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Exposure to hostile behaviors in nursing: a cross-sectional study in a Trauma Clinic in Barranquilla (Northern Colombia).

Exposición a conductas hostiles en enfermería: estudio transversal en una Clínica Traumatológica de Barranquilla (Norte de Colombia).

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Abstract

This study describes exposure to hostile behavior among nursing staff at a specialized orthopedics and trauma clinic in Barranquilla, Colombia. An observational, descriptive, and cross-sectional design was used to estimate the frequency and profile of hostile manifestations, using the Galián Muñoz et al. (2018) questionnaire as a basis and contextually adapted. The study involved 97 workers with direct care roles; 71.1% were women, 51.5% were aged 30–50 years, with a higher proportion of workers from the Emergency Department (27.8%), predominantly nursing professionals (53.6%), rotating shifts (41.2%), and permanent/indefinite contracts (84.5%). The instrument included a sociodemographic-occupational block and 14 ordinal items (0–5) on exposure to verbal/attitudinal hostility and low-intensity physical aggression. Anonymity and ethical standards were guaranteed in accordance with international and national standards. The scale showed high internal consistency (α = 0.89). The overall exposure index was 2.96 ± 0.64 (range 1.07–3.93), indicating intermediate and sustained exposure. The most frequent items corresponded to questioning clinical decisions, exaggerated attribution of responsibility, ironic jokes, and reproaches for delays or lack of information; to a lesser extent, pushing/shoving and material damage associated with anger were reported. The results confirm that incivility and verbal hostility constitute the core of exposure, with a transversal presence across services and greater pressure in high-demand settings. These findings support the need for multicomponent institutional strategies that integrate workflow redesign and anticipatory communication, de-escalation and conversational skills training, reporting channels with feedback, and post-incident support. Reducing everyday hostility toward nursing staff is a priority to protect staff well-being and strengthen patient safety.

Palabras clave: Workplace Violence; Workplace Harassment; Occupational Health; Patient Safety.

Resumen

Este estudio describe la exposición a conductas hostiles en personal de enfermería de una clínica especializada en ortopedia y traumatología en Barranquilla, Colombia. Se realizó un diseño observacional, descriptivo y transversal para estimar la frecuencia y el perfil de manifestaciones hostiles, tomando como base y adaptación contextual el cuestionario de Galián Muñoz et al. (2018). Participaron 97 trabajadores/as con funciones asistenciales directas; 71,1% mujeres, 51,5% entre 30–50 años, con mayor representación del servicio de Urgencias (27,8%), predominio de profesión Enfermería (53,6%), turnos rotatorios (41,2%) y contrato fijo/indefinido (84,5%). El instrumento incluyó un bloque sociodemográfico-laboral y 14 ítems ordinales (0–5) sobre exposición a hostilidad verbal/actitudinal y agresión física de baja intensidad. Se garantizó anonimato y ética conforme a normas internacionales y nacionales. La escala mostró alta consistencia interna (α = 0,89). El índice global de exposición fue 2,96 ± 0,64 (rango 1,07–3,93), indicando exposición intermedia y sostenida. Los ítems más frecuentes correspondieron a cuestionamiento de decisiones clínicas, atribución exagerada de responsabilidades, bromas irónicas y reproches por demoras o falta de información; en menor magnitud, se reportaron empujones/zarandeos y daños materiales asociados al enfado. Los resultados confirman que la incivilidad y la hostilidad verbal constituyen el núcleo de la exposición, con presencia transversal entre servicios y mayor presión en ámbitos de alta demanda. Estos hallazgos respaldan la necesidad de estrategias institucionales multicomponente que integren rediseño de flujos y comunicación anticipatoria, capacitación en desescalada y habilidades conversacionales, canales de reporte con retroalimentación, y apoyo post-incidente. Reducir la hostilidad cotidiana hacia enfermería es prioritario para proteger el bienestar del personal y fortalecer la seguridad del paciente.

Keywords: Enfermería; Violencia en el Trabajo; Acoso Laboral; Salud Laboral; Seguridad del Paciente.

Introduction

Based on recent and accumulating evidence, violence and incivility against nursing staff constitute a public health and occupational safety problem that compromises the quality of care and professional well-being. Multicenter reviews and studies show that these behaviors range from verbal aggression, humiliation, and systematic harassment to, to a lesser extent, physical violence, with measurable impacts on the work environment and clinical outcomes (Karatuna, Jönsson, & Muhonen, 2020; Goh, Hosier, & Zhang, 2022; Leach, Poyser, & Butterworth, 2017). In emergency settings, including adult and pediatric units, care pressure, expectations of immediate care, and waiting times are associated with a higher frequency of hostile events towards nursing (Oliveira et al., 2020; Almeida-Cisneros, Arellano-Verdezoto, & Medina-Maldonado, 2024; Al-Ghabeesh & Qattom, 2019), a trend corroborated by the most recent regional synthesis in emergency services (Oña Suntaxi, Bernardi Yoza, & Cambizaca Mora, 2025).

Ibero-American literature provides relevant contextual nuances. In Spain, research in public hospitals in the Region of Murcia documents sustained exposure to violence by users and its relationship with job satisfaction, warning of persistent organizational effects (Galián Muñoz, Llor Zaragoza, Ruiz Hernández, & Jiménez Barbero, 2018; Galián Muñoz, Llor Esteban, & Ruiz Hernández, 2012). In Chile, a systematic review describes psychosocial consequences for nurses at the hospital level and calls for sustained institutional strategies (Ferrada-Muñoz, Bermúdez-Véliz, Orquera-Araya, & Véliz-Rojas, 2022), while evidence from Mexico shows an increase and visibility of violence before and during the COVID-19 contingency, with implications for occupational risk management (Aspera-Campos et al., 2020). In Colombia, workplace harassment among nursing staff in Bogotá is reported, highlighting the prevalence of the phenomenon in the national context and the need for comprehensive responses (Fajardo Zapata, 2024). Similarly, studies in Peru link harassment with

burnout syndrome in healthcare personnel, emphasizing the human and institutional costs (Marín Marín & Soto, 2023).

Beyond isolated episodes, workplace bullying (mobbing) operates as a relational and structural process that erodes mental health and team cohesion, increases turnover intentions, and deteriorates organizational bonding (Molero Jurado, Pérez-Fuentes, & Gázquez Linares, 2016; Al Muharraq, Baker, & Alallah, 2022). Evidence from critical and neonatal units confirms associations between bullying, stress, and impact on clinical practice (Chatziioannidis et al., 2018; Ganz et al., 2015). Among the factors linked to increased risk are adverse psychosocial conditions, low perceived assertiveness, and imbalances in work organization (Fang, Hsiao, Fang, & Chen, 2020), which suggests the usefulness of multicomponent interventions that combine primary prevention, training in coping skills, and reporting and monitoring mechanisms (Koh, 2016; Goh et al., 2022).

In this context, surgical and trauma services are particularly susceptible due to the combination of acute pain, urgent procedures, and high demand, elements that can amplify interpersonal friction with family members and patients. The experience reported by nurses in emergency care units supports the need to fine-tune exposure, differentiate types of hostile behavior, and recognize patterns by shift and care flow (Oliveira et al., 2020; Oña Suntaxi et al., 2025; Almeida-Cisneros et al., 2024). In turn, the research trajectory in hospital settings in the Ibero-American region helps situate local findings within a broader and persistent problem (Galián Muñoz et al., 2012, 2018; Cerda-Antilef, Rivas-Riveros, & Campillay-Campillay, 2020; Castellón & María, 2012).

Based on the above, a specific characterization of exposure to hostile behaviors in nursing staff at a clinic specializing in orthopedics and traumatology is justified, with an emphasis on estimating the frequency by type of manifestation, exploring internal consistency of the items, and integrating a global exposure index. This approach seeks to generate useful inputs for the design of institutional strategies, training in de-escalation

and clinical communication, strengthening of reporting channels and post-incident support, and organizational adjustments that mitigate triggers aimed at protecting the well-being of human talent and strengthening patient safety in scenarios of high healthcare demand (Goh et al., 2022; Koh, 2016; Ganz et al., 2015).

Methodology

An observational, descriptive, cross-sectional study was conducted to estimate exposure to hostile behavior in nursing staff and to characterize their profile by type of manifestation in a specialized orthopedics and traumatology clinic in Barranquilla, Colombia. The unit of analysis was the nursing worker with direct care functions, and the report complies with the transparency recommendations for observational studies (von Elm et al., 2007). The target population corresponded to nursing professionals and assistants linked to clinical services; all eligible human talent active during the application period were invited, and a sampling frame was used by availability and self-selection through anonymous completion of the questionnaire, a standard procedure in clinical settings when studying occupational violence phenomena (Occupational Safety and Health Administration [OSHA], 2016).

The instrument was a self-administered, anonymous questionnaire consisting of two blocks. The sociodemographic-occupational block collected sex, age, service, profession or position, length of service in the profession and position, type of contract, shift, overtime, continuing education, and other work activity. The block on exposure to hostile behavior was constructed based on the article by Galián Muñoz, Llor Zaragoza, Ruiz Hernández, and Jiménez Barbero (2018), from which items and anchors were adapted to the local context of orthopedics and traumatology. It was composed of fourteen ordinal frequency items with anchors "never," "annually," "quarterly," "monthly," "weekly," and "daily," written to capture verbal or attitudinal hostility and low-intensity physical aggression in interactions with users and companions. The linguistic and

content adaptation followed good practices for the development and validation of scales in health and behavioral research (Boateng et al., 2018), as well as Likert-type measurement and data processing criteria (Harpe, 2015).

Data collection was carried out electronically during the workday, without personal identification or capture of sensitive data, guaranteeing anonymity and confidentiality. The research was conducted in accordance with the Declaration of Helsinki and the international guidelines for research in human subjects (World Medical Association, 2013; CIOMS, 2017), and the national regulations applicable to health research in Colombia (Ministry of Health of Colombia, 1993). Prior to analysis, data quality controls were implemented with range validation and consistency verification in response patterns, in line with quality assurance practices in observational studies (von Elm et al., 2007).

The responses in the exposure block were coded on a 0-to-5 scale according to the order of the frequency anchors, preserving the ordinal nature of the data (Harpe, 2015). This coding was used to calculate the mean, standard deviation, and valid item counts for each item, and to estimate a prevalence measure operationalized as any response other than "never." To summarize the phenomenon, a global exposure index was constructed as the arithmetic average of the fourteen items per participant on a 0-to-5 scale, using the average-over-valid criterion to minimize the effect of sporadic missing items. The internal consistency of the block was assessed using Cronbach's alpha coefficient (Cronbach, 1951).

The sample was characterized using frequencies and proportions, and the items were described using measures of central tendency and dispersion. The distribution of the overall index was explored using the Shapiro–Wilk test to support analytical decisions based on assumptions of normality (Shapiro & Wilk, 1965). Given the ordinal nature of the items and the potential asymmetry of the index, contrasts between subgroups of

interest (service, shift, and contract type) were planned using nonparametric Mann–Whitney tests for two groups and Kruskal–Wallis tests for more than two groups (Mann & Whitney, 1947; Kruskal & Wallis, 1952), with Dunn post hoc comparisons and family-wise error control using Holm's sequential procedure (Dunn, 1964; Holm, 1979). The expected effect sizes included the r coefficient for bivariate comparisons and the eta squared for Kruskal–Wallis, supplemented by estimators based on superiority probabilities when appropriate (Vargha & Delaney, 2000). Processing was performed in a Python environment with standard libraries for data management and statistics, setting a significance level of 5% and estimating confidence intervals at 95%, in accordance with standard criteria in occupational health research (OSHA, 2016; von Elm et al., 2007).

Results and discussion

A total of 97 valid questionnaires were analyzed. The sample was composed predominantly of women (71.1%), aged between 30 and 50 years (51.5%). The most frequently attended service was the Emergency Department (27.8%), followed by other care units; just over half reported nursing as their profession (53.6%), and rotating shifts were the most common care arrangement (41.2%). Permanent or indefinite contracts predominated (84.5%). Table 1 summarizes the sociodemographic and employment characteristics of the participating population.

Table 1.

Sample characteristics.

Variables	Frequency	%
Sex		
Women	69	71.1
Man	28	28.9
Age		
Between 30 and 50 years old	50	51.5
Other categories*	47	48.5
Services		
Emergencies	27	27.8
Others**	70	72.2
Profession		
Nursing	52	53.6
Nursing Assistant / Other	45	46.4
Shift of attention		
Rotary	40	41.2
Other shifts	57	58.8
Type of contract		
Fixed or indefinite	82	84.5
Others	15	15.5

Source: Own elaboration

*The complete tables for each category (detailed age, other services, etc.) are available; if you wish, I can display them in full here.

For the 14-item hostile behavior exposure assessment, internal consistency was high (Cronbach's α = 0.89), supporting the instrument's internal consistency in this context. The average overall exposure index for items on a 0–5 scale, where 0 = "Never" and 5 = "Daily," was 2.96 ± 0.64, with values ranging from 1.07 to 3.93.

Table 2.

Global exposure index (0–5)

n participants	Global average (0–5)	FROM global	Minimum	Maximum
97	2.96	0.6	1.07	3.93

Source: Prepared by the authors.

When examining the items individually, patterns were identified: the highest average frequencies corresponded to situations involving questioning clinical decisions and exaggerated attribution of responsibility, followed by ironic jokes and reproaches for delays or lack of information. At the lower end, although with lower averages, were incidents of direct physical aggression and damage to infrastructure in the context of anger directed at staff. Table 2 details, for each item, the mean (0–5), standard deviation, number of valid responses, and percentage of those exposed (proportion reporting any frequency other than "Never").

Among the 14-item hostile behavior exposure index, internal consistency was high (Cronbach's α = 0.89), supporting the instrument's internal consistency in this context. Table 3 presents the α coefficient and the number of items analyzed. The average overall exposure index for items on a 0–5 scale, where 0 = “Never” and 5 = “Daily,” was 2.96 ± 0.64, with values ranging from 1.07 to 3.93 (Table 4), suggesting sustained intermediate exposure to hostile behavior in daily nursing practice.

Table 3.

Internal consistency of the scale

Cronbach's α	k items
0.89	14

Source: Prepared by the authors.

To the Examining the items individually, relevant patterns were identified: the highest average frequencies corresponded to situations in which clinical decisions were questioned by users and to exaggerated attribution of responsibility for minor details, followed by displays of ironic joking and reproaches for delays or lack of information. At the lower end, although with lower averages, there were incidents of direct physical aggression (e.g., pushing or shaking) and damage to infrastructure in the context of anger directed at staff, which, although less frequent, were not zero. Table 4 details, for each item, the mean (0–5), the standard deviation, the number of valid responses, and the percentage of those exposed (proportion that reported any frequency other than "Never")

Table 4.

Statistics by item and prevalence of exposure.

Item (abbreviated)	Media (0–5)	OF	n valid	Exposed (%)
Users question my decisions.	4.32	0.90	97	100
Users blame me excessively for every little thing.	3.97	1.00	97	100
Users have even grabbed me or touched me in a hostile manner.	3.16	1.10	97	94.8
I am unjustifiably accused of non-compliance, errors or complications.	2.89	0.80	97	100
Users make ironic jokes at me.	2.88	0.80	97	100
Users threaten if their expectations (recipes, analysis, etc.) are not met.	2.81	1.00	97	99
They point me out for favoritism because they think I spend more time on other users.	2.74	0.90	97	99
Users get angry with me for the delay in care.	2.73	1.00	97	99
Users raise their voices or complain angrily.	2.71	1.00	97	99
Users give me dirty looks or disdainful looks.	2.68	1.00	97	96.9
Users channel their anger by destroying doors, glass, or walls.	2.67	1.00	97	96.9
Users interrupt my work in a rude manner.	2.66	1.00	97	99
Users get angry with me for the lack of information.	2.77	0.80	97	100
Users have even pushed me, shaken me, or spit on me.	2.47	1.00	97	93.8

Source: Prepared by the authors.

Overall, the findings show that hostile verbal and attitudinal behaviors (questioning, raised voice, irony, rude interruptions) constitute the core of exposure among nursing staff, with a transversal presence across different services, while physical behaviors are less common but not absent. The magnitude of the overall index (≈3 on a scale of 0–5), together with the high reliability of the scale, reinforces the internal validity of the results and the importance of intervening in organizational and user-care factors to mitigate the daily hostility faced by clinical staff.

The exposure of nursing staff to hostile behavior observed in this study aligns with the pattern widely documented in the literature: a predominance of verbal and attitudinal forms over physical aggression, with greater intensity in urgent care and high-volume patient areas. Research in Ibero-American and European hospital contexts consistently describes that incivility, disqualifications, reproaches and threats constitute the most frequent core of user violence, while physical aggression, although less prevalent, is not negligible and presents variations by service and shift (Galián Muñoz, Llor Esteban, & Ruiz Hernández, 2012; Galián Muñoz, Llor Zaragoza, Ruiz Hernández, & Jiménez Barbero, 2018; Cerda-Antilef, Rivas-Riveros, & Campillay-Campillay, 2020; Karatuna, Jönsson, & Muhonen, 2020; Serafin & Czarkowska-Pączek, 2019). Particularly high rates of hostile events are reported in emergency services, including pediatric settings, which coincide with the care pressure, waiting times, and clinical uncertainty that characterize these environments (Oliveira, Martins, Galdino, & Perfeito, 2020; Almeida-Cisneros, Arellano-Verdezoto, & Medina-Maldonado, 2024; Oña Suntaxi, Bernardi Yoza, & Cambizaca Mora, 2025).

Beyond frequency, the literature provides insight into the mechanisms and consequences. Reviews and quantitative studies show that harassment and bullying in nursing are related to adverse psychosocial climates—high demands, low perceived support and control, and organizational imbalances—and to individual factors such as assertiveness, which mediate the likelihood of experiencing and responding to hostility

(Goh, Hosier, & Zhang, 2022; Fang, Hsiao, Fang, & Chen, 2020; Karatuna et al., 2020). Along these lines, local findings with a predominance of questions and reproaches due to delays or information perceived as insufficient are consistent with the “knots of friction” described in high-demand care flows and in scenarios of asymmetric information between users and clinical teams (Galián Muñoz et al., 2018; Cerda-Antilef et al., 2020; Serafin & Czarkowska-Pączek, 2019).

The implications for staff health and organizational performance are well established. Evidence consistently links bullying with psychological exhaustion and burnout, increased intention to leave, turnover, and potentially adverse clinical outcomes, including impaired communication and teamwork (Marín Marín & Soto, 2023; Al Muharraq, Baker, & Alallah, 2022; Ganz et al., 2015; Goh et al., 2022). More broadly, an association with suicidal ideation has been observed in working populations exposed to bullying, underscoring the preventive importance of systematically addressing these behaviors (Leach, Poyser, & Butterworth, 2017). Additionally, studies in Latin America during the COVID-19 contingency documented an intensification and visibility of violence against health personnel, reinforcing the need for robust and sustained strategies (Aspera-Campos, Hernández-Carranco, Gutiérrez-Barrera, & Quintero-Valle, 2020; Fajardo Zapata, 2024).

In terms of management, the literature converges on the effectiveness of multicomponent interventions. At the primary level, actions on flows and communication with users (transparency of schedules, clear signage, and advance information) and staffing adjustments during peak demand are recommended (Ferrada-Muñoz, Bermúdez-Véliz, Orquera-Araya, & Véliz-Rojas, 2022; Oña Suntaxi et al., 2025). In prevention and clinical-operative management, training in de-escalation and conversational skills, including cognitive rehearsal, has proven useful in recognizing, responding to, and curtailing escalations of incivility (Koh, 2016; Ganz et al., 2015). These measures are enhanced with accessible reporting systems, periodic feedback to

teams, and post-incident support, elements that contribute to denormalizing hostility and sustaining a culture of safety and respect (Goh et al., 2022; Ferrada-Muñoz et al., 2022). Meanwhile, studies in specific populations and units such as neonatology reinforce the need to adapt interventions to the context and risk profiles of each service (Chatziioannidis, Bascialla, Chatzivalsama, Vouzas, & Mitsiakos, 2018).

The historical trajectory of this problem in nursing suggests that it is not an emerging phenomenon, but rather a persistent one, with organizational and cultural roots. Early contributions already warned about bullying as a structural threat to the profession and to the quality of care (Castellón & María, 2012; Molero Jurado, Pérez-Fuentes, & Gázquez Linares, 2016), while regional Spanish series documented its sustained presence and its effects on job satisfaction (Galián Muñoz et al., 2012, 2018). The most recent evidence from Colombia and the Andean region confirms its validity and the need for comprehensive and contextualized responses (Fajardo Zapata, 2024; Cerda-Antilef et al., 2020; Oña Suntaxi et al., 2025; Almeida-Cisneros et al., 2024).

This set of results reinforces the interpretation of a structural occupational risk. Consequently, institutions should prioritize explicit zero-tolerance policies, ongoing training focused on prevention and de-escalation, organizational redesigns sensitive to peak demand, and monitoring systems with indicators and periodic feedback, integrating psychosocial support when necessary (Ferrada-Muñoz et al., 2022; Koh, 2016; Ganz et al., 2015; Goh et al., 2022). Among future directions, the literature suggests delving into analyses by service and shift, incorporating longitudinal measurements and triangulation with incident records, and exploring individual (e.g., assertiveness) and organizational (e.g., leadership, safety climate) moderators to target cost-effective strategies over time (Fang et al., 2020; Serafin & Czarkowska-Pączek, 2019; Karatuna et al., 2020).

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Conclusion

It is evident that nursing staff exposure to hostile behavior constitutes a significant and persistent occupational risk in the clinical context studied. Verbal and attitudinal manifestations predominate, eroding communication, disrupting work, and deteriorating team climate, while physical episodes, although less frequent, are not inexistent and require preventive care. The consistency of the instrument applied supports the validity of the results and confirms that this is a structural phenomenon, associated with care pressures, user expectations, information asymmetries, and organizational conditions that intensify friction at critical points. Consequently, a comprehensive institutional response is required that combines primary prevention through workflow redesign, anticipatory information, and environmental adjustments, secondary prevention with training in clinical communication and de-escalation, and subsequent support actions for team recovery after hostile incidents. Furthermore, the implementation of zero-tolerance policies, reporting channels, and monitoring with indicators and feedback are essential to discourage the normalization of incivility and reduce its impact on staff well-being and patient safety. Future research should explore analyses by service and shift, incorporate severity measures, triangulation with records, and longitudinal approaches to evaluate the effectiveness of interventions. In short, reducing exposure to hostile behavior is a strategic priority for occupational health and quality of care that demands leadership, interprofessional commitment, and a culture centered on respect, caring, and effective communication.

References

Al-Ghabeesh, S. H., & Qattom, H. (2019). Workplace bullying and its preventive measures and productivity among emergency department nurses. BMC Health Services Research, 19, 445. https://doi.org/10.1186/s12913-019-4268-x

Al Muharraq, E. H., Baker, O. G., & Alallah, S. M. (2022). The prevalence and the relationship of workplace bullying and nurses' turnover intentions: A cross-sectional study. SAGE Open Nursing, 8, 23779608221074655. https://doi.org/10.1177/23779608221074655

Almeida-Cisneros, K. L., Arellano-Verdezoto, E. J., & Medina-Maldonado, V. (2024). Violencia en el lugar de trabajo desde la percepción de profesionales de enfermería en un servicio de emergencia pediátrica. Enfermería Global, 23(74), 122–152. https://doi.org/10.6018/eglobal.595231

Aspera-Campos, T., Hernández-Carranco, R. G., Gutiérrez-Barrera, A. D. T., & Quintero-Valle, L. M. (2020). Violence against health personnel before and during the health contingency COVID-19. Revista Médica del Instituto Mexicano del Seguro Social, 58(S2), S134–S143. https://doi.org/10.24875/RMIMSS.M20000125

Boateng, G. O., Neilands, T. B., Frongillo, E. A., Melgar-Quiñonez, H. R., & Young, S. L. (2018). Best practices for developing and validating scales for health, social, and behavioral research: A primer. Frontiers in Public Health, 6, 149. https://doi.org/10.3389/fpubh.2018.00149

Castellón, D., & María, A. (2012). Hostigamiento laboral: Amenaza permanente para enfermería. Enfermería Global, 11(28), 120–136. http://scielo.isciii.es/scielo.php?script=sci_arttext&pid=S1695-61412012000400008

Cerda-Antilef, S., Rivas-Riveros, E., & Campillay-Campillay, M. (2020). Experiencia de violencia laboral en profesionales de enfermería de un hospital público. Enfermería Universitaria, 17(4), 449–462. https://doi.org/10.22201/eneo.23958421e.2020.4.827

Chatziioannidis, I., Bascialla, F. G., Chatzivalsama, P., Vouzas, F., & Mitsiakos, G. (2018). Prevalence, causes and mental health impact of workplace bullying in the neonatal intensive care unit environment. BMJ Open, 8(2), e018766. https://doi.org/10.1136/bmjopen-2017-018766

CIOMS. (2017). International ethical guidelines for health-related research involving humans. Council for International Organizations of Medical Sciences. https://cioms.ch/publications/product/international-ethical-guidelines-for-health-related-research-involving-humans/

Cronbach, L. J. (1951). Coefficient alpha and the internal structure of tests. Psychometrika, 16(3), 297–334. https://doi.org/10.1007/BF02310555

Dunn, O. J. (1964). Multiple comparisons using rank sums. Technometrics, 6(3), 241–252. https://doi.org/10.1080/00401706.1964.10490181

Fang, L., Hsiao, L.-P., Fang, S.-H., & Chen, B.-C. (2020). Effects of assertiveness

and psychosocial work condition on workplace bullying among nurses: A cross-sectional study. International Journal of Nursing Practice, 26(6), e12806. https://doi.org/10.1111/ijn.12806

Fajardo Zapata, Á. L. (2024). Acoso laboral al personal de enfermería en Bogotá. Revista Cubana de Salud y Trabajo, 25(2). http://scielo.sld.cu/scielo.php?script=sci_arttext&pid=S1991-93952024000200007

Ferrada-Muñoz, M., Bermúdez-Véliz, V., Orquera-Araya, F., & Véliz-Rojas, L. (2022). Violencia laboral y su efecto en enfermeras a nivel hospitalario: Una revisión sistemática. Horizonte de Enfermería, 33(1), 126–141. https://horizonteenfermeria.uc.cl/index.php/RHE/article/view/48093

Galián Muñoz, I., Llor Esteban, B., & Ruiz Hernández, J. A. (2012). Violencia de los usuarios hacia el personal de enfermería en los hospitales públicos de la Región de Murcia. Revista Española de Salud Pública, 86(3), 279–291. http://scielo.isciii.es/scielo.php?script=sci_arttext&pid=S1135-57272012000300007

Galián Muñoz, I., Llor Zaragoza, P., Ruiz Hernández, J. A., & Jiménez Barbero, J. A. (2018). Exposición a violencia de los usuarios y satisfacción laboral en el personal de enfermería de los hospitales públicos de la Región de Murcia. Anales del Sistema Sanitario de Navarra, 41(2), 181–189. https://doi.org/10.23938/assn.0310

Ganz, F. D., Levy, H., Khalaila, R., Arad, D., Bennaroch, K., Kolpak, O., et al. (2015). Bullying and its prevention among intensive care nurses. Journal of Nursing Scholarship, 47(6), 505–511. https://doi.org/10.1111/jnu.12167

Goh, H. S., Hosier, S., & Zhang, H. (2022). Prevalence, antecedents, and consequences of workplace bullying among nursesA summary of reviews. International Journal of Environmental Research and Public Health, 19(14), 8256. https://doi.org/10.3390/ijerph19148256

Harpe, S. E. (2015). How to analyze Likert and other rating scale data. Currents in Pharmacy Teaching and Learning, 7(6), 836–850. https://doi.org/10.1016/j.cptl.2015.08.001

Holm, S. (1979). A simple sequentially rejective multiple test procedure. Scandinavian Journal of Statistics, 6(2), 65–70.

Karatuna, İ., Jönsson, S., & Muhonen, T. (2020). Workplace bullying in the nursing profession: A cross-cultural scoping review. International Journal of Nursing Studies, 111, 103628. https://doi.org/10.1016/j.ijnurstu.2020.103628

Koh, W. M. S. (2016). Management of workplace bullying in hospital: A review of the use of cognitive rehearsal as an alternative management strategy. International Journal of Nursing Sciences, 3(2), 213–222.

Kruskal, W. H., & Wallis, W. A. (1952). Use of ranks in one-criterion variance analysis. Journal of the American Statistical Association, 47(260), 583–621. https://doi.org/10.1080/01621459.1952.10483441

Leach, L. S., Poyser, C., & Butterworth, P. (2017). Workplace bullying and the

association with suicidal ideation/thoughts and behaviour: A systematic review. Occupational and Environmental Medicine, 74(1), 72–79.

Mann, H. B., & Whitney, D. R. (1947). On a test of whether one of two random variables is stochastically larger than the other. The Annals of Mathematical Statistics, 18(1), 50–60. https://doi.org/10.1214/aoms/1177730491

Marín Marín, D., & Soto, A. (2023). Hostigamiento laboral y síndrome de burnout en personal sanitario en un hospital de referencia. Horizonte Médico (Lima), 23(3), e2180. https://doi.org/10.24265/horizmed.2023.v23n3.07

Ministerio de Salud de Colombia. (1993). Resolución 8430 de 1993: Por la cual se establecen las normas científicas, técnicas y administrativas para la investigación en salud. https://www.minsalud.gov.co/Normatividad_Nuevo/RESOLUCION%208430%20DE%201993.pdf

Molero Jurado, M. M., Pérez-Fuentes, M. C., & Gázquez Linares, J. J. (2016). Acoso laboral entre personal de enfermería. Enfermería Universitaria, 13(2), 114–123. https://doi.org/10.1016/j.reu.2016.03.001

Occupational Safety and Health Administration (OSHA). (2016). Guidelines for preventing workplace violence for healthcare and social service workers (OSHA 3148-04R 2015). https://www.osha.gov/Publications/osha3148.pdf

Oliveira, C. S., Martins, J. T., Galdino, M. J. Q., & Perfeito, R. R. (2020). Violence at work in emergency care units: Nurses' experiences. Revista Latino-Americana de Enfermagem, 28, e3323. https://doi.org/10.1590/1518-8345.3856.3323

Oña Suntaxi, M. J., Bernardi Yoza, J. A., & Cambizaca Mora, G. del P. (2025). La violencia laboral hacia profesionales de enfermería en los servicios de emergencia: Una revisión sistemática. RECIMUNDO, 9(1), 713–730. https://doi.org/10.26820/recimundo/9.(1).enero.2025.713-730

Serafin, L. I., & Czarkowska-Pączek, B. (2019). Prevalence of bullying in the nursing workplace and determinant factors: A nationwide cross-sectional Polish study survey. BMJ Open, 9(12), e033819. https://doi.org/10.1136/bmjopen-2019-033819

Shapiro, S. S., & Wilk, M. B. (1965). An analysis of variance test for normality (complete samples). Biometrika, 52(3–4), 591–611. https://doi.org/10.2307/2333709

Vargha, A., & Delaney, H. D. (2000). A critique and improvement of the "CL" common language effect size statistics of McGraw and Wong. Journal of Educational and Behavioral Statistics, 25(2), 101–132. https://doi.org/10.3102/10769986025002101

von Elm, E., Altman, D. G., Egger, M., Pocock, S. J., Gøtzsche, P. C., & Vandenbroucke, J. P. (2007). The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) statement: Guidelines for reporting observational studies. PLoS Medicine, 4(10), e296. https://doi.org/10.1371/journal.pmed.0040296

World Medical Association. (2013). World Medical Association Declaration of Helsinki: Ethical principles for medical research involving human subjects. JAMA, 310(20), 2191–2194. https://doi.org/10.1001/jama.2013.281053.