

Toxic Leadership: Conflict Management Style and Organizational Commitment among Intensive Care Nursing Staff

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ABSTRACT

Context: Toxic leadership becomes a real problem in nursing administration. Its toxicity harms the nursing staff's progress and creates a challenging work environment full of struggles that, in turn, produce adverse outcomes on the nursing staff's commitment toward the organization.

Aim: This study envisioned to compare toxic leadership among intensive care nursing staff at Tanta University Hospital and El Menshawy hospital and assess its relation to their conflict management style used and organizational commitment at the two hospitals.

Methods: A descriptive, comparative, via cross-sectional research design was applied. All intensive care units at Tanta University Hospitals and El-Menshawy General Hospital were included. All available nurses (n=544) at Tanta University hospitals' ICUs (n=301) and El-Menshawy hospital's ICUs (n=243) was incorporated. Toxic leadership, conflict management styles assessment, and organizational commitment scales were utilized to achieve this study's aim.

Results: The nursing staff perceived that their leaders had high 10.6%, 11.5%, and moderate 12%, 11.9% overall toxic leadership levels at Tanta University Hospitals, and Elmenshawy Hospital, respectively. 43.9% of the nursing staff had a high level of using compromising style to manage conflict with their supervisors at Tanta University hospitals contrasted to 36.6% using competing style at El Menshawy hospital. 78.4% of the nursing staff had a low level of overall organizational commitment at Tanta University hospital's ICUs compared to 63% at El-Menshawy General hospital's ICUs.

Conclusion: Toxic leadership affected the nursing staff's choice of conflict management style used when handling conflict with toxic leaders at two hospitals and had a negative effect on affective and normative dimensions of organizational commitment in both hospitals. Therefore, improving leadership experiences is necessary by conducting a leadership development program to meet the nursing staff's expectations and improve their commitment. Also, adjusting the hospital's policies is vital to permit nursing staffs' involvement in leadership evaluation as a mean for early detection of leaders' toxic behaviors.

Keywords: Conflict management, nursing staff, organizational commitment, toxic leadership

1. Introduction

Intensive care units are among hard work exhaustive enterprises with innovative medical technology and specified healthcare providers requiring proficient, caring, and authentic leaders to direct and organize nurses' work to reach the desired targets (Orgev & Demir, 2019). Nurses' work in ICUs depends on a high level of cooperation and harmony between the units and staff unity to deliver efficient and productive care in emergencies (Akca, 2017).

In this context, nursing leadership is of great paramount during current challenging times of healthcare advance to ensure that nursing teams can be used effectively and competently in the organization (Ozer et al., 2017). Nurse leaders' stressors of limited resources, competition, and increase petition for a high quality of care evoke some types of dark leadership as toxic leadership (Pelletier et al., 2019; Roter, 2011; Velickovic et al., 2014). Toxic leadership intentionally or unintentionally seeks to achieve the needs through decisiveness, coercion, and punishment (Erickson et al., 2015).

In healthcare organizations, toxicity can occur at structural and individual levels. Toxicity at the structure level demonstrates that when teams stop collaborating, failure in the organizational communication system occurs, unreasonable goals are set, and extreme internal competition is encouraged (Weberg, 2019). At the individual level, it takes place when individuals stop speaking up, encounter cultures of blame and passive conflict, spread misinformation, inability to achieve goals, lose expectation in leadership, and when average performance is rewarded through low levels of accountability (Mehta & Maheshwari, 2013).

Though most superiors do not deliberately create a toxic environment, their lack of attention to certain aspects of leading can result in negative team relationships and uncertainty that lay the foundation for toxicity to flourish (Weberg, 2010). Padilla et al. (2007) has shown toxic leadership as a toxic triangle, including three critical domains; destructive leader, susceptible followers, and conducive environment that 'stimulate a leader's toxicity. The destructive leader is the apex of the triangle made up of five serious factors: charisma, personalized need for power,

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narcissism, negative life themes, and an ideology of hate (Pelletier, 2010). Susceptible followers are powerless to resist domineering and abusive leaders searching for safety, group affiliation, and predictability in an ambiguous organization. The third element is the environment that surrounds leaders, followers, and their interactions. Four serious environmental factors are: Organizational instability, perceived threat, cultural values, and absence of checks and balances (Mulvey & Padilla, 2010). The three fragments framework of the toxic triangle calls attention and offers insight to identify potentially toxic leaders, provide needed control at the lower organizational level, ascertain the strength, and empower followers to inhibit toxic leadership in a healthcare organization (Padilla et al., 2007).

A leader's deviated behaviors can be manifested by self-promotion, abusive supervision, unpredictability, narcissism, and authoritarianism. At self-promotion, the leader selects his desires first, tries to minimize staff threats, and passes his failure on them. Abusive supervision refers to a destructive behavior where staff perceives their supervisors' actions as hostile verbal or non-verbal expression to gain and retain control over them (Liu et al., 2019). Unpredictability is a deviated behavior of the instability in a leader's mood and behavior reflected on work conditions (Ozer et al., 2017). Narcissism is a behavior charisma incorporating grandiosity, overconfidence, self-absorption, weak self-esteem, and sometimes hostility (O'Boyle et al., 2013). Lastly, an authoritarian leader needs to maintain continuous control of their nursing staff with arbitrary, unilateral decisions, and prevail over them (Zhang & Xie, 2017).

These dysfunctional behaviors create a profound, long-lasting toxic impact on nursing staff and the organization's well-being and disturb job performance and productivity that undercuts its goals and reputation (Fahie, 2019; Boddy & Croft, 2016). What more, is decreasing staff satisfaction, motivation, creativity, and commitment and increasing work stress and turnover (Burns, 2017; Akca, 2017). Nursing staff who deal with this type of leader feel that they are forced and become more irritant, frustrated, and resist this leader so, conflict is predictable (Bhandarker & Rai, 2019; Murray, 2017; Schyns & Schilling, 2013).

Conflict is defined as a brawl that happens when there are discrepancies in two or more parties' needs, opinions, or behavior (Hube, 2018). Nursing staff can use different styles to manage their conflict (Avgar, 2016). Nursing staff may practice avoiding style and lose to keep away from the toxicity of leader or use accommodating style by forfeiting their own needs to manage conflict and satisfy the leader's need (Karatuna, 2015; Obied & Sayed 2013).

In other situations, nurses can use the collaborating style when they feel that a toxic leader respects their ideas. They together exert effort to find a solution that satisfied them (Moisoglou et al., 2014). The compromising style also may be useful when each conflict gives up something, and sharing occurs to reach an agreement, but in a competing style, one party seeks to win regardless of the cost to others (Mohamed & Yousef 2014; Abudahi 2012). Unsuccessful

conflict management increase stress, decreased the quality of nursing care, satisfaction with work, decreases organizational commitment that hurts the organization (Abudahi, 2012; Kantek & Kayla, 2007).

Organizational commitment is a vital element that assures nursing staff's obligation with the quality of care, even in high-stress environments, as ICUs and work settings with scarce human and organizational resources. Organizational commitment refers to the existence of a craving, a necessity, and a responsibility to remain as a member of an organization (Orgambidez & Almedia, 2018). These three forms of attachment are portrayed by three dimensions: affective, continuous, and normative commitment. Affective commitment refers to the emotional link between the nursing staff and the organization, the staff's strength positive outlooks toward the organization (Liou, 2008).

Continuous commitment refers to the connected nursing staff establish with their organization due to the investments through time. It is allied to the economic costs for staff if they had to leave the organization. However, normative commitment consists of the nursing staff's ethical accountability to continue bonds with the organization in reaching organizational goals (Liou, 2008). Among factors that contribute to a high level of nurses' organizational commitment including perceived organizational support, transformational leadership behavior, relationships and collaboration, occasions for learning, job satisfaction, patient care, and job security (Li et al. 2017; Velicakovic et al., 2014).

As of its importance for the healthcare organization, staff commitment is one of the most critical challenges for nurses to maintain performance improvement and work satisfaction. Nevertheless, toxic leaders' unhealthy behavior shakes nursing staff and leads to chancy and harmful working environments (Weberg, 2019). Thus, the healthcare organizations' focal intention is continuously assessing any toxicity in leaders' behavior and seeks to reduce and eliminate this toxicity to keep nursing staff commitment (Hubbard, 2018; Borhani et al., 2014).

2. Significance of the study

For many years, leadership concepts focused on its positive aspects, leading to a bias toward leadership. However, the reality is that there are undesirable leadership samples of nonproductive behaviors in organizations, as revealed by Wageeh (2019), in a study conducted on teaching hospitals in Egypt. The study reported that the extent of many leaders' destructive behavior and its drawbacks in the healthcare organization is very vast. The study of such behaviors in organizations seems viable and can affect job satisfaction and organizational commitment. As toxic leadership is a relatively new concept in the healthcare organizations in Egypt, this study directed to assess leadership toxicity at two different health care sectors and determine its effect on the conflict management style of the nursing staff used when dealing with the toxic

leaders as well as on nursing staff's organizational commitment.

3. Aim of the study

This study envisioned to

- Compare toxic leadership among intensive care nursing staff at Tanta university hospital and El Menshawey hospital.
- Assess its relation to their conflict management style used and organizational commitment at the two hospitals.

3.1. Research Questions

- What are the levels of toxic leadership perceived by nursing staff at Tanta University Hospitals' ICUs and El-Menshawey General hospital's ICUs?
- What is the prominent conflict management style used by nursing staff at Tanta University Hospitals' ICUs and El-Menshawey General Hospital's ICUs?
- What are the nurses' organizational commitment levels at Tanta University Hospitals' ICUs and El-Menshawey General Hospital's ICUs?
- Are there differences between Tanta University Hospitals' ICUs and El-Menshawey General hospital's ICUs regarding toxic leadership levels, nursing staff's conflict management style used, and organizational commitment?
- Can toxic leadership affect the nursing staff's conflict management style and organizational commitment at Tanta University Hospitals' ICUs and El-Menshawey General Hospital's ICUs?

4. Subjects and Methods

4.1. Research design

A descriptive, comparative, via cross-sectional research design was applied. This design is used to describe, compare, and examine differences in variables in two or more groups that occur in a setting at one given point in time (*Grove et al., 2015*).

4.2. Research Setting

This study was completed in all intensive care units (ICUs), including High-risk neonates (NICU), Emergency ICU, Medical ICU, Neurology ICU, General ICU, Pediatric ICU, and Cardiology ICU at Tanta University Hospitals and El-Menshawey General Hospital affiliated to the Ministry of Health and Population.

Tanta University Hospitals included the main university hospital with capacity (950 beds) and an emergency hospital with capacity (380 beds). El Menshawey hospital is divided into three main buildings A, B, and C, including inpatient, outpatient, and seven ICUs mentioned above with a total capacity of 320 beds capacity.

4.3. Subjects

All available nursing staff (n=544) in the hospitals mentioned above incorporated in this study; Tanta University Hospitals' ICUs (n=301) and El-Menshawey General Hospital's ICUs (n=243).

4.4. Tools of data collection

Three tools were used to gather data of the study.

4.4.1. Toxic Leadership Assessment Scale

This tool reliant on *Özer et al. (2017)*; *Schmidt (2008)* to discover to what extent nursing staff perceived their head nurses as toxic leaders. The toxic leadership assessment scale included 30 items categorized into five dimensions: self-promotion (7 items), abusive supervision (7 items), unpredictability (5 items), narcissism (6 items), and authoritarian leadership (5 items), besides six items related to nursing staff demographic characteristics. The nursing staff responses were on 5-points Likert scaling varying from 1 (strongly disagree) to 5 (strongly agree). Levels of toxic leadership represented statistically based on the cut of value into $\geq 75\%$ as high level; $< 75\%$ -60% as moderate level and low; $< 60\%$. A higher score denoted that the nursing staff perceived that their head nurses display toxic leadership.

4.4.2. Conflict Management Styles Assessment Scale

Conflict Management Assessment Scale developed by (*Rahim 1983*) and modified by the researchers by omitting and merging the items with the same meaning to identify how they handle conflict with their leader (head nurse). It consisted of 20 items classified into five independent styles dimensions: Avoiding style (4 items), accommodating style (4 items), collaborating style (5 items), compromising style (3 items), and competing style (4 items). The nursing staff responses were evaluated against 5-points Likert scaling varying from 1 (strongly disagree) to 5 (strongly agree). Levels of using conflict management styles interpreted statistically based on the cut of value into three levels; $\geq 75\%$ as high level; $< 75\%$ -60% as moderate level; $< 60\%$ as low using conflict style.

4.4.3. Organizational Commitment Assessment Scale

The scale was based on the later version of *Meyer and Tett (1993)*; *Meyer and Allen (1997)* that designed to assess nursing staff organizational commitment (affective, continuance, and normative). It contained 18 items (6 items for each scale). The scale was five Likert-type responses from 1 (strongly disagree) to 5 (strongly agree). Nursing staff organizational commitment levels scored statistically based on the cut of value as; $\geq 75\%$ as high level; $< 75\%$ -60% as moderate level; $< 60\%$ as low organizational commitment.

4.5. Procedures

Ethical considerations: The researchers obtained approval from the authoritative bodies at two hospitals before initiating the data collection. Informed consent was attained from the nursing staff after clarifying the aim of the study. The study's contribution was voluntary, and they were told that their answers would be kept confidential.

Fieldwork: Data were collected through a self-administered questionnaire, which translated into the Arabic language to be clear for all participants' education levels and back-translated to ensure accuracy. The questionnaire was distributed to the nursing staff at their units in small groups. The destined time to complete the questionnaires was about 15-20 minutes.

A panel of five experts was invited to review the questionnaire from the nursing administration specialty to assess the face and content validity, as well as to check the fidelity. Based on this revision, necessary modifications were done, and a pilot study was conducted on 10% (who are excluded from the study sample). The tool was also examined for reliability two times (test-retest reliability) with separate two weeks to ensure the applicability of the questionnaire and stability of the respondents' answers. Cronbach coefficient Alpha test was drawn on to find out the tools' internal consistency. The test outcome was viewed as satisfactory as the questionnaires had high inner consistency; toxic leadership assessment scale ($\alpha = 0.85$), conflict style assessment scale, ($\alpha = 0.91$), and organizational commitment assessment scale was ($\alpha = 0.90$), and the test-retest reliability value for nominal data was more significant than 0.8.

4.6. Data analysis

Data were fed to the computer and analyzed using IBM SPSS software package version 20.0. Qualitative data were described using number and percent, while the quantitative data were described using mean and standard deviation. The significance of the obtained results was judged at the 5% level. Chi-square test (for categorical variables) was used to compare between different groups; Monte Carlo correction for chi-square when more than 20% of the cells have predictable count fewer than 5. Student t-test was used to compare two studied groups; Pearson coefficient to correlate between two normally distributed quantitative variables, and F-test (ANOVA) to compare between more than two groups.

5. Results

Table 1 compares the nursing staff's characteristics at Tanta University Hospital and El -Menshawey General Hospital. At Tanta university hospitals, 22.9%, 17.3% of nursing staff working in general ICU, high-risk neonates, and neurological ICU, respectively, while at El-Menshawey hospital, 25.1%, 23.5% of them working in neurological and medical ICU respectively. 63.1% of nursing staff at both hospitals were at age 20-30 while only 1.5% at 51+ with mean age of 30.39 ± 7.18 . More than ninety percent (95.6%) of nurses in both hospitals were female, and the most (88.2%) were married.

Regarding qualification, at Tanta university hospitals, more than fifty percent (50.5%) of the nursing staff had associate degrees, and 26.9 % had bachelor's degrees compared to El-Menshawey hospital, 43.2% of the nursing staff had a bachelor degree, and 34.6% had an associate degree. Highest percentages (70.8%, 67.5%) nursing staff

had equal or less than ten years of experience at Tanta university hospitals and El-Menshawey hospital. No significant difference between both groups regarding their mean age, marital status, and years of experience.

Table 2 shows that toxic leadership's self-promotion and authoritarian dimensions presented a statistically significant difference at $p \leq 0.05$ between the two hospitals. Whereas in total, more than one third (21.7%, 17.5%) of nursing staff perceived their leaders highly and moderately narcissistic, and nearly one third (15.3%, 15.1%) perceived that their leaders exhibit unpredictability behaviors at a high and moderate level. Moreover, nearly a quarter (11.8%, 9.7%) of nurses rated their leaders as abusive at moderate and high levels.

Figure 1 illustrates that nearly a quarter of nursing staff had a high and moderate overall toxic leadership (10.6% and 12%) at Tanta University hospital ICUs and (11.5% and 11.9%) at El Menshawey hospital ICUs.

Table 3 demonstrates that nearly half (47.2%, 49.4%) of the nursing staff had a high level of using collaborating style at Tanta university hospitals' ICUs and El Menshawey hospital's ICUs, respectively. 43.9% of nursing staff at Tanta university hospitals highly use compromising style to manage conflict with their supervisors, while more than one third (36.6%) highly use competing styles at El Menshawey hospital. There were statistically significant differences between the two hospitals in using accommodating and competing styles of conflict management.

Table 4 reveals that nurses' organizational affective and normative commitment levels presented a statistically significant difference ($P=0.001$) between the two hospitals. At Tanta university hospitals' ICUs, 79.1% and more than two-thirds (70.8%) of the nursing staff had a low level of normative and affective commitment respectively, contrasted to 70% and more than half (55.6%) at El Menshawey hospital's ICUs.

Figure 2 illustrates that 78.4% of nurses had a low level of overall organizational commitment at Tanta University- hospital's ICUs compared to 63% at El-Menshawey General hospital's ICUs.

Table 5 demonstrates the correlation between overall toxic leadership and conflict management styles in both hospitals. There was a statistically significant positive correlation between toxic leadership and competing style at Tanta University Hospitals, while a significant negative correlation with collaborating style was found. While at El-Menshawey hospital, there was a statistically significant positive correlation between toxic leadership and all conflict management styles, except that the collaborating style negatively correlated.

Table 6 illuminated the correlation between overall toxic leadership and nursing staff's organizational commitment at both hospitals. There was a significant negative correlation between toxic leadership and affective & normative dimensions of organizational commitment at both hospitals.

Table 7 presents the relation between overall toxic leadership and demographic characteristics of the studied nurses. There was a statistically significant relationship

between toxic leadership and all nursing staff demographic characteristics except marital status. The table shows that the highest toxicity of leadership appears in the neurological ICU, where (23%, 20.4%) of the nursing staff had a high and moderate level, respectively, followed by (15.9%, 12.7%) had high and moderate level at cardio ICU respectively.

A quarter of nursing staff (25%) at age 41-50 perceived their leaders as had a moderate level of toxicity, and the other quarter (13.7%, 11.4%) of the nursing staff had a high and moderate level of toxicity at age 20-30. Adding that,

25% of male nurses perceived that their leaders had a high level of toxic leadership. Concerning qualification, nearly one-fifth (18.8%) of bachelor's degree nursing staff perceived their leaders as had a high level of leadership toxicity while (14.4%, 12.6%) of nursing staff who had associate and diploma degrees perceived their leaders as had a moderate level of toxicity. Nearly one-seventh (14.6%) of the nursing staff had less than ten years of experience perceived their leaders as had a high level of leadership toxicity.

Table (1): Comparison between nurses' characteristics at Tanta University Hospital and El-Menshawey General Hospital.

Variables	Total (n = 544)		Tanta University (N = 301)		El-Menshawey (N = 243)		Test of Sig.	p
	No.	%	No.	%	No.	%		
Department								
High-Risk Neonates	79	14.5	52	17.3	27	11.1	$\chi^2=116.028$	<0.001
Emergency ICU	35	6.4	35	11.6	0	0.0		
General ICU	104	19.1	69	22.9	35	14.4		
Medical ICU	97	17.8	40	13.3	57	23.5		
Neuro ICU	113	20.9	52	17.3	61	25.1		
Cardio ICU	63	11.6	25	8.3	38	15.6		
Pediatric ICU	53	9.7	28	9.3	25	10.3		
Age (years)								
20 – 30	343	63.1	194	64.5	149	61.3	$\chi^2=9.237$	MCp=0.024
31 – 40	145	26.7	68	22.6	77	31.7		
41 – 50	48	8.8	34	11.3	14	5.8		
51+	8	1.5	5	1.7	3	1.2		
Mean ± SD.	30.39 ± 7.18		30.43 ± 7.48		30.35 ± 6.81		t=0.139	0.889
Gender								
Male	24	4.4	4	1.3	20	8.2	$\chi^2=15.186$	<0.001
Female	520	95.6	297	98.7	223	91.8		
Marital status								
Single	57	10.5	24	8.0	33	13.6	$\chi^2=5.008$	MCp=0.079
Married	480	88.2	272	90.4	208	85.6		
Other	7	1.3	5	1.7	2	0.8		
Qualification								
Diploma degree	119	21.9	68	22.6	51	21.0	$\chi^2=21.759$	MCP<0.001
Associate degree	236	43.4	152	50.5	84	34.6		
Bachelor degree	186	34.2	81	26.9	105	43.2		
Master degree	3	0.6	0	0.0	3	1.2		
Experience (years)								
≤10	377	69.3	213	70.8	164	67.5	$\chi^2=0.678$	0.410
>10	167	30.7	88	29.2	79	32.5		
Mean ± SD.	9.58 ± 7.79		9.67 ± 8.05		9.46 ± 7.47		t=0.308	0.758

χ^2 : Chi-square test

MC: Monte Carlo

t: Student t-test

Table (2): Comparison between toxic leadership levels as perceived by nursing staff at Tanta University Hospitals and El-Menshawey General Hospital.

Toxic Leadership	Total (n = 544)		Tanta University (n= 301)		El-Menshawey (n= 243)		χ^2	P
	No.	%	N-	%	No.	%		
Self-promotion			50					
Low	385	70.8	220	73.1	165	67.9	7.379	0.025
Moderate	68	12.5	42	14.0	26	10.7		
High	91	16.7	39	13.0	52	21.4		
Abusive supervision								
Low	427	78.5	237	78.7	190	78.2	0.577	0.749
Moderate	64	11.8	37	12.3	27	11.1		
High	53	9.7	27	9.0	26	10.7		
Unpredictability								
Low	379	69.7	207	68.8	172	70.8	0.546	0.761
Moderate	82	15.1	45	15.0	37	15.2		
High	83	15.3	49	16.3	34	14.0		
Narcissism								
Low	331	60.8	185	61.5	146	60.1	0.683	0.711
Moderate	95	17.5	49	16.3	46	18.9		
High	118	21.7	67	22.3	51	21.0		
Authoritarian leadership								
Low	396	72.8	199	66.1	197	81.1	27.708*	<0.001*
Moderate	63	11.6	54	17.9	9	3.7		
High	85	15.6	48	15.9	37	15.2		

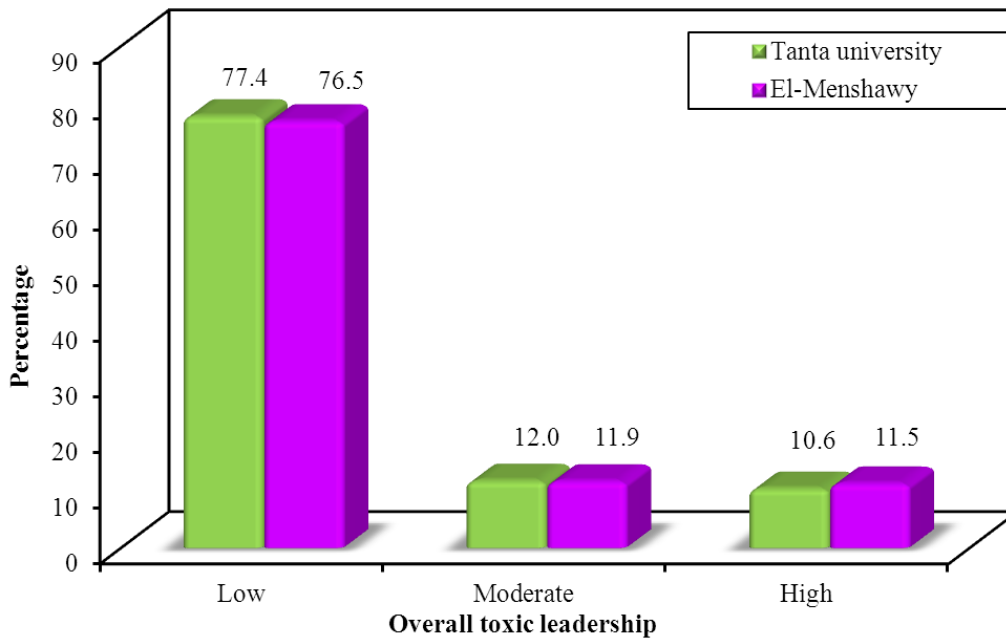


Figure (1): Percentage distribution of the overall toxic leadership at Tanta University Hospital and El- Menshawey General Hospital.

Table (3): Comparison between levels of conflict management styles used by nursing staff at Tanta University hospital and El-Menshawey General hospital.

Conflict management styles	Total (n = 544)		Tanta University Hospital (n= 301)		El-Menshawey Hospital (n= 243)		χ^2	p
	No.	%	No.	%	No.	%		
Avoiding style								
Low	242	44.5	136	45.2	106	43.6	5.476	0.065
Moderate	161	29.6	78	25.9	83	34.2		
High	141	25.9	87	28.9	54	22.2		
Accommodating style								
Low	260	47.8	154	51.2	106	43.6	6.402*	0.041
Moderate	134	24.6	77	25.6	57	23.5		
High	150	27.6	70	23.3	80	32.9		
Collaborating style								
Low	186	34.2	107	35.5	79	32.5	0.551	0.759
Moderate	96	17.6	52	17.3	44	18.1		
High	262	48.2	142	47.2	120	49.4		
Compromising style								
Low	217	39.9	109	36.2	108	44.4	5.277	0.071
Moderate	111	20.4	60	19.9	51	21.0		
High	216	39.7	132	43.9	84	34.6		
Competing style								
Low	374	68.8	239	79.4	135	55.6	36.175	<0.001
Moderate	33	6.1	14	4.7	19	7.8		
High	137	25.2	48	15.9	89	36.6		

Table (4): Comparison between levels of nursing staff's organizational commitment at Tanta University Hospitals and El-Menshawey General Hospital.

Organizational commitment dimensions	Tanta university hospital (n = 301)		El-Menshawey Hospital (n = 243)		χ^2	p
	No.	%	No.	%		
Affective commitment						
Low	213	70.8	135	55.6	13.635	0.001
Moderate	40	13.3	52	21.4		
High	48	15.9	56	23.0		
Continuance commitment						
Low	206	68.4	168	69.1	0.503	0.778
Moderate	52	17.3	45	18.5		
High	43	14.3	30	12.3		
Normative commitment						
Low	238	79.1	170	70.0	11.846	0.003
Moderate	39	13.0	30	12.3		
High	24	8.0	43	17.7		

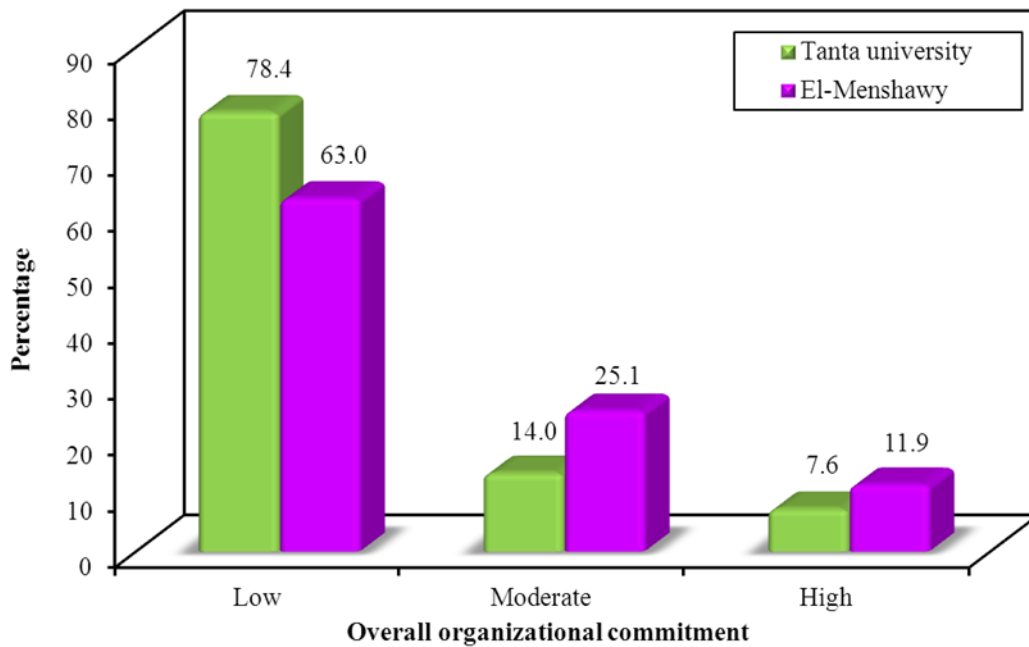


Figure (2): Percentage distribution of the overall nursing staff's organizational commitment at Tanta University Hospital and El- Menshawey General Hospital.

Table (5): Correlation between overall toxic leadership and conflict management styles at Tanta University Hospitals and El-Menshawey General Hospital.

Conflict management styles	Sign. test*	Overall Toxic leadership	
		Tanta University Hospital	El-Menshawey Hospital
Avoiding style	r	0.092	0.176
	p	0.113	0.006
Accommodating style	r	-0.017	0.214
	p	0.768	0.001
Collaborating style	r	-0.197	-0.216
	p	0.001	0.001
Compromising style	r	-0.108	0.147
	p	0.061	0.022
Competing style	r	0.132	0.363
	p	0.022*	<0.001

*r: Pearson coefficient

Table (6): Correlation between total toxic leadership and nursing staff's organizational commitment at Tanta University Hospitals and El-Menshawey General Hospital.

Organizational commitment dimensions	Sign. test*	Overall Toxic Leadership	
		Tanta University Hospital	El-Menshawey hospital
Affective commitment	r	-0.174	-0.143
	p	0.002	0.026
Continuance commitment	r	0.076	0.049
	p	0.187	0.447
Normative commitment	r	-0.192	-0.135
	p	0.001	0.035

*r: Pearson coefficient

Table (7): Correlation between overall toxic leadership and nursing staff's demographic characteristics of the studied subjects (n = 544).

Variables	Toxic leadership						Sign. test*	P
	Low (<60%)		Moderate (60%-<75%)		High (>75%)			
	No.	%	No.	%	No.	%		
Department								
High risk	68	86.1	0	0.0	11	13.9		
Emergency ICU	26	74.1	8	22.9	1	2.9		
General ICU	89	85.6	9	8.7	6	5.8		
Medical ICU	85	87.6	12	12.4	0	0.0	73.688	MC _P <0.001
Neuro ICU	64	56.6	23	20.4	26	23.0		
Cardio ICU	45	71.4	8	12.7	10	15.9		
Pediatric ICU	42	79.2	5	9.4	6	11.3		
Age (years)								
20 – 30	257	75	39	11.4	47	13.7		
31 – 40	118	81.4	14	9.7	13	9.0		
41 – 50	36	75.0	12	25.0	0	0.0	18.619	0.005
51+	8	100.0	0	0.0	0	0.0		
Mean ± SD.	30.50 ± 7.41		31.46 ± 8.05		28.48 ± 3.13		F=2.910	0.055
Gender								
Male	18	75.0	0	0.0	6	25.0	7.110	MC _P =0.024
Female	401	77.1	65	12.5	54	10.4		
Marital status								
Single	43	75.4	5	8.8	9	15.0		
Married	369	76.9	60	12.5	51	10.6	2.541	MC _P =0.587
Other	7	100	0	0.0	0	0.0		
Qualification								
Diploma degree	99	23.6	15	12.6	5	4.2		
Associate degree	182	43.4	34	14.4	20	8.5		MC _P =0.002
Bachelor degree	135	32.2	16	8.6	35	18.8	20.285	
Master degree	3	0.7	0	0.0	0	0.0		
Experience (years)								
≤10	280	74.3	42	11.1	55	14.6	15.985	<0.001
>10	139	83.2	23	13.8	5	3.0		
Mean ± SD.	9.80 ± 8.03		11.0 ± 8.52		6.43 ± 3.12		F=6.271	0.002

 χ^2 : Chi-square test

MC: Monte Carlo

F: F for ANOVA test

6. Discussion

Nowadays, healthcare organizations require constructive and influential leaders aware of struggles and challenges to keep its existence, be useful, and adapt to changes like in any competitive environment (Aydıntug, 2016). However, toxic and ineffective leaders destruct healthcare systems. It is deteriorating nursing staff morale and performance and impeding their creativity that produces unnecessary workplace stress and conflict, which affect nurses' commitment toward their organization (Swiggard et al., 2009). Because toxic leadership has mostly not been discussed in the health care setting, it is become imperative to identify toxic leadership and its relation to nurse's conflict management styles and organizational commitment in two different settings.

The result showed that more than one-third of nursing staff perceived that their leaders had a high and moderate level of narcissism, and about one third had high and moderate unpredictability behaviors of toxic leadership. This finding may be because leaders exhibit narcissism because of the excessive need for recognition, admiration, and superiority to achieve the dream of power and success. The leader's unpredictable behavior vacillates between multiple types of behavior because of the stressful nature of

the working environment of ICUs, the unpredictability of the situations, and fast changeability of patients' conditions that need quick actions and unilateral decision-making. The young age and little experience of current study nursing staff burden those leaders, mainly when they are incompetent, impatient, and inflexible. Steele (2011) supported the previous justification and addressed that toxic leaders exercise toxicity in the workplace, searching for more authority, safety in position, feeling of one-self unique, and fitting regardless of their staff's interpersonal relationships and needs.

The same result was founded by Örg ev and Demir (2019), who revealed that the health staff in a public university hospital is exposed to toxic leadership. As well, Ozer et al. (2017); Sezici (2016); Roter (2011) discovered that registered nurses perceive toxic leadership behaviors at health institutions. The result agrees with Hithcock (2015), who stated that toxicity is detected in all the organizational positions, precisely in senior leaders. Swiggard et al. (2009) confirmed the same results and specified that health care organizations are setting that can demonstrate toxic leadership because healthcare settings are a convenient environment for toxic relations. Krasikova et al. (2013) stated that toxic leaders in the workplace on the broadest impact result in toxic cultures that enhance more toxic

leaders' likelihood. Therefore, the result supports early intervention before the behaviors are becoming more common and possibly entrenched.

On the other line, this result disagrees with *Al-Masry et al. (2018)*, who displayed that staff nurses are satisfied with the leaders who encourage them to solve problems, build good relations among staff, offer training opportunities, and take an interest in their demands. Also, *Asiri et al. (2016)* demonstrated that nursing leaders enhance the nursing work environment by practicing appropriate leadership styles and empowering strategies, including greater nursing staff participation in the decision-making process.

The current study's result points out a statistical significance difference between two hospitals in self-promotion levels and the authoritarian leadership dimension of toxic leadership ($p \leq 0.05$). This finding can be explained by the fact that teaching hospitals have hierarchies and strong structures that promote a top-down management system than governmental hospitals. This structure allows Tanta University Hospital leaders to exercise authoritarian leadership in decision-making and the power to control their staff's tasks. Conversely, governmental hospitals' weak structure makes leaders try to gain power and control by displaying self-promotion behavior by passing failure on to the staff, and accepting credit for others' success as in El Menshawey hospital. *Reyhanoğlu and Akin (2016)* supported the finding and pointed out that toxic leaders' poisoned behavior feeds more from executive hierarchical power and an autocratic, bureaucratic, and hands-off work environment.

As evidenced in these results, nearly a quarter of nursing staff perceived that their leaders had a high and moderate overall toxic leadership style at El-Menshawey and Tanta University Hospitals. This result may be attributed to a lack of leadership experiences and preparation to move up into leadership positions where leadership is a whole of learnable behaviors and talents that can be reinforced by action learning as confirmed by (*Gündüz & Dedekorkut, 2014*). *Roter (2011)* supported the preceding interpretation and reported that when the leader lacked leadership skills and competence, the leader reacted aggressively to cope with the situations. In the same context, *Hogan and Kaiser (2005)* noted that leaders' behaviors directly determine leadership style, which affects the nursing staff's attitudes, team functioning, and ultimately organizational performance.

As evidenced in the current study results, nearly half of the nursing staff use a collaborating style to resolve conflict with their supervisors, followed by more than one-third of them use a compromising style in total. Using these two nurses' styles is expected because many nurses perceived their leaders as nontoxic and have positive leadership characteristics, which inspire collaboration and communication. *Arasli et al. (2020)* supported the interpretation and noted that constructive leadership encourages nurses to handle conflict with leaders by cooperation, teamwork, and integration of ideas using assertiveness and negotiation skills to come up with a decision jointly. As well, this result in agreement with

Badder et al. (2016); *Al Hemdan et al. (2014)*, who showed that collaborating and compromising styles are the dominant and most preferred modes of conflict management used by nurses.

The results also discover statistically significant differences between the two hospitals in using accommodating and competing conflict management styles. More than one-third of nurses at El Menshawey hospital's ICUs highly using accommodating and competing styles when managing conflict with their supervisors contrasted to a quarter moderately using accommodating style and the minority using competing styles Tanta university hospitals. The result because the nursing staff at El Menshawey hospital had more years of experience and high educational level than the nursing staff at Tanta university hospitals, which give them the power to use competing style when managing conflict with their supervisors and make decisions in their favor in emergencies when faster decisions are needed.

The same result also was founded by *Al Hemdan (2014)*, who revealed that government hospitals significantly different from teaching hospitals in using conflict management styles. *Kilman (2012)* clarified that nurses adopt different conflict resolution styles, but it varies significantly with workplace settings and their demographic characteristics. *Al Hemdan (2009)*; *Hendel et al. (2007)* supported the result and revealed that accommodation and competing for each had a statistically significant relationship with years of experience and education in the position.

Present study results reveal that over three-quarters of nursing staff at Tanta University hospital's ICUs, compared to nearly two-third at El Menshawey hospital's ICUs, had a low overall organizational level commitment. Also, nurses' organizational affective and normative commitment levels presented a statistically significant difference between them. Theses finding may be due to those nurses at Tanta University Hospitals' ICUs are more overloaded by providing direct and indirect patient care for large numbers of patients. It can be affected by diverse dimensions of the organization's work environment as; lack of time accessible to them, competition with coworkers, attainment of new skills, and knowledge advancement for higher positions, which influence their inspiration and job satisfaction. The same result was founded by *Dorgham (2012)*, who revealed a low staff nurses' commitment level at Tanta university hospitals due to negative organizational climate perceptions.

Existing study results showed a statistically significant positive correlation between toxic leadership and competing styles of conflict management in both hospitals while collaborating style negatively correlated at both hospitals Hospitals. Whereas at El-Menshawey hospital, a significant positive correlation between toxic leadership and all conflict management styles, except the collaborating style, was negatively correlated. The reasons for these results lie mainly in the malicious behavior of toxic leaders as well as multifaceted characteristics of ICUs at Tanta university hospitals where severely ill patients are admitted,

more complex patients' problems are treated, an increased number of transferred cases from another setting (private or governmental hospitals like El-Menshawey General hospital). Therefore, to keep patient's safety and maintain quality of service, the nursing staff has to compete against incompetent toxic leaders who resolve the conflict by force and depend on strict rules, structure, and power relationships of the university hospitals. In the same context, *Kraybill (2005)* identified that competing styles are appreciated and crucial in emergencies when decisions need to be made fast.

Conversely, at governmental hospitals where rules are set but are not strictly followed, make nursing staff at El Menshawey hospital likely to manage conflict in various styles according to the situation, depending on their skills and practice in the workplace, as demonstrated by *Khalid and Fatima (2016)*. The two hospitals are similar in the antagonistic relation between toxic leadership and collaborating style. This result is predictable because toxic leaders' character damages relations and harms the trust between sides, preventing nursing staff from interacting, cooperating, and collaborating with this type of leader. *Norton (2016)* noted that toxic leaders' de-motivational behaviors negatively impress the followers' communication and well-being in the work environment.

As the present study revealed, toxic leadership affected the nursing staff's organizational commitment as indicated by the statistically significant negative correlation between toxic leadership and affective and normative dimensions of organizational commitment at two hospitals. This result indicated that those nurses need to have a more supportive, safe environment caring for them, maximizing their satisfaction, and allowing a high degree of trust and commitment. *Erickson et al. (2015)* supported the results and noted that toxic leadership is cancer with the organization ruins the employee's lives and destroys their commitment within the organization and its objectives. *Mathieu et al. (2014)* also revealed that toxic leadership affects the staff's behavior and job satisfaction, resulting in a low level of organizational commitment. Indeed, the leader's behavior is vital in shaping trust and commitment in the work unit and organization. Without commitment, there will never be a good quality of services and, therefore, lead to a bad image and poor outcomes. *Khan et al. (2011)*; *Omoniyi and Adedapo (2012)* pointed out that more committed nursing staff is less expected to quit from work and is more ready to make sacrifices for the organization as it replicates the extent to which individuals recognize and accept organizational goals, work under different circumstances and are willing to work hard.

Furthermore, statistically significant relationships were apparent between overall toxic leadership and nurses' age, gender, qualification, and years of experience. A quarter of nursing staff at age 41-50 and more years of experience perceived a moderate toxicity level. These findings may be due to the old and more experienced staff being proficient, autonomous, and thinking in their work decisions that may differ from their leaders. In the same perspective, *Wilson (2003)* supported the preceding rationalization. He reported

that toxic leaders reward individuals who are like-minded and punished others for thinking differently by separation, preventing them from moving in the position and holding their knowledge under control. Contrary to *Sezici (2016)*, young and inexperienced staff were exposed to destructive leadership behaviors, and their destructive leadership perceptions about managers are high.

Concerning gender, males were perceived leadership toxicity than females might be due to that individual being more familiar with communication from the same gender. A similar result was founded by *Orgev and Demir (2019)*, who revealed toxic leadership levels of health care workers differ according to socio-demographic variables, including gender. *Ozer et al. (2017)* reported statistically significant differences between health care workers according to the ages and experiences of employees, but no statistical difference regarding gender and educational level.

Concerning the educational level, the fact is that the nursing staff's education helps in dealing with fear and anxiety, which makes them susceptible to toxic leaders. *Hitchcock (2015)* confirmed this result, who determined that toxic leadership opinions of the individuals who received an additional degree of education were at a higher level of toxicity. Additionally, *Singh et al. (2017)* showed that subordinate leaders' apparent toxicity shows a negative correlation with gender and positive with education level.

7. Conclusion

This study finding indicated that the two hospitals were similar in the overall toxic leadership level. Nearly a quarter of nursing staff reported a moderate and high level of toxic leadership at Tanta University hospital's ICUs and El Menshawey general hospital's ICUs. Simultaneously, a statistically significant difference was found between the two hospitals in the level of self-promotion and authoritarian leadership dimensions of toxic leadership. The collaborating style was the predominant conflict management style that nursing staff used when managing conflict with supervisors at two hospitals as perceived by nearly half of nursing staff at El Menshawey hospital's ICUs and Tanta University Hospital ICUs. However, there was a statistically significant difference between the two hospitals using accommodating and competing conflict management styles.

Over three-quarters of the nursing staff had a low level of overall organizational commitment at Tanta University hospital's ICUs compared to nearly two-third at El Menshawey general hospital's ICUs. Toxic leadership affected nursing staff choice of conflict management style used when handling struggles with toxic leaders at two hospitals (El Menshawey general and Tanta University), and toxic leadership affects the affective and normative dimensions of organizational commitment in both hospitals.

8. Recommendations

For the hospital's administration

- Adjust hospital policies that permit nursing staff to participate in leadership evaluation and appraisal process

as a mean for early detection of toxic behavior, greater willingness to challenge the behavior, and give nurses' a sense of involvement that increases their organizational commitment.

- Creating regular feedback and assessment tools based on competency models that focus on positive attributes associated with influential leaders and required leader qualities and behaviors.
- A leadership development program is necessary to arm health care leaders with the skills they need to build an organization of collaboration, participative management styles that improve their interactions with their teams even in conflict times.
- Training of future leaders in terms of behaviors, ethical standards in management, stress management, and emotional intelligence before the promotion process into a leadership role.
- Building health care networks that meet leaders' needs to avoid leadership toxicity and create constructive relationships with staff members improve organizational commitment.
- Providing a supportive work climate with enough resources that allow cooperative and innovative work and upkeep decision making autonomy, integration, and involvement in improving their organizational commitment and obligation, especially at Tanta University Hospitals.

For head nurses

- Prime importance was put on working with high performing behaviors by sharing transparent information widely with nursing staff, allowing team input, putting the staff in priority and at their expectation, and constant praising that increases their satisfaction and commitment.
- Supporting meaningful strong interpersonal relationships and connection was emphasized by embracing the human side of the staff, encouraging nurses, and fostering trust that stimulates negotiation, flexibility, and cooperation preferred in managing conflict in a nontoxic environment.
- Empowering nurses' access to opportunities, information, training, resources, and facilities, all of which certainly stimulate nursing team functioning and meet nursing staff expectation, satisfaction, and commitment.
- It is of paramount importance to create the work with rules that make nursing staff feel free and work effectively by focusing on their work.
- Further research is recommended on toxic leadership in healthcare sectors to identify the relationship between toxic leadership dimensions with job outcomes, turnover intentions, and organizational performance, which are deemed to be influenced by toxic leadership.

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