited time for family responsibilities or personal care was consistently reported across both genders as one of the most stressful dimensions of their professional role.

Recognition and support were likewise considered critical. Nurses who reported higher levels of quality of life (10 females and 7 males) frequently highlighted the significance of recognition from hospital management, along with emotional and practical support from family members and colleagues. Within this group, female nurses aged 24–40 years (n = 6) and 40–50 years (n = 4), together with male nurses aged 24–40 years (n = 2) and 40–50 years (n = 5), underscored the value of supportive leadership and robust social networks in sustaining their well-being.

Quality of life was also closely associated with resilience. Higher resilience was evident among nurses who experienced a more manageable workload (12 females, 9 males), enjoyed supportive relationships, and received recognition from leadership. In contrast, those subjected to greater work pressure and substantial disruptions to family or personal life—particularly nurses aged 40–50 years (n = 2) and 50–55 years (n = 3)—reported lower resilience, rendering them more susceptible to burnout and psychological strain (Table 5).

A nurse conveyed a perspective that: "*My quality of life is quite good due to family support, but the job is demanding and often causes stress and tension. Nevertheless, I love my profession, and this keeps me positive*." (Male Nurse, 32 years old, 8 years of experience).

A nurse said: "*My quality of life is not bad professionally, but personal issues affect me a lot. Workload and long shifts exacerbate my exhaustion*." (Male Nurse, 38 years old, 12 years of experience).

A participant reflected: "*Recently, my quality of life has been significantly affected. Personal issues, such as divorce, weigh heavily, and the daily stress at work is overwhelming*." (Female Nurse, 45 years old, 20 years of experience).

A nurse articulated: "*I feel very satisfied with my life, both professionally and personally. Despite a heavy schedule, my work is rewarding and meaningful*." (Female Nurse, 29 years old, 5 years of experience)

Work factors play a critical role in shaping nurses' quality of life, affecting both their job satisfaction and psychological well-being. In line with this, indicative responses from nurses are presented below.

A participant indicated: "*Support from colleagues and good collaboration enhance my quality of life, but understaffing and intense shifts exhaust me.*" (Male Nurse, 32 years old, 8 years of experience).

A nurse conveyed a perspective that: "*Good teamwork and support from colleagues are very positive, but lack of staff and unclear communication with management reduce my quality of life*." (Male Nurse, 38 years old, 12 years of experience).

One nurse commented that: "*The working conditions are demanding, and lack of personnel further exacerbates the situation. Administrative support is minimal, and recognition is rare*." (Female Nurse, 45 years old, 20 years of experience).

One participant emphasized: "*Collaboration and support from colleagues improve my ability to cope with stress and enhance my quality of life*." (Female Nurse, 29 years old, 5 years of experience).

Regarding the impact of working conditions on resilience to mobbing, nurses reported that both organizational support and workplace stress significantly influence their ability to cope. Their responses highlight how favorable conditions can strengthen resilience, while high stress and lack of support diminish it.

A nurse identified that: *«Under high stress and pressure, my resilience drops, and it is difficult to manage mobbing."* (Male Nurse, 32 years old, 8 years of experience).

A nurse substantiated: *"If work is well-organized and there is support from colleagues and management, I feel stronger and more capable of dealing calmly with harassment."* (Male Nurse, 38 years old, 12 years of experience).

A participant expounded: *"Currently, my resilience is low. When supported by colleagues and supervisors, I feel more able to handle any negative behavior."* (Female Nurse, 45 years old, 20 years of experience).

One nurse interpreted: *«It is hard to stay mentally resilient under demanding conditions. Stress and exhaustion make it very difficult to protect myself."* (Female Nurse, 29 years old, 5 years of experience).

Table 5. Occupational Stressors, Positive Influences, and Resilience among Nurses

Age Group (years)	Gender	Key Stressors	Positive Influences	Resilience / QoL
24–40	Female	Shift work, limited free time	Supportive colleagues, recognition, social support	High
24–40	Male	Shift work, limited free time	Supportive colleagues, recognition, social support	High
40–50	Female	Shift work, family disruption	Supportive leadership, recognition	Moderate
40–50	Male	Shift work, family disruption	Supportive leadership, recognition	Moderate
50–55	Female	Work overload, disrupted personal/family time	Limited support	Low

Note: This table summarizes the main occupational stressors and positive factors influencing nurses' quality of life (QoL) and resilience. High resilience and QoL are linked to supportive work environments, recognition, and balanced workloads, while excessive work demands and disrupted personal/family time correlate with reduced resilience.

Psychological Resilience and Mobbing among Emergency Department Nurses

Psychological resilience among most participants was found to be primarily rooted in emotional support received from patients and family members. Nurses reporting higher levels of resilience were predominantly younger professionals aged 24–40 years, who demonstrated strong intrinsic motivation to help others, coupled with a sense of commitment and dedication to their work. By contrast, older nurses aged 50–55 years described greater difficulties in maintaining resilience, attributing these challenges to increased family responsibilities and personal burdens.

The data also indicated that 12% of male nurses within the 24–40 age group had experienced some form of mobbing from supervisors or colleagues. A considerable number chose not to formally report these incidents, citing fears of retaliation or negative career consequences. Among female nurses, 18% reported exposure to mobbing. Those most affected by its psychological impact were older women, particularly those who were divorced or widowed, who explained that personal hardships further undermined their resilience in the workplace.

When asked whether psychological resilience alone is sufficient to effectively cope with mobbing, the majority of participants agreed that although resilience is essential, it is not adequate on its own to neutralize the adverse effects of such experiences. Female nurses aged 24–40 years (n = 12) generally expressed greater confidence in their coping abilities, often linking their resilience to personal motivation and strong emotional support from family and colleagues. In contrast, female nurses aged 40–50 (n = 10) and 50–55 (n = 3) voiced more reservations, emphasizing the critical role of organizational support and effective workplace policies in addressing mobbing.

Similarly, male nurses aged 24–40 years (n = 4) described resilience as strengthened by peer support, while those aged 40–50 (n = 8) and 50–55 (n = 3) highlighted the erosion of resilience due to cumulative occupational stress and personal pressures. These participants stressed the importance of external interventions to reinforce coping mechanisms and sustain psychological balance.

The responses further explored nurses' conceptualizations of resilience, the strategies employed to cultivate it, and their perspectives on its effectiveness in managing workplace stress and harassment. Understanding these dimensions is essential for enhancing staff well-being and optimizing patient care outcomes. Table 6 summarizes the key findings, presenting the distribution of resilience levels, reported experiences of mobbing, and participants' views on the adequacy of resilience in confronting workplace adversity.

One nurse exemplified: "*For me, mental resilience is the capacity to maintain professional focus and composure in the face of workplace adversity. It involves sustaining performance standards despite emotional strain and recovering from stressors without allowing them to undermine my confidence or professional identity*". (Female nurse, 42 years old, 15 years of experience, Ass. Nurse).

A nurse highlighted: "*I understand mental resilience as the ability to endure prolonged occupational challenges and moral distress without psychological breakdown. It is the skill of adapting constructively to negative circumstances while safeguarding one's mental well-being and commitment to patient care*." (Male nurse, 51 years old, 28 years of experience).

A nurse articulated: "*Mental resilience, to me, means having the psychological strength to overcome both professional and personal stressors without losing balance. It is about regaining stability after setbacks and preserving the capacity to provide high-quality care in a demanding environment.*"(Male nurse, 36 years old, 12 years of experience, Ass. Nurse).

One nurse affirmed: "*I define mental resilience as the ability to confront injustice and persistent workplace difficulties without allowing them to erode my professional motivation. It encompasses emotional endurance, composure under pressure, and the capacity to recover after emotionally taxing events.*"(Female nurse, 54 years old, 31 years of experience)

The responses highlight that mental resilience is not solely an individual effort. It is strengthened through peer support, effective time management, self-care practices, and maintaining focus on professional purpose. Organizational support and clear workplace policies further enhance the ability to cope with occupational challenges.

One of the participants said: "*I focus on constructive peer interactions, discussing challenges with colleagues who understand the context. I also incorporate short restorative breaks during shifts to reduce accumulated stress and maintain mental clarity.*" (Female **nurse, 39 years old, 14 years of experience).**

A participant shared: *«My primary strategy is to remain committed to the quality of patient care, as it reinforces my sense of purpose. I also engage in reflective conversations with trusted colleagues*

and deliberately take pauses during high-pressure periods to regain focus." (Female n**urse, 50 years old, 29 years of experience).**

A nurse asserted: "*I try to emphasize the positive aspects of my work and intentionally seek brief moments for personal relaxation. While these strategies are not always sufficient, they provide short-term relief from occupational stress.*" (Male n**urse, 34 years old, 10 years of experience).**

A participant elaborated: "*Time management, peer communication, and occasional detachment from the immediate stressor are essential components of my coping approach. I also utilize structured debriefing with colleagues to process emotionally charged experiences.*" **(Nurse, 55 years old, 33 years of experience).**

Based on the question, the nurses' responses emphasize that while mental resilience is important, it alone is not sufficient to cope with mobbing. Their answers highlight the need for organizational support, clear policies, and peer solidarity alongside individual coping strategies.

One nurse expressed: "*While mental resilience is indispensable, it is insufficient as a standalone defense against moral harassment. Organizational support, including clear anti-harassment policies and active managerial intervention, is equally critical.*" (Female nurse, 41 years old, 16 years of experience, Ass. Nurse).

One nurse suggested that: "*No, resilience alone cannot counteract the sustained impact of moral harassment. Without a supportive institutional framework and responsive leadership, even the most resilient professionals may experience burnout and psychological harm.*" (Male nurse, 50 years old, 30 years of experience).

A nurse described: "*Although resilience can mitigate some of the psychological effects of harassment, it does not address the systemic factors that perpetuate it. Effective prevention requires coordinated organizational action alongside individual coping mechanisms.*" (Female nurse, 37 years old, 11 years of experience).

One nurse explained: "*I believe mental resilience is a valuable protective factor, but insufficient in isolation. Lasting solutions demand organizational accountability, peer solidarity, and consistent enforcement of workplace conduct standards*." (Female nurse, 54 years old, 32 years of experience).

Table 6. Psychological Resilience, Mobbing, and Coping Strategies among Emergency Department Nurses

Age Group (years)	Gender	Resilience Level	% Reporting Harassment	Key Sources of Resilience	Coping Perception
24–40	Female	High	18%	Family & colleague support, intrinsic motivation	Often sufficient with external support beneficial
40–50	Female	Moderate	18%	Recognition, peer support	Insufficient without organizational measures
50–55	Female	Low	18%	Minimal support, personal hardship	Insufficient; strong institutional support needed
24–40	Male	High	12%	Peer support, motivation to help	Often sufficient with peer support
40–50	Male	Moderate	12%	Peer support, recognition	Insufficient without policy enforcement
50–55	Male	Low	12%	Limited support, high stress	Insufficient; external interventions essential

Note: Higher resilience levels were predominantly observed among younger nurses with strong social and emotional support networks. Lower resilience correlated with personal hardships, high workload, and insufficient organizational measures to address mobbing.

Strategies for Prevention and Support

Participants consistently emphasized the importance of targeted training on the recognition and management of mobbing, noting that such initiatives would contribute significantly to establishing a safer and more supportive work environment. A substantial proportion of the sample—23 female nurses (57.5% of the total sample) and 12 male nurses (30%)—identified staff training and awareness-raising programs as essential preventive measures. Regarding the role of hospital administration, 2 female nurses (5%) and 3 male nurses (7.5%) underscored the necessity of adopting a zero-tolerance policy toward mobbing incidents, accompanied by immediate and concrete actions to address them.

With respect to enhancing collegiality and teamwork, 20 female nurses (50%) and 9 male nurses (22.5%) stressed the value of communication and cooperation through regular meetings, structured dialogue sessions, and collective activities. Meanwhile, the remaining participants (5 female nurses – 12.5% and 6 male nurses – 15%) highlighted mutual respect among colleagues as the most critical factor in preventing mobbing. Collectively, these findings demonstrate that participants view mobbing prevention as a multidimensional process requiring education, organizational commitment, and

interpersonal respect. A structured summary of the strategies identified by nurses to promote a safe and supportive workplace is presented in Table 7.

Effective prevention of mobbing in healthcare environments demands both individual awareness and institutional responsibility. The perspectives shared by nurses underscore the vital role of clear policies, continuous education, and organizational support in mitigating harassment. Their insights provide valuable, practice-oriented guidance for the design of interventions aimed at fostering a respectful and psychologically safe working culture.

A nurse remarked: *"Clear procedures and continuous staff training are essential. Above all, management's zero-tolerance stance and active support for employees are crucial, as current support seems insufficient.*" (Female nurse, 42 years old, 15 years of experience).
One nurse noted: "*Reporting protocols must be transparent, ensuring victims feel safe. Leadership must take responsibility and educate personnel to recognize and prevent harassment.*" (Male nurse, 36 years old, 12 years of experience)
One participant stated: *Awareness and training on what constitutes moral harassment are critical. A clearly defined reporting policy and protection for all employees are necessary.* (Male nurse, 48 years old, 25 years of experience):
One nurse observed: "*Education and sensitization are key. Established protocols for reporting and addressing harassment must be enforced, guaranteeing that no one feels neglected or unfairly treated*." (Female nurse, 51 years old, 28 years of experience).
Management plays a pivotal role in creating a safe and respectful workplace. Nurses consistently emphasize that proactive leadership, enforcement of clear rules, and visible support for staff are indispensable in preventing mobbing.
A nurse highlighted: "*Management must be more active, demonstrating support for staff and fostering an environment that encourages reporting incidents*." (Female nurse, 39 years old, 14 years of experience).
A nurse remarked: "*Leadership should show sensitivity and enforce zero-tolerance policies with strict sanctions against perpetrators.*" (Female nurse, 45 years old, 22 years of experience).
One participant indicated: "*Management should promote respect and collaboration, ensuring clear rules and employee support to reduce such behaviors.*" (Male nurse, 52 years old, 30 years of experience).
One nurse expressed: "*Active and responsible management, clear commitment to zero-tolerance, and consistent support make employees feel secure and encouraged to report harassment*." (Male nurse, 47 years old, 20 years of experience).
Interpersonal collaboration is a key factor in mitigating workplace harassment. Nurses' observations underscore the importance of communication, trust, and structured team-building activities in fostering a supportive work environment.
One nurse noted: "*Opportunities to enhance teamwork, such as discussion groups or joint activities, can help colleagues support one another in managing stress.*" (Male nurse, 34 years old, 10 years of experience).
One participant indicated: "*Training and activities that promote mutual support and respect for personal boundaries are essential."* (Male nurse, 40 years old, 18 years of experience).
A nurse elucidated: "*Open communication, shared activities, and team cohesion strengthen relationships and prevent negative behaviors."* (Female nurse, 49 years old, 26 years of experience).
A nurse substantiated: "*Trust-building and recognition of colleagues' emotions and challenges, alongside regular meetings, enhance collaboration and reduce harassment risk*." (Female nurse, 38

years old, 15 years of experience).

Table 7. Strategies for the Prevention of and Support against Mobbing among Emergency Department Nurses

Strategy	Female Nurses n (%)	Male Nurses n (%)	Description
Targeted training and awareness-raising	23 (57.5%)	12 (30%)	Education on recognition and management of mobbing to promote a safe work environment
Zero-tolerance policy by hospital administration	2 (5%)	3 (7.5%)	Immediate and concrete measures to address incidents
Communication and teamwork enhancement	20 (50%)	9 (22.5%)	Regular meetings, structured dialogue, and joint activities
Promotion of mutual respect	5 (12.5%)	6 (15%)	Encouraging respectful interactions among colleagues

Note: The table summarizes the key prevention and support strategies proposed by participants, highlighting the predominance of staff training and structured communication as core measures.

Overall Assessment

The thematic analysis reveals that nurses frequently experience emotional distress in the workplace, primarily as a result of heavy workloads and limited support from either management or broader societal structures. Despite these challenges, psychological resilience, together with emotional and practical support from colleagues and family, emerged as pivotal resources enabling nurses to sustain their professional roles and achieve success. Importantly, the findings also highlight that moral harassment persists as an underlying concern, underscoring the need for greater acknowledgment of the issue and the adoption of targeted preventive measures.

DISCUSSION

Experience of Positive and Negative Emotions in the Workplace

The findings of this study reveal the dual nature of nurses' emotional experiences in Emergency Departments (EDs), where both positive and negative emotions coexist and significantly shape professional well-being. The majority of participants reported positive emotions such as satisfaction and gratitude, particularly when witnessing patient recovery or receiving recognition for their efforts. These results are in line with prior evidence suggesting that positive affect enhances resilience, facilitates effective teamwork, and strengthens interpersonal functioning in high-stress clinical environments (Fredrickson, 2004; Tugade & Fredrickson, 2004; Scheier & Carver, 1985). For younger nurses, collaborative work was a prominent source of satisfaction, whereas older nurses emphasized personal recognition and meaningful patient care. This age-related variation reflects

literature indicating that professional maturity influences the sources of emotional reward in nursing practice (Laschinger, Finegan, & Wilk, 2009). At the same time, participants consistently associated negative emotions with workload pressures, staff shortages, and insufficient recognition—factors that have long been linked to stress, frustration, and burnout in healthcare professionals (Maslach & Leiter, 2016; Gómez-Urquiza, et al., 2017). Of particular note, older female nurses reported that personal life challenges such as divorce or widowhood exacerbated feelings of isolation and psychological strain. This observation echoes studies demonstrating that occupational stressors often interact with personal circumstances, compounding the emotional burden of frontline nursing (Mc Vicar, 2003).

The strategies employed by nurses to maintain positive emotions, such as taking short breaks, hydrating, or engaging in collegial conversations, align with research emphasizing the value of micro-restorative activities in preserving mental clarity and emotional stability during demanding shifts (Tucker, Folkard, Macdonald, 2003; Hunter, Wu, Guo, Sutton, Wang, Liao, 2020). Additionally, participants highlighted broader coping strategies, including patient-centered focus, structured work organization, and reliance on social support networks. These findings support previous research showing that maintaining positive affect is associated with greater job satisfaction, higher resilience, and improved quality of care in high-pressure healthcare settings (Fredrickson, 2004; Yildirim, Aycan, 2008; McAllister, McKinnon, 2009).

Nevertheless, the results also underscore the potential risks of overreliance on positivity as a coping mechanism. While positive emotions can buffer stress and reduce conflict escalation, prior studies warn that the absence of formal support systems or assertive reporting practices may inadvertently foster tolerance of harmful behaviors such as mobbing or incivility (. Hutchinson, Vickers, Wilkes, Jackson, 2009; Hogh. Mikkelsen, Hansen, 2020). This suggests that while interpersonal strategies and individual resilience are vital, they must be reinforced by organizational interventions addressing systemic stressors—including workload reduction, recognition mechanisms, and structured support programs. Without such measures, sustained positivity may become unsustainable, ultimately giving way to emotional exhaustion and disengagement (Cooper, Brown, Rees, Leslie, 2020). Taken together, these findings indicate that emotional well-being among ED nurses is shaped by a dynamic interplay of workplace conditions, personal circumstances, and organizational culture. The evidence highlights the need for multifaceted interventions that both empower nurses to cultivate positive emotions and address structural barriers that undermine their emotional health.

Quality of Life and Working Conditions

The findings of this study indicate that nurses' quality of life (QoL) is profoundly affected by workload, staff shortages, long shifts, and irregular working hours. A large proportion of participants (88% of female nurses and 80% of male nurses) emphasized that these factors significantly compromised their well-being, underscoring the central role of working conditions in shaping QoL. These results are consistent with previous research showing that excessive workload and insufficient staffing are among the most critical determinants of occupational well-being in nursing populations (Dall'Ora, Griffiths, Ball, Simon, Aiken, 2015; Dall'Ora, Ball, Reinius, Griffiths, 2020).

The negative consequences of shift work and limited free time were particularly highlighted by

participants aged 24–50 years, who reported difficulties in maintaining family relationships and personal balance. Such experiences resonate with existing evidence linking irregular schedules and prolonged shifts to work–family conflict, disrupted circadian rhythms, and diminished life satisfaction among healthcare professionals (Geiger-Brown, Trinkoff, Rogers, 2011; Booker, Magee, Rajaratnam, Sletten, Howard, 2018). These findings suggest that the strain of demanding work schedules extends beyond the professional domain, directly influencing nurses' personal and family life.

Despite these challenges, participants emphasized the importance of interpersonal relationships as a buffer against adverse working conditions. More than half of both male and female nurses recognized collegial support and teamwork as protective factors contributing to improved QoL. This aligns with previous studies demonstrating that effective collaboration and positive social interactions moderate the impact of occupational stress and foster well-being in healthcare professionals (West, Dawson, 2012; Van Bogaert, Timmermans, Weeks, van Heusden, Wouters, Franck, 2014).

Recognition and support also emerged as critical determinants of perceived QoL. Nurses reporting higher levels of well-being frequently cited acknowledgment from hospital administration, as well as emotional and practical support from colleagues and family, as decisive in enhancing their resilience. These observations are consistent with evidence showing that supportive leadership, organizational recognition, and strong social networks play a vital role in promoting nurse well-being and job satisfaction (Hart, Brannan, De Chesnay, 2014; Cooper, Brown, Rees, Leslie, 2020).

Importantly, this study highlights the close interconnection between QoL and resilience. Participants who reported a manageable workload, favorable work–life balance, and adequate recognition demonstrated higher resilience, while those facing excessive work pressure and family disruption—particularly in the 40–55 years age group—were more vulnerable to burnout and psychological distress. This finding concurs with previous research identifying resilience as a protective factor against workplace stressors in high-demand healthcare environments (Hart, Brannan, De Chesnay, 2014; Cooper, Brown, Rees, Leslie, 2020; Hogh, Mikkelsen, Hansen, 2020; Maslach, Schaufeli, Leiter, 2001). It further suggests that resilience is not an isolated personal trait, but one shaped and reinforced by organizational and social contexts. Overall, the present findings support the view that QoL in nurses is a multidimensional construct shaped by structural, interpersonal, and organizational factors. They converge with prior evidence underscoring the need for systemic interventions—such as improved staffing, supportive leadership, and recognition frameworks—to safeguard both the well-being and resilience of nurses working in demanding clinical environments.

Psychological Resilience and Mobbing among Emergency Department Nurses

The findings of this study highlight the complex relationship between psychological resilience and exposure to mobbing in Emergency Departments (EDs). Younger nurses (24–40 years) reported higher levels of resilience, often rooted in intrinsic motivation, patient appreciation, and support from family members. This aligns with evidence that younger professionals are more likely to draw on optimism, emotional regulation, and social networks to buffer occupational stress (Hart, Brannan, De Chesnay, 2014; Mealer, Jones, Newman, McFann, Rothbaum, Moss, 2012). In contrast, older nurses (≥50 years) indicated that personal challenges and increased familial responsibilities compromised their capacity to maintain resilience, echoing literature which emphasizes that cumulative life

stressors can diminish coping resources over time (Jackson, Firtko, Edenborough, 2007; Wu, Feder, Cohen, Kim, Calderon, Charney, Mathé, 2013).

A noteworthy finding is that both male and female nurses reported experiences of mobbing, with prevalence higher among female participants. Consistent with prior studies, many victims refrained from formal reporting due to fear of retaliation or professional consequences (Einarsen, Hoel, Zapf, & Cooper, 2011 ; Simons, 2008). This silence reflects a broader pattern in healthcare, where hierarchical structures and power imbalances often inhibit disclosure of harassment (Johnson, 2009). Furthermore, the results indicate that women with additional personal vulnerabilities, such as divorce or widowhood, were disproportionately affected, suggesting that mobbing exacerbates pre-existing psychosocial strains.

Importantly, participants acknowledged that psychological resilience alone, while critical, is insufficient to counteract the detrimental effects of mobbing. This resonates with research underscoring that resilience functions primarily as a protective buffer, mitigating stress in the short term, but does not eliminate systemic sources of workplace hostility (Cooper, Brown, Rees, Leslie, 2020; Hartin, Birks, Lindsay, Campbell, 2020). Nurses across age groups emphasized the need for organizational interventions, including clear anti-harassment policies, managerial accountability, and peer solidarity, to effectively address mobbing. Prior studies corroborate this view, demonstrating that without institutional support, reliance solely on individual resilience may inadvertently reinforce tolerance of harmful behaviors (Hutchinson, Wilkes, Vickers, Jackson, 2008; Hogh, Mikkelsen, Hansen, 2020; Etienne, 2014).

Coping strategies identified in this study—such as peer communication, time management, restorative breaks, and reflective dialogue—mirror practices highlighted in previous research as effective for sustaining emotional balance and reducing burnout (Rushton, Batcheller, Schroeder, Donohue, 2015; Yu, Raphael, Mackay, Smith, King, 2019). However, their effectiveness is contingent on supportive organizational climates. For example, structured debriefing and managerial recognition have been found to strengthen resilience and mitigate the psychological toll of harassment (Söderbacka, Nyholm, Fagerström, 2020). Thus, the interplay between individual strategies and organizational frameworks is crucial.

These findings underscore that resilience should be understood not as an individual trait alone but as a dynamic process shaped by both personal and contextual factors. While resilient nurses can endure significant occupational stress, sustainable well-being in ED settings requires systemic interventions that address mobbing at its roots. As such, fostering resilience must be complemented by institutional accountability, peer support networks, and consistent enforcement of workplace conduct standards.

Strategies for Prevention and Support

Our findings portray prevention of mobbing as a multifaceted endeavor that hinges on three mutually reinforcing pillars: (a) targeted education and awareness, (b) clear organizational policies with visible leadership commitment, and (c) strengthened interpersonal collaboration. More than half of participants prioritised staff training and awareness-raising (57.5% of women; 30% of men) as foundational. This aligns with evidence that education improves recognition of bullying behaviours, enhances bystander efficacy, and increases use of formal channels—outcomes repeatedly associated

with lower exposure and harm (Escartín, 2016; Einarsen, Hoel, Zapf, & Cooper, 2011; Nielsen, Einarsen, 2018). In ED settings, where pace and acuity intensify interpersonal stressors, structured training that combines communication skills, de-escalation, and team reflexivity is particularly salient (Weaver, Dy, Rosen, 2014; Gates, Gillespie, Succop, 2011). Team-training programmes (e.g., Team STEPPS) and civility interventions (e.g., CREW) have been shown to improve teamwork climate, psychological safety, and respectful communication, thereby reducing the interpersonal conditions in which mobbing thrives (Weaver, Dy, Rosen, 2014; Laschinger, Leiter, Day, Gilin, 2009; Leiter, Laschinger, Day, Oore, 2011; Salin, 2003).

Participants also underscored the centrality of organizational commitment. Calls for zero-tolerance policies, transparent reporting protocols, and active managerial follow-through echo the literature showing that bullying flourishes where rules are ambiguous and sanctions inconsistent (Escartín, 2016; Hodgins, MacCurtain, Mannix-McNamara, 2014; Rayner, Lewis, 2011). Fear of retaliation—reported in our sample and widely documented—remains a critical barrier to disclosure (Simons, 2008; Etienne, 2014). Evidence indicates that implementation fidelity matters as much as policy content: policies reduce harm only when leaders communicate expectations, act promptly on reports, protect complainants, and audit outcomes (Hodgins, MacCurtain, Mannix-McNamara, 2014; Rayner, Lewis, 2011). Leadership behaviors that enable psychological safety—approachability, fair conflict resolution, recognition—buffer the emotional toll of incivility and attenuate downstream burnout (Laschinger, Leiter, Day, Gilin, 2009; Edmondson, 1999; West, Dyrbye, Erwin, Shanafelt, 2016). These dynamics are consistent with our data linking supportive leadership to participants' sense of security and willingness to report.

A third set of strategies identified by participants involved cooperation and collegiality: regular meetings, structured dialogue, and joint activities. These mirror interventions that cultivate relational coordination (shared goals, shared knowledge, mutual respect) and have been associated with improved well-being and patient outcomes in high-pressure units (Gittell, Weinberg, Pfefferle, Bishop, 2008). Micro-level practices reported by nurses—brief restorative breaks, peer huddles, and structured debriefings—are supported by evidence showing small, protected pauses reduce cognitive load, improve affect regulation, and lessen error risk (Tucker, Folkard, Macdonald, 2003; Hunter, Wu, Guo, Sutton, Wang, Liao, 2020). Importantly, our respondents who emphasized mutual respect as the primary preventive factor converge with trials showing that unit-level civility training and peer norms shift daily micro-interactions, which cumulatively determines whether mobbing behaviors are challenged or normalized (Leiter, Laschinger, Day, Oore, 2011; Clark, Olender, Cardoni, Kenski, 2011).

Notably, the data also highlight a dose–response between organizational infrastructure and the effectiveness of individual strategies. While nurses described practical, person-level tactics to maintain composure, they also stressed these measures are insufficient in isolation. This is consistent with integrative reviews indicating that resilience-oriented or individual coping interventions have modest, short-term benefits unless embedded within system-level changes (Nielsen, Einarsen, 2018; West, Dyrbye, Erwin, Shanafelt, 2016; Cooper, Brown, Rees, Leslie, 2020). In line with our participants' emphasis on clear rules and managerial accountability, the most promising approaches in the literature are hybrid, combining: (i) policy clarity and confidential reporting; (ii) leader training plus accountability metrics; (iii) team-training and civility programmes; and (iv) accessible support (e.g., debriefing, Schwartz-type rounds, peer support) (Weaver, Dy, Rosen, 2014; Laschinger, Leiter,

Day, Gilin, 2009; Rayner, Lewis, 2011; Cooper, Brown, Rees, Leslie, 2020; Maben, Taylor, Dawson, Leamy, McCarthy, 2018).

In sum, the strategies proposed by our participants closely track contemporary evidence. Education and awareness build recognition and bystander action; zero-tolerance, transparent procedures, and active leadership convert policy into protection; and team-based communication, structured meetings, and peer support nurture the everyday civility that prevents escalation. Translating these into practice requires explicit implementation plans (responsibilities, timelines, feedback loops) and routine evaluation of uptake and outcomes. Without these organizational commitments, reliance on individual diligence risks leaving staff exposed in precisely the high-demand conditions where mobbing is most damaging.

Research Implications

The present study offers critical insights into the psychological and social consequences of mobbing within the high-pressure environment of emergency departments. By qualitatively exploring how ED nurses define and conceptualize mobbing, as well as the ways they identify its subtle and overt forms, the study provides health professionals with the knowledge to recognize early signs of abusive behaviors from colleagues or supervisors. Early recognition is essential for timely intervention, minimizing potential harm to mental health and professional functioning.

The findings are expected to contribute to the conceptual clarity of mobbing, emphasizing its various manifestations—from overt aggression to more covert forms of exclusion or manipulation—and demonstrating how these behaviors intersect with emotional responses and coping mechanisms. These insights will not only deepen academic understanding but also equip practitioners with practical awareness to manage such situations more effectively.

From a professional development perspective, this research can serve as a foundation for targeted training in resilience-building and positive emotion cultivation, empowering ED nurses to maintain psychological well-being despite exposure to challenging workplace dynamics. The dissemination of results—through seminars, professional networks, and digital platforms—will promote awareness and foster organizational cultures that are proactive in preventing workplace harassment.

Furthermore, by examining the role of resilience and positive emotions as protective factors, this study highlights avenues for intervention programs that integrate counseling, peer support groups, and mental health resources tailored to the needs of ED staff. The outcomes could guide hospital administrations and policymakers, including bodies such as the National Institute of Labor and Human Resources, in designing evidence-based anti-bullying policies and in training facilitators for mobbing awareness initiatives.

Ultimately, this research aspires to strengthen care and support systems within public hospitals—bolstering emotional resilience, reinforcing a positive professional identity, and safeguarding the mental health of frontline emergency care providers. It also serves as a stepping stone for future qualitative and mixed-method studies, potentially expanding into other clinical contexts to develop a broader, systemic understanding of mobbing and its mitigation in healthcare.

CONCLUSIONS AND RECOMMENDATIONS

The findings of this study highlight the multifactorial interplay among individual, interpersonal, and organizational parameters in shaping nurses' emotional well-being, quality of life (QoL), and exposure to moral harassment in Emergency Departments (EDs). Nurses simultaneously experience positive emotions—such as satisfaction from patient recovery, recognition, and effective interdisciplinary collaboration—alongside negative emotions, including stress, frustration, and professional burnout, which stem from increased workload, staff shortages, and insufficient institutional support (Han, Duan, Jiang, Zeng, Zhang, Zhao, 2023; Tamata, Mohammadnezhad, 2023; Hogh, Mikkelsen, Hansen, 2022; Khatatbeh, Pakai, Al-Dwaikat, Onchonga, Amer, Prémusz, Oláh, 2022; Isbell, Tager, Beals, Liu, 2020).

Emotional resilience emerges as a protective factor; however, it proves insufficient in mitigating systemic stressors and moral harassment, underscoring the necessity of implementing organizational interventions in parallel with individual coping strategies (Han, Duan, Jiang, Zeng, Zhang, Zhao, 2023; Hogh, Mikkelsen, Hansen, 2022; Khatatbeh, Pakai, Al-Dwaikat, Onchonga, Amer, Prémusz, Oláh, 2022). Nurses' QoL is significantly influenced by work–life balance, working conditions, and recognition by peers and leadership, whereas interpersonal relationships, teamwork, and collegial support function as essential protective factors (Tamata, Mohammadnezhad, 2023; Khatatbeh, Pakai, Al-Dwaikat, Onchonga, Amer, Prémusz, Oláh, 2022; Isbell, Tager, Beals, Liu, 2020).

Preventing mobbing requires a multidimensional and comprehensive approach that incorporates educational interventions, strong leadership commitment, and enhanced interpersonal collaboration. Individual-level strategies—such as micro-restorative breaks and effective peer communication—are more effective when supported by clear institutional policies, transparent reporting procedures, and active managerial involvement (Hogh, Mikkelsen, Hansen, 2022; ANA, 2025; Royal College of Nursing, 2025; RNAO, 2025)

Based on these findings, the following recommendations are proposed:

- Implementation of targeted educational programs on moral harassment recognition, conflict resolution, and communication skills (Hogh, Mikkelsen, Hansen, 2022; ANA, 2025).
- Promotion of awareness campaigns and clarification of reporting channels (ANA, 2025; Royal College of Nursing, 2025).
- Establishment and strict enforcement of zero-tolerance policies and protective measures, combined with active managerial support and systematic monitoring (Hogh, Mikkelsen, Hansen, 2022; ANA, 2025; RNAO, 2025).
- Organization of structured team meetings, dialogue sessions, and reflective debriefings to strengthen collegial support and emotional regulation (Han, Duan, Jiang, Zeng, Zhang, Zhao, 2023; Isbell, Tager, Beals, Liu, 2020; RNAO, 2025)
- Optimization of staffing levels and shift scheduling to reduce professional burnout and work–life conflict (Tamata, Mohammadnezhad, 2023; Khatatbeh, Pakai, Al-Dwaikat, Onchonga, Amer, Prémusz, Oláh, 2022).
- Integration of individual and systemic strategies, combining resilience training with organizational support, regulatory clarity, and accessible support structures (Han, Duan, Jiang, Zeng, Zhang, Zhao, 2023; Hogh, Mikkelsen, Hansen, 2022; ANA, 2025; Royal College of Nursing, 2025; RNAO, 2025). Future research should include longitudinal studies to evaluate

the effectiveness of combined interventions, exploration of age- and gender-related differences in resilience and coping mechanisms, as well as assessment of the fidelity of policy and training implementation.

In sum, the results demonstrate that fostering a safe, supportive, and emotionally healthy work environment in EDs requires coordinated and evidence-based action across individual, interpersonal, and organizational levels, with the dual aim of enhancing nurses' well-being and improving patient care outcomes.

Critical Gaps and Future Directions

Despite the expanding body of qualitative research, several important gaps remain. One key limitation is the under-theorization of positive emotions: in most ED studies, their protective role is inferred rather than explicitly measured or theorized, underscoring the need for future work grounded in frameworks from positive psychology and affective science. A second issue concerns the frequent conflation of resilience with mere endurance or stoicism; genuine resilience involves adaptive growth and positive adjustment, rather than passive tolerance of mobbing (Liu, Zhang, Liu, Han, Zhuang, Jiang, 2023; Jiang, Liu, Chi, Liu, Han, Sun, Zhuang, 2024). Cultural variation also warrants further exploration, as most qualitative evidence to date derives from Asian and Middle Eastern contexts (Jiang, Liu, Chi, Liu, Han, Sun, Zhuang, 2024; Al-Qadi, Maruca, Beck, Walsh, 2022; Yıldız & Yıldız, 2022), with limited comparative research in Western healthcare systems. Such cross-cultural studies could illuminate differences in both the experience of mobbing and the buffering role of protective factors such as resilience and positive emotions. Finally, while qualitative findings provide rich and nuanced insights, integration with quantitative approaches is essential to validate how resilience and positive emotions statistically mediate the relationship between mobbing and outcomes such as burnout, turnover, and job satisfaction.

Research Limitations

The study sample was relatively small (n = 40) and drawn exclusively from four public hospitals in the Thessaly region, which may limit the generalizability of the findings to other geographic areas or healthcare contexts. Furthermore, the exclusion of psychiatric hospitals and Health Centers potentially omitted perspectives from care environments where mobbing and workplace stressors may manifest differently. The use of purposive sampling and the voluntary nature of participation may also introduce self-selection bias, as individuals more willing to share their experiences of sensitive issues could differ systematically from those who chose not to participate.

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Conflicts of Interest

The authors declare no conflicts of interest.

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