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Research Article

Coping with Workplace Bullying: Strategies Employed by Nurses in the Healthcare Setting

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Purpose. As regards nursing professionals, workplace bullying is characterized by a set of repeated and banalized negative behaviors carried out by the aggressors that have more power than victims. Such behaviors adversely affect both the victims and the healthcare institutions where the events occur. Upon repeated exposure to workplace bullying, the victims use coping strategies to modify their work environment and adapt to the aggressor, as they try to reduce the discomfort caused by the bullying behavior. The present work aims to describe the psychometric characteristics of the NAQ-R (Negative Act Questionnaire-Revised) and COPE (COPE Inventory) assessment instruments. In addition, it aims to assess the coping strategies employed by nurses who were victims of workplace bullying. *Methods*. This study is quantitative, descriptive, correlational, and cross-sectional in nature. Data were collected through a digital survey which consisted of sociodemographic and professional components. The NAQ-R and COPE scales were used to evaluate these components. The study included a total of 2015 Portuguese nurses in the sample. *Results*. Talking to coworkers and confronting the aggressors were the main strategies adopted by nurses who experienced bullying behaviors at work. Also, based on the first and third evaluation criteria, nurses who faced workplace bullying presented a higher average value of "support seeking" and "substance use" and resorted more to "evasion" when compared to those who had not been bullied. Based on the second assessment criterion, nurses who endured workplace bullying resorted more to "evasion" and "substance use" and exhibited less "acceptance." *Conclusions*. When confronted with workplace bullying, nurses predominantly chose negative coping strategies and, in their majority, nurses had not received training on that topic. In this regard, nurses' training is considered important, so as to encourage the use of positive coping strategies that minimize the negative effects of the phenomenon.

1. Introduction

Workplace bullying is a harmful phenomenon, characterized by repeated actions and practices directed against one or more workers, which may be carried out deliberately or unconsciously. It causes a sense of humiliation, offense, and anguish that interferes with the victims' work performance and/or leads to an unpleasant work environment [1]. In a general manner, healthcare professionals are at high risk of experiencing workplace bullying. But the impact and prevalence of this phenomenon among nurses is particularly worrying, when compared to the reality of other professionals [2].

The study of coping strategies in workplace bullying situations enables the evaluation of actions and approaches adopted by individuals to deal with stress, negative emotions, and the harmful effects of bullying in the work environment. These strategies aim primarily to confront the bullying situation, minimize its emotional impacts, and safeguard the physical and psychological well-being of the individuals involved [3]. Nonetheless, the appraisal of the coping strategies used by the victims has been approached in few recent studies [4]. This study defends that seeking social support for emotional reasons and mental disengagement increased the association between role ambiguity and role conflict. To prevent bullying, organizations can train

employees to moderate emotion-focused coping strategies, especially when they experience insecurity in the work, role conflict, or role ambiguity [4].

The evaluation and analysis of the most frequently employed coping strategies allows assessing the most common reactions, as well as identifying the main difficulties and raising awareness toward this problem, which facilitates acting in line with the victims' needs [5]. Understanding bullying behaviors at work, and the associated risk factors, is vital for designing, and implementing, adequate prevention and intervention programs [6]. Appropriate training is also an important factor, which influences the nurses' psychological ability and coping process [7]. In this sense, the present work seeks to evaluate the coping strategies employed by nurses who were bullied at work, based on the three evaluation criteria defined in [8], which will be explained in more detail in the methodology section.

1.1. Background. Workplace bullying occurs when individuals are repeatedly exposed to negative behaviors over an extended period, in situations where they have limited or no opportunity to defend themselves [9]. Healthcare workers, especially nurses, are at a high risk of experiencing workplace bullying [2]. In Portugal, on average, each nurse suffers 11 acts of aggression in their main place of work. The types of aggression suffered most intensely by victims are blocking communication and discredit at work, and the predominant types of mobbing are the horizontal type and the descending type [10]. Victims of workplace bullying exhibit a lower coping capacity and tend to face stressful events more negatively. Knowing the victims' reaction to stressful events is important to establish the best intervention strategies against bullying behaviors at work [5].

Researchers and psychoanalysts conceptualized coping as an unconscious defense mechanism used to manage sexual and aggressive conflicts [11]. Lazarus and Folkman had an impact on shifting the paradigm, defining coping as a set of constantly changing cognitive and behavioral efforts developed to manage specific external and/or internal demands assessed by the individual as exceeding their resources [12].

Coping is characterized by a set of behavioral responses, exhibited by individuals facing stressful situations, which enables them to modify the surrounding environment and adapt to the stress-causing agent, with the intent of reducing discomfort. In this sense, it can be stated that coping allows reducing negative reactions to a given situation [13], thus acting as a defense mechanism, or, more specifically, as a stable and unconscious mental process used to manage internal and/or external conflicts [14].

The rate of workplace bullying incidents rose with the decrease in victims' self-confidence [15, 16]. Victims should, thus, express themselves in an assertive manner, rather than resorting to passive and/or aggressive communication [16]. Only in this way will they be able to effectively communicate their thoughts, feelings, and opinions regarding an event, while respecting the rights of others and allowing them to share and provide feedback [17].

Notwithstanding, when nurses distance themselves from the situation and try to find positive aspects, namely, those concerning professional growth and/or enrichment, they can learn to react emotionally without exhibiting feelings of anguish and anger. The use of humor allows looking at a situation from a different, and more positive, perspective, while also promoting optimism about future outcome. As such, reacting optimistically helps nurses to reduce their levels of work-related stress, even when confronted with bullying situations [18].

In their majority, nurses who experience workplace bullying tend to act passively and do not confront their aggressor(s) directly [15, 16]. Thus, given the lack of penalty for their actions, aggressors may feel encouraged to keep behaving inadequately, possibly leading other team members to consider workplace bullying as something normal [19].

Coping strategies based on evasion correlate to the impact of workplace bullying on productivity [20]. The author also points out that, when the professionals' strategy for dealing with bullying is based on institutional loyalty, their results/productivity may not be satisfactory. This outcome derives from the physical effects experienced by workers exposed to this kind of violence, as well as from their focus being affected by the psychological consequences.

Given the above, it would be important for nurse managers to effectively support—and to establish interventions aimed at—nurses facing higher risks, such as those who employ passive coping strategies [21]. However, healthcare professionals (nurses and physicians, among others) receive little support from the institutions they worked for, after going through bullying situations. In this regard, those professionals reported receiving support only from themselves, their families, friends, and those coworkers with whom they had a closer relationship [22].

The approaches to this phenomenon require adequate training, and nurses should be taught how to respond directly to inappropriate behavior, in an assertive and nonhostile manner [23]. The victims, in particular, besides training, should also receive counseling, in order to channel their negative reactions into more constructive and effective coping strategies, enabling them to reduce the physical and psychological consequences of workplace bullying [24]. This is especially important, since destructive coping can lead the victims to behave in intimidating manners toward others, as a means to vent their frustrations [25].

2. Materials and Methods

2.1. Research Design. This study is of a quantitative, descriptive, correlational, and cross-sectional nature. Data were collected through a digital survey, which served as the instrument for data collection. The survey consisted of sociodemographic and professional components that were evaluated using the following scales: NAQ-R (Negative Act Questionnaire-Revised) [8] and the COPE Inventory scale for assessing coping strategies [26]. It also included questions meant to assess the need for training on the topic of workplace bullying. This study in question is part of an extended study on a related phenomenon [27].

2.2. Research Instruments. The NAQ-R scale allows evaluating the nurses' perceptions regarding exposure to bullying behaviors at work. It comprises 22 items, with the following options: "never," "sometimes," "monthly," "weekly," and "daily." Furthermore, there are three criteria used to appraise the perception of bullying prevalence at work [8, 20, 28, 29]. The first criterion consists of a positive answer, with intensity 4 ("weekly") or 5 ("daily"), to at least one of the 22 items on the scale, concerning events that occurred in the previous six months. In the second criterion, study participants identify themselves as victims of psychological violence at work by responding affirmatively to item 23 with an intensity of 3 (yes, occasionally); 4 (yes, several times a week); or 5 (yes, almost every day) in the last six months. Responses 1 (no) and 2 (yes, but only rarely) do not score. Finally, the third criterion consists of a positive reply to both the first and the second criteria.

The COPE Inventory scale consists of 60 items and allows assessing how nurses react when facing difficult, or stressful, events in their lives. It is a Likert-type scale, comprising the following four options: "I usually do not do this at all," "I usually do this a little bit," "I usually do this a medium amount," and "I usually do this a lot."

Authorization to use the NAQ-R and COPE Inventory scale was requested to the respective authors, who allowed their use. With respect to the COPE Inventory scale, since no prior validation study involving Portuguese nurses was found, a decision was made to translate it to Portuguese and back translate it to English, resorting to two different translators, so as to verify the translation's consistency.

2.3. Research Procedure. With the purpose of evaluating the survey's objectivity and intelligibility, a pilot study was conducted using a reduced sample of 30 nurses. After making the required modifications, a final questionnaire was created and a formal request was made to the Ordem dos Enfermeiros (OE) for its national distribution. With permission granted, the survey was prepared in digital format using Google Docs and shared as an attachment in the monthly newsletter sent to all registered nurses at OE through e-mail.

To ensure data protection, the study was registered with the Portuguese Data Protection Authority (Comissão Nacional de Proteção de Dados, CNPD), which issued a decision (deliberation no. 931) confirming that no personal data were being processed. In terms of ethics, the Ethics Committee of the Nursing School of Coimbra (P435-06) approved the study, indicating that it met the necessary ethical requirements for implementation.

Once the questionnaires were collected, the relevant statistical data were analyzed using the Statistical Package for the Social Sciences (SPSS) software, version 24.

2.4. Research Hypotheses. With the purpose of assessing the correlation between workplace bullying and the coping strategies employed by nurses, the following hypotheses were considered:

(i) Based on the first evaluation criterion, workplace bullying significantly affects the coping strategies applied by nurses.

(ii) Based on the second evaluation criterion, workplace bullying significantly affects the coping strategies used by nurses.

(iii) Based on the third evaluation criterion, workplace bullying significantly affects the coping strategies employed by nurses.

2.5. Research Participants. The eligibility criteria consisted of nurses performing management tasks, or care provision, at Portuguese health institutions, whether public or private. As stated previously, the questionnaire was compiled in digital format, using Google Docs. This was done to ensure the anonymity and sincerity of the replies, which would be difficult to guarantee if the questionnaire was to be delivered in paper format. The Portuguese Nursing Order sent the questionnaire link to all Portuguese nurses through their newsletter. The questionnaire link was active for 3 months, from 8th November to 8th February.

In total, 2066 questionnaires were obtained, of which 51 were incomplete or incorrectly filled out. Therefore, the obtained sample was comprised of 2015 questionnaires suitable for statistical analysis. Thus, the study's sample comprised 2015 nurses, which represented 2.74% of the population under analysis, based on the available data on the number of nurses registered at Portuguese Nursing Order [30].

Concerning the sociodemographic and professional makeup of the sample, 82.68% were female, and 62.78% were either married or in a nonmarital partnership. The age range varied from 21 to 72, with an average of 38.51 years (see Table 1).

In terms of education, 99.40% of the nurses were graduates, with 23.18% holding a master's degree and 30.02% specializing in a specific area of nursing (see Table 1).

Regarding length of service, the average was 12.10 years, with 40.25% of the nurses having worked in their profession for 5 to 10 years. Additionally, 92.75% of the sample reported having a stable job, with 46.10% employed in public functions and 46.65% having an open-ended contract. 70.17% of the sample worked in hospitals, 25.06% held double employment, and 62.03% had "shifts" as their primary work schedule. The reported average weekly workload was 39.62 hours (see Table 1).

3. Results

3.1. Instruments' Validation. Concerning the use of the NAQ-R scale, a measure of suitability was implemented to evaluate its validity. The data's consistency was assessed through a KMO sphericity test, which provided a value of 0.963, considered excellent. Concomitantly, Bartlett's test exhibited a value of $\chi^2\ (231) = 27530.009$, with statistical significance ($p < 0.001$), indicating a considerable correlation between the variables.

Table 1: The sample's demographic characteristics.

		Male	Female	Total	%
		349	1666	2015	100
Age	Less than 30 years old	56	333	389	19.3
	Between 30 and 40 years old	149	677	826	41.0
	Between 40 and 50 years old	80	389	469	23.3
	Between 50 and 60 years old	62	249	311	15.4
Marital status	Married/nonmarital partnership	229	1036	1265	62.8
	Single	104	480	584	29.0
	Divorced/separated	15	143	158	7.8
Qualifications	Graduation	347	1656	2003	99.4
	Master's degree	84	383	467	23.2
	Specialty	105	500	605	30.0
Professional category	Nurse (nongraduate)	190	944	1134	56.3
	Nurse (graduate)	68	351	419	20.8
	Nurse specialist	52	244	296	14.7
	Nurse manager	21	65	86	4.3
Workplace	Hospital	244	1170	1414	70.2
	Health center	64	334	398	19.8
	Long-term care unit	15	66	81	4.0
Geographic region	North	91	462	553	36.7
	Center	77	275	352	23.4
	South	87	378	465	30.9
	Archipelago of the Azores and Madeira	23	113	136	9.0
Length of time in profession	Up to 5 years	81	452	533	26.5
	Between 5 and 15 years	144	667	811	40.3
	Between 15 and 25 years	83	387	470	23.3
	More than 25 years	41	160	201	10.0
Schedule type	Shifts	243	1007	1250	62.0
	Fixed	106	659	765	38.0
Bound/contract	Public functions	162	767	929	46.1
	Individual open-ended contract	164	776	940	46.7
	Individual fixed-term contract	11	65	76	3.8
	Independent worker	11	50	61	3.0

The exploratory factor analysis of the NAQ-R scale was subsequently carried out, producing three factors with eigenvalues greater than 1.0 (Kaiser criterion), which is consistent with the number attained [20]. However, this analysis did not reproduce the results obtained in that study, since the items were grouped differently, at a factor level. The three factors explained 61.63% of the total variance. The first factor, named "Person-Related Bullying," comprising 15 items, represented 49.49% of the total variance and exhibited an eigenvalue of 10.89. The second factor, named "Work-Related Bullying," composed of 5 items, accounted for 7.07% of the total variance and presented an eigenvalue of 1.56. The third and last factor, named "Intimidating Physical Bullying," consisting of 2 items, was responsible for 5.07% of the total variance and exhibited an eigenvalue of 1.0.

The global scale, or "Total Bullying," attained an excellent value (0.947). Concerning the first factor, "Person-Related Bullying," its Cronbach's alpha coefficient was also considered excellent (0.946). With respect to the second factor, "Work-Related Bullying," Cronbach's alpha coefficient was considered good (0.828). As for the third factor, "Intimidating Physical Bullying," it revealed a low Cronbach's alpha coefficient (0.644), which was still acceptable for the study's purposes.

The validation of the COPE scale's factor analysis was also performed, using the KMO sphericity test. This presented a value of 0.916, which was considered excellent. Bartlett's test exhibited a value of χ^2 (1770) = 53345.274, with statistical significance ($p = 0.001$), also indicating the existence of a significant correlation between the variables.

The COPE scale was not validated in the Portuguese population. Therefore, the exploratory factor analysis of the COPE scale was subsequently performed, producing 13 factors with eigenvalues greater than 1.0. However, it was found that this factor analysis did not replicate the 15-factor model attained [26]. Using the scree plot criterion, it was observed that the COPE scale's data could be represented by 7 or 8 factors.

Thus, following the scree plot criterion and using, as basis, the study by Donoghue, which obtained 7 factors with the COPE scale [31], a new exploratory factor analysis was carried out, forced to 7 factors and applying a varimax rotation, which explained 47.89% of the total variance.

Taking into account the theoretical framework, the factors comprising the COPE scale were named: "active/reflective coping," "support seeking," "evasion," "humor," "religious coping," "substance use," and "acceptance."

Cronbach's alpha test was performed to appraise the reliability of the COPE scale's results. In this scope, Cronbach's alpha coefficient attained by the totality of the items was 0.895, demonstrating a good degree of homogeneity.

As regards the factors composing the scale, it was found that "religious coping" (0.931) and "substance use" (0.922) had excellent alpha coefficients. In turn, the "active/reflective coping" (0.893), "support seeking" (0.876), and "humor" (0.875) factors achieved good alpha coefficients. Conversely, the "evasion" factor presented a reasonable alpha coefficient (0.726) and the "acceptance" factor exhibited a weak alpha coefficient (0.657), which were still acceptable for the study's purposes. Therefore, it can be said that Cronbach's alpha coefficients demonstrated appropriate internal consistency of the COPE scale and its suitability for the present study.

3.2. Coping and Workplace Bullying. Regarding the entire sample under analysis ($n = 2015$ nurses), the most frequently used coping strategies were "support seeking" (average value = 2.89) and "active/reflective coping" (average value = 2.83) (Table 2). In contrast, the least frequently used coping strategies were "substance use" (average value = 1.10) and "evasion" (average value = 1.84) (Table 2).

With respect to the measures taken by nurses who suffered bullying at work ($n = 679$), the following were the most frequently mentioned: telling coworkers about the bullying (34.16%), confronting the aggressor(s) (33.08%), and ignoring the aggressor(s) (25.13%). Only 12.57% of the nurses reported being unable to act against, or feeling incapable of confronting, the bullying behaviors (Table 3).

With regard to training, it was found that only 11.41% of the participants had attended specific training on workplace bullying. However, most of them (93.20%) considered important receiving adequate training on this topic, in the institution they worked at. Furthermore, the majority of nurses (73.20%) responded positively to the possibility of resorting to a support service dedicated to this issue, if such a service existed.

3.3. Workplace Bullying Assessment Criteria and Coping Strategies. Concerning the first evaluation criterion for workplace bullying, applying a Manova multivariate test allowed verifying the existence of statistically significant differences between the average values of at least one COPE scale factor, with *Wilks' lambda* = 0.958, $F(8, 2006) = 10.882$, and $p = 0.001$.

Based on the first evaluation criterion, nurses who experienced workplace bullying exhibited significantly higher average values of "support seeking" ($p = 0.011$), "evasion" ($p = 0.001$), and "substance use" ($p = 0.001$), combined with lower average values of "religious coping" ($p = 0.033$) and "acceptance" ($p = 0.001$), when compared those who did not suffer workplace bullying (1.93 vs. 2.01; 2.51 vs. 2.61) (Table 4).

As regards the second evaluation criterion for workplace bullying, applying a Manova multivariate test also allowed observing the presence of statistically significant differences between the average values of at least one COPE scale factor, with *Wilks' lambda* = 0.941, $F(8, 2006) = 15.795$, and $p = 0.001$.

Table 2: Minimum, maximum, means, and standard deviations of COPE scale dimensions.

	Min.	Max.	Mean	SD
Active/reflective coping	1.00	4.00	2.83	0.44
Support seeking	1.00	4.00	2.89	0.56
Evasion	1.00	4.00	1.84	0.42
Humor	1.00	4.00	2.20	0.73
Religious coping	1.00	4.00	1.97	0.92
Substance use	1.00	4.00	1.10	0.36
Acceptance	1.00	4.00	2.56	0.58

Min = minimum; Max = maximum; SD = standard deviation.

Based on this criterion, nurses who endured workplace bullying exhibited higher average values of "evasion" ($p = 0.001$) and "substance use" ($p = 0.004$) than those who were not bullied at work (1.97 vs. 1.79; 1.14 vs. 1.09). Conversely, nurses who suffered workplace bullying presented a lower average value of "acceptance" ($p = 0.001$), when compared to those who reported not being bullied at work (2.46 vs. 2.61) (Table 4).

With respect to the third evaluation criterion for workplace bullying, applying a Manova multivariate test also allowed revealing the existence of statistically significant differences between the average values of the COPE scale factors, with *Wilks' lambda* = 0.948, $F(8, 2006) = 13.705$, and $p = 0.001$.

Based on this criterion, nurses who suffered workplace bullying exhibited significantly higher average values of "evasion" ($p = 0.001$) and "substance use" ($p = 0.001$) than those who were not bullied (2.93 vs. 2.87; 1.98 vs. 1.80; 1.15 vs. 1.09) (Table 4). Nonetheless, still based on this criterion, nurses experiencing workplace bullying presented a significantly lower average value of "acceptance" ($p = 0.001$) than those who did not report being bullied (2.46 vs. 2.60) (Table 4).

4. Discussion

In the present research study, the aim was to assess the coping strategies employed by nurses who were victims of workplace bullying. It was found that nurses who identified themselves as victims predominantly used avoidance, resorted to substance use, and exhibited lower levels of acceptance as their primary coping mechanisms.

Regarding the total sample, the coping strategies most used by nurses corresponded to seeking support and active/reflective coping. This is in agreement with the other study where nurses resorted mostly to planning, active coping, and acceptance [32]. On the other hand, Sequeira [33] had found that nurses employed confrontation and active problem solving as main coping strategies. This may be considered a positive outcome, since resorting to active coping allows for solutions to be found in an active manner, which may reduce and/or eliminate likely problem-causing elements

Table 3: Distribution based on the measures taken, by the victims, to stop the bullying behavior(s) at their workplace.

Measure(s) taken to stop the bullying behavior(s) at the workplace	*N*	%
No, I was not able to/could not do anything	117	12.6
Yes, I told my coworkers about the bullying behavior(s) I was facing	318	34.2
Yes, I confronted the aggressor(s)	308	33.1
Yes, I ignored the aggressor(s)	234	25.1
Yes, I ignored the bullying behavior(s)	224	24.1
Yes, I reported the bullying behavior(s) to my workplace management	200	21.5
Yes, I requested a service transfer	182	19.6
Yes, I asked the aggressor(s) to stop the bullying behavior(s)	92	9.9
Yes, I reported the bullying behavior(s) to a union delegate	78	8.4
Yes, I reported the bullying behavior(s) to the human resources department	31	3.3
Yes, I reported the bullying behavior(s) to the Ordem dos Enfermeiros	14	1.5
Yes, I resigned	11	1.2
Yes, I took legal action against the aggressor(s)	11	1.2
Yes, I took another measure	13	1.4

Table 4: Significance of the COPE scale factors' differences based on workplace bullying assessment criteria.

Has experienced workplace bullying (first evaluation criterion)	No		Yes		Sig.
	M	SD	M	SD	
Active/reflective coping	2.83	0.45	2.84	0.44	0.427
Support seeking	2.86	0.54	2.92	0.57	0.011*
Evasion	1.79	0.42	1.90	0.42	0.001***
Humor	2.17	0.70	2.23	0.76	0.065
Religious coping	2.01	0.91	1.93	0.92	0.033*
Substance use	1.08	0.30	1.13	0.42	0.001***
Acceptance	2.61	0.57	2.51	0.59	0.001***
Has experienced workplace bullying (second evaluation criterion)	No		Yes		Sig.
	M	SD	M	SD	
Active/reflective coping	2.84	0.44	2.81	0.45	0.106
Support seeking	2.87	0.55	2.92	0.58	0.124
Evasion	1.79	0.41	1.97	0.43	0.001***
Humor	2.20	0.70	2.20	0.79	0.993
Religious coping	1.95	0.91	2.03	0.94	0.096
Substance use	1.09	0.33	1.14	0.43	0.004**
Acceptance	2.61	0.57	2.46	0.60	0.001***
Has experienced workplace bullying (third evaluation criterion)	No		Yes		Sig.
	M	SD	M	SD	
Active/reflective coping	2.84	0.44	2.82	0.45	0.357
Support seeking	2.87	0.54	2.93	0.59	0.051
Evasion	1.80	0.41	1.98	0.43	0.001***
Humor	2.19	0.71	2.22	0.81	0.425
Religious coping	1.97	0.91	1.99	0.94	0.589
Substance use	1.09	0.32	1.15	0.46	0.001***
Acceptance	2.60	0.56	2.46	0.62	0.001***

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$; M = mean; SD = standard deviation.

[12, 32, 34]. Talking to their coworkers and confronting the aggressors were the main strategies adopted by nurses, when facing bullying behaviors at work. Rivera emphasizes the importance of the victims talking to their coworkers, so as to raise awareness for their version of the facts. In this way, the coworkers will become aware of both versions and not only that of the aggressor [35].

However, 12.57% of the affected nurses stated being unable to act against, or feeling incapable of confronting, the aggressive behaviors and most victims chose to do nothing, or to abandon the institution, instead [5, 19]. Research suggests that nurses resorted mainly to passive coping strategies, when facing aggressive behaviors. Those strategies included keeping in silence, ignoring the aggressor(s), and telling their friends and family about the incident(s) [36]. Also, this tendency for inaction/evasion may lead to the problem's persistence, or aggravation, since the perpetrators are not penalized for the aggressions they practiced [19]. Coping strategies such as ignoring work tasks, taking more sick leave than necessary, and changing work schedules to

minimize contact with the aggressor(s) have negative effects on the victims' physical and/or psychological health as well as on their work performance [25].

Based on the first evaluation criterion, nurses who experienced workplace bullying resorted significantly more to coping strategies related to "support seeking," "evasion," and "substance use." Concomitantly, they resorted significantly less to "religious coping" and to "acceptance," when compared to nurses who, based on this criterion, did not suffer workplace bullying. Therefore, the hypothesis "based on the first evaluation criterion, workplace bullying significantly affects the coping strategies applied by nurses" was verified in the following factors: "support seeking," "evasion," "substance use," "religious coping," and "acceptance."

With respect to the second evaluation criterion, it was found that nurses who experienced workplace bullying resorted significantly more to "evasion" and to "substance use." However, they showed significantly less "acceptance," when compared to those who did not report suffering workplace bullying. Hence, the hypothesis "based on the second evaluation criterion, workplace bullying significantly affects the coping strategies used by nurses" was verified in the following factors: "evasion," "substance use," and "acceptance."

Based on the third evaluation criterion, nurses who suffered bullying at work exhibited significantly higher values associated with "evasion" and "substance use." However, they presented a lower average value of "acceptance," when compared to nurses who did not endure workplace bullying. As such, the hypothesis "based on the third evaluation criterion, workplace bullying significantly affects the coping strategies employed by nurses" was verified in the following factors: "evasion," "substance use," and "acceptance." As regards workplace bullying incidents, victims commonly believe it is difficult to escape, or defend themselves, in those situations [5]. Also, such mindset facilitates the use of coping strategies consisting of ignoring, or avoiding, the aggressor(s) and/or the problem, as the present study confirms. Concomitantly, other authors also observed, in their study, that none of the victims confronted the aggressor(s) directly [37].

Nurses who are aware of being victims and who meet the second and third criteria do not exhibit significant differences in terms of "religious coping" and "support seeking." However, nurses who are considered victims, according to the first criterion (answering at least one item on the NAQ-R scale with an intensity of 4 or 5), use "religious coping" less and engage in more "support seeking." According to the Royal College of Nursing, the fact that victims share their experience of bullying with trusted friends, family, and work colleagues is very important for their awareness of what they are going through, to assess the problem, and jointly define strategies to overcome the bullying [38].

In all the criteria for assessing workplace bullying, the first, second, and third criteria, victims tend to employ "evasion" and "substance use" as coping strategies and use "acceptance" less frequently.

The most commonly used coping mechanisms by total of nurses were "support seeking" and "active/reflective coping." However, in situations where nurses are victims of workplace bullying, the most frequently employed coping mechanisms are "evasion," "substance use," and low "acceptance." This suggests that nurses tend to adopt more negative coping strategies in bullying situations. Therefore, it is important to reflect on why nurses do not react actively to bullying. One justification could be that workplace bullying is considered an assault on dignity and self-confidence. The victim does not understand what is happening, nor does he know how to respond, and the work ultimately ends up losing its meaning, leading them to seek solutions that are sometimes not the most appropriate, due to the development of depression or excessive anxiety attacks [39]. In other situations, the deficit in positive coping strategies used by victims to address emotional needs is associated with nurses' feelings of fear and discouragement in confronting workplace bullying [40].

In this way, it becomes important to develop training in institutions in order to prepare nurses to deal more effectively with workplace bullying, both for the victims and for the observers, enabling them to have the ability to recognize inappropriate behaviors and respond assertively, as well as seek appropriate support when necessary. Additionally, training on positive coping strategies will promote resilience and well-being among nurses, strengthening their ability to confront harassment and its consequences.

4.1. Limitations. Although the sample was randomly collected from various regions of Portugal, it is possible that the completion of the questionnaire was influenced by the nurses' identification with the phenomenon. Therefore, it can be speculated that individuals who have experienced workplace bullying may have been more interested and motivated to participate in the study. Furthermore, the study focused on the subjective perspective of the respondents, rather than that of other factors such as their family or network of friends.

5. Conclusions

With respect to the second evaluation criterion, it was found that nurses who experienced workplace bullying resorted significantly more to "evasion" ($p = 0.001$) and to "substance use" ($p = 0.004$). Conversely, they showed significantly less "acceptance," when compared to those who were not victims of workplace bullying. As such, the hypothesis "based on the second evaluation criterion, workplace bullying significantly affects the coping strategies employed by nurses" was verified in the following factors: "evasion," "substance use," and "acceptance."

As regards the use of coping strategies, based on the first and third evaluation criteria, nurses who suffered workplace bullying resorted more to "support seeking" as well as to "evasion" and "substance use." As for the second evaluation criterion, it was found that nurses being bullied at work resorted more to "evasion" and "substance use" and exhibited less "acceptance." Furthermore, when dealing with bullying behaviors, nurses resorted more frequently to coping strategies of a negative nature, marked by passive

attitudes. This, in turn, contributed to unhealthy behaviors, such as avoiding the problem and/or the aggressor(s), as well as to potential substance use.

Workplace bullying compromises the victims' work performance, as well as the relationship with the coworkers and the quality of the provided care. It should be noted that most nurses reported not having received specific training on workplace bullying but were interested in receiving such training. It is, thus, important for administrations and nurse managers to get involved in the prevention of workplace bullying, namely, by promoting adequate training on this topic. Ultimately, this will endow the nurses with positive and active coping strategies, particularly helpful for those providing care. The inclusion of this topic in in-service training programs also allows sharing information about coping strategies, which facilitates the management of situations that lead to workplace bullying and helps minimizing its negative effects.

A path must be followed that "defends and ensures respect for others, while also promoting healthy interpersonal relationships within the work context, capable of contributing to the workers' personal well-being and, simultaneously, to the better functioning of the healthcare institutions" (p.27) [41].

Data Availability

The data used to support the findings of this study are available from the corresponding author upon reasonable request.

Conflicts of Interest

The authors declare that there are no conflicts of interest regarding the publication of this paper.

Authors' Contributions

ALJ made contributions to the conception and design and was also involved in the acquisition, analysis, and interpretation of data. ALJ and AP participated in drafting the manuscript and critically revising it for important intellectual content. Additionally, both authors provided final approval of the version to be published.

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