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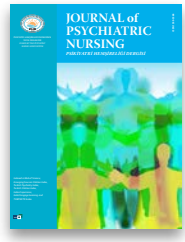

Original Article

The relationship between conflict management styles used by nurse managers in psychiatric clinics and the stress level of their subordinates

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Abstract

Objectives: This study aimed to determine the relationship between the opinions of nurses working in psychiatric wards regarding their managers' conflict management styles and their self-perceived stress levels.

Methods: This was a descriptive, comparative, and correlational study. The population consisted of 580 nurses working in psychiatric clinics of public and private hospitals in Istanbul, and 199 nurses were included in the sample. The "Personal Information Form," "Rahim Organizational Conflict Inventory–II (ROCI-II) Form A," and "Perceived Stress Scale" were used for data collection. Data were analyzed using frequency and percentage distributions, the Kruskal–Wallis test, Spearman correlation analysis, and the Mann–Whitney U test.

Results: The participants' mean scores on the Conflict Management Scale were as follows: integration subscale 2.50±0.90; obliging subscale 3.03±0.74; dominating subscale 2.92±0.85; avoiding subscale 2.98±0.66; and compromising subscale 2.61±0.83. The mean score of the Perceived Stress Scale was 13.78±4.74. The mean score for the perceived stress subdimension was 4.49±2.04, and for the perceived coping subdimension was 9.30±3.45. A statistically significant, weak positive correlation was found between the perceived stress subdimension and the dominating subscale, while a weak negative correlation was observed with the compromising and integration subdimensions. A weak negative correlation was also found between the perceived coping subdimension and the integration, obliging, and compromising subdimensions.

Conclusion: According to the nurses, their managers most frequently use obliging, avoiding, dominating, compromising, and integration styles, respectively, in conflict management. As managers' use of compromising and integration styles increases, the nurses' perceived stress levels decrease.

Keywords: Conflict management; organizational conflict in nursing; psychiatric nursing; stress management in nursing

Conflict can be defined as disagreements between individuals and organizations arising from deficiencies in communication, prejudices, differences in beliefs, and personality differences.[1] Conflict is seen as a result of differences in perspectives, ideas, values, preferences, desires, interests, beliefs, and goals.[2] In recent years, it has been observed that the workforce has become more diverse in organizations, and conflicts have emerged as a result of this social diversity.[1]

It is seen that organizational conflicts affect motivation and organizational performance. Therefore, it is important for managers to manage conflicts effectively in achieving organizational success and goals.[3] For organizational effectiveness and efficient conflict management, it is necessary to have a certain level of conflict and to manage it with appropriate conflict strategies. In other words, it is not desirable to have no conflicts; rather, it is important to have conflicts that can

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lead to positive functional outcomes. The aim of conflict management is to prevent negative outcomes such as inefficiency, to resolve conflict in functional ways, and to support positive conflict. The way to achieve this is through a well-functioning management process.[4] Within the scope of the management process, conflict-related problems should be analyzed correctly so that they can be resolved in a timely manner. Otherwise, physical, psychological, and organizational negative consequences may ocur.[5]

The management of organizational conflicts includes the use of different styles in conflict management, diagnosing the conflict, and helping and intervening simultaneously to ensure that the conflict is kept at a moderate level and handled comprehensively.[6] The ways of coping with conflict were first explained in 1926 by Mary Parker Follett with the concepts of compromising, dominating, and integration. Later, avoiding and obliging styles were added as sub-factors. Rahim and Bonomo, on the other hand, argued that conflict management styles depend on the levels of self-interest and interest in others; based on this, they stated that integration, obliging, dominating, avoiding, and compromising styles are used. In 1983, Rahim developed the scale known as the Organizational Conflict Inventory (ROCI) to determine which conflict management styles managers use.[7] The conflict management styles that constitute the subdimensions of the scale are explained below:

Integration: Also known as the problem-solving method. The individual's interest is focused on both himself/herself and the individual with whom he/she is in conflict.[8] Both sides should express their thoughts about the issue of conflict and the solutions they think are appropriate in a clear and open way. Individuals in the organization should handle the conflict in cooperation and harmony. For this reason, the integration style can also be defined as a win-win method.[9,10]

Obliging: The obliging style is also referred to as softening or calming in some sources. This style is a method in which the differences between individuals are ignored and similarities are emphasized in order to attract the attention of the other party. The most important point here is sacrifice.[8] The party who prefers the conformity style tries to meet the expectations of the other party instead of his/her own wishes and thoughts. Individuals who adopt this method tend to sacrifice their own feelings and thoughts in an effort to protect the communication and interaction they have established.[9,10]

Dominating: In the dominating style, the individual's interest in himself/herself is high, while his/her interest in other individuals is very low. This style can be called competition or competing. It is defined as a win-lose directive or as a pressure to achieve a position.[11] The sole aim of the individual is to win at all costs.[12]

Avoiding: The prominent features of this method can be listed as withdrawal, not taking on the violation or consequences of tasks, ignorance, and indifference.[8] Individuals do not want to take responsibility, do not want to talk about the problem, or try to ignore it. The reason why individuals do not want to enter into conflict is that they believe conflict will cause destructive and negative results within the organization.[13]

What is presently known on this subject?

- Hospitals are organizations where conflicts are frequently experienced. Effective conflict management is important in terms of increasing the efficiency of employees and reducing stress levels. Nurses, who are the healthcare professionals with the most frequent contact with patients, are affected by the conflict management styles used by their managers.

What does this article add to the existing knowledge?

- Psychiatric nurses' perceptions of their own stress levels and coping with stress differ according to their perceptions of the conflict management styles used by their managers. According to psychiatric nurses, their managers use the obliging style most frequently and the integration style least frequently in conflict management. The stress levels of psychiatric nurses decrease as the preference of their managers for compromising and integration styles increases.

What are the implications for practice?

- It emphasises the importance of using an appropriate conflict management style in psychiatric nursing. According to the results of the study, psychiatric nurse managers may prefer compromising and integration styles to reduce the stress level of their subordinates. In addition, the study provides data for the evaluation of the conflict management styles used by nurse managers in psychiatric clinics in terms of their subordinates.

Compromising: As a result of the mutual concessions and sacrifices of individuals, a compromise is reached at a middle point. In this case, there are neither winners nor losers among individuals. In other words, there is no clear outcome in the form of gain or loss. Both parties are satisfied with the agreement.[11]

Conflict management is important for hospitals as in other organizations. In hospitals, conflicts are frequently seen due to the fact that they are large and complex organizations, role ambiguity, role conflict, interpersonal conflict, intense workload, lack of time, etc.[14]

Sources of conflict experienced by nurses include high stress levels, different management styles, competition, and differing goals.[14] Nurses who experience stressors and problems due to working conditions—such as low number of nurses, high nurse turnover rate, shift working system, increased workload, and unclear job descriptions—may experience conflicts with patients and their relatives because they may feel intense emotional involvement toward their patients.[15] In addition, the majority of nurses reported that they experienced conflicts with physicians and other healthcare professionals. The majority of this feedback was provided by managers or experienced nurses.[16]

Constructive resolution of conflicts experienced by nurses reduces stress levels, provides an efficient working environment, and increases job satisfaction. If the conflict ends in a destructive way, it prepares the ground for the formation of new conflicts and causes an increase in the stress levels of nurses.[17,18] Effective and positive conflict resolution is also considered important for psychiatric nurses.

In conflict management, nurse managers state that they prefer interaction and communication that produce common ideas and create an organizational culture where ideas can be easily discussed mutually, while from the nurses' point of view, the conflict resolution methods preferred by their managers are stated as changing the unit of people who experience conflict in the organization, creating authority and pressure, ignoring subordinates, and trying to resolve the conflict by disciplining them.[19,20]

Psychiatry services are one of the areas where conflict management should be applied due to the nature of the work.[21] Mental health nurses provide care to patients in a very long and intensive treatment process. In this process, they face some difficulties specific to psychiatry clinics, and this situation causes them to experience intense stress. Mental health nurses are affected by the symptoms of psychiatric patients, such as being exposed to stigmatization, feeling discriminated against, and intense feelings of guilt. This issue constitutes a risk group for mental health nurses. Mental health nurses often experience negative conditions such as burnout, excessive stress, inadequate job satisfaction, and depression.[22,23]

Using the appropriate conflict management style will be effective in reducing the stress level of nurses caused by conflict. Therefore, nurse managers should be aware of their own conflict management styles and should be able to quickly identify the factors that cause conflict in health institutions. Conflict resolution with the appropriate style is of great importance in terms of reducing the stress on nurses and thus increasing the quality of patient care and creating an environment of trust and support. Regarding this issue, it was evaluated that nurses' perceptions of conflict management styles used by their managers may be a factor affecting their stress levels. In this context, the study aimed to examine the relationship between the conflict management styles used by the managers, according to the nurses working in psychiatry services, and their self-perceived stress levels.

Research Questions

- According to psychiatric nurses, which conflict management styles do their managers use and how often?
- What is the level of stress perceived by psychiatric nurses?
- How are psychiatric nurses' perceptions of coping with stress?
- Is there a difference between the conflict management styles that psychiatric nurses think their managers use according to their demographic and working characteristics?
- Is there a difference between perceived stress levels and coping with stress according to the demographic and working characteristics of psychiatric nurses?
- Is there a relationship between conflict management styles used by managers according to psychiatric nurses?
- Is there a relationship between the stress level perceived by psychiatric nurses and the conflict management styles they think their managers use?
- Is there a relationship between psychiatric nurses' perceptions of coping with stress and the conflict management styles they think their managers use?

Materials and Method

Design of the Research

The study employed a quantitative research design and was descriptive, comparative, and correlational in nature.

Setting and Time of the Research

The research was not conducted in a specific institution; nurses working in psychiatry clinics of private and public hospitals in İstanbul were reached via e-mail and social networking. Data were collected between February and April 2020.

Population and Sample of the Study

A total of 580 nurses working in psychiatry clinics of public and private hospitals in İstanbul constituted the population of the study. The number of nurses in the population was obtained from the Psychiatric Nurses Association. The sample size was calculated as 173 with a 5% margin of error and a 95% confidence interval using the sample calculation formula shown below. A total of 199 nurses who volunteered to participate in the study and who had been working in the psychiatric service for at least three months were reached by the snowball sampling method.

$$n=\frac{Nt^2pq}{d^{(2)}\,(N-1)+t^2pq}$$

- N: Number of individuals in the population
- n: Number of individuals to be sampled
- p: Frequency of occurrence of the event under investigation
- q: Frequency of non-occurrence of the event (1–p)
- t: The theoretical value found from the t-table at the specified degrees of freedom and specified level of error
- d: The desired deviation according to the frequency of the event.

$$n=\frac{(580)(1.96)^{(2)}(0.8)(0.2)}{(0.05)^{(2)}(580-1)+(1.96)^{(2)}(0.8)(0.2)}=173$$

Inclusion criteria were residing in the province of İstanbul, actively working as a nurse in the psychiatry service for a minimum of three months, and volunteering to participate in the

study. Exclusion criteria were working outside the hospital, working outside the psychiatry service, and having less than three months of experience in the psychiatry service.

Measurements

The research data were obtained by using the "Personal Information Form," "Conflict Management Strategies Scale," and "Perceived Stress Scale."

Personal Information Form: This form was prepared by the researcher based on the literatüre.[15] It consists of 10 open-ended and closed-ended questions prepared to determine the socio-demographic characteristics (age, gender, marital status, educational status, income status) and professional experiences (type of hospital they work in, working time in the profession, shift type, priority preference for psychiatry service, and previous training/seminar/course on conflict management) of nurses who have worked in the clinic for at least three months.

The Rahim Organizational Inventory–ROC II Form A: This scale was developed by Pakistani scientist M. Afzalur Rahim to determine the methods of resolving conflicts within the organization. The scale was adapted into Turkish by Gümüşeli. "Rahim Organizational Conflict Scale–II" (ROC-II) is referred to in the literature as "The Rahim Organizational Inventory–II" and more commonly as ROC-II. This scale has three forms: A, B, and C. Form A determines the conflict management style that subordinates perceive in superiors, Form B determines which solution methods are used in conflicts with subordinates, and Form C determines which solution methods are used in conflicts with peers (people working at the same level).[2] In this study, Form A was used in accordance with the purpose.

The scale consists of five dimensions and 28 items in total. The scale has five sub-dimensions: "Integration," "Obliging," "Dominating," "Compromising," and "Avoiding." In order to determine how often each conflict management style is used, the mean scores are calculated and interpreted as follows: 4.20–5.00 always, 3.40–4.19 mostly, 2.60–3.39 occasionally, 1.80–2.59 rarely, 1.00–1.79 very rarely.

The scale is scored based on the sub-dimensions that make up the scale. The subscale with the highest mean score indicates the most preferred conflict management style by individuals, while the subscale with the lowest mean score indicates the least preferred style.[24]

Perceived Stress Scale (PSS): The scale was developed by Cohen, Kamarck, and Mermelstein in 1983 and adapted into Turkish by Bilge, Öğce, Genç, and Oran in 2007. The Cronbach's alpha value of the scale was found to be 0.81.

The PSS consists of two sub-dimensions and eight items in total: items 1, 2, 3, 7, and 8 belong to the perceived stress subscale, while items 4, 5, and 6 belong to the coping with perceived stress sub-dimension. Three items of the scale are reverse-coded (items 4, 5, 6), and five items are positively coded (items 1, 2, 3, 7, 8). The scale is prepared in a five-point Likert format (0=never, 4=very often).

A score of 0–20 is obtained from the perceived stress sub-dimension, 0–12 from the coping with stress subscale, and 0–32 from the scale in total. The scale is evaluated based on both total score and subscale scores. A high score in the sub-dimensions indicates a negative condition.[25]

Data Collection Process

Data were collected by reaching nurses working in psychiatric wards of hospitals in İstanbul via e-mail and social networks.

Ethical Considerations

This study was approved by the Ethics Committee of İstanbul Okan University at the meeting number 115 held on 20.11.2019. Permission was obtained for the scales via e-mail. On the first page of the questionnaire, information about the purpose of the study was provided, and only the participants who ticked the box indicating that they agreed to participate in the study were allowed to access the questionnaire. This study was conducted in accordance with the Declaration of Helsinki.

Data Analysis

SPSS 26 statistical package programme was used for data analysis. Frequency and percentage distributions, mean and standard deviation values of the findings obtained from the nurses were presented. The distribution of dependent variables with quantitative data was tested by the Kolmogorov–Smirnov test, and it was found that they did not show normal distribution ($p<0.05$).

Mann–Whitney U test was used to compare data with two groups, and Kruskal–Wallis test was used to compare data with more than two groups. Mann–Whitney U test with Bonferroni correction was used in pairwise comparisons to determine which group showed the difference in variables with more than two categories. Spearman Correlation Analysis was used to compare two quantitative variables. Data were tested at 95% confidence interval and 5% significance level.

Results

The distribution of the nurses participating in the study according to their sociodemographic and working characteristics is shown in Table 1.

Of the participants, 86.9% were female, 32.7% were between the ages of 26–35, 56.8% were married, and 65.3% were undergraduate graduates. A total of 17.1% of the nurses stated that their income was less than their expenses, and 63.3% stated that their income was equal to their expenses. Among the nurses, 85.4% worked in a public hospital, and 42.7% had 1–5

Table 1. Distribution of participants according to socio-demographic and working characteristics (n=199)

Variables	n	%	Variables	n	%
Gender			Hospital type		
Female	173	86.9	Public Hospital	170	85.4
Male	26	13.1	Private Hospital	29	14.6
Age			Working experience		
18–25	55	27.6	1–5 years	85	42.7
26–35	65	32.7	6–10 years	33	16.6
36–45	54	27.1	11–20 years	28	14.1
46–55	20	10.1	21–30 years	43	21.6
56+	5	2.5	31+	10	5.0
Marital status			Shift		
Single	86	43.2	Night	9	4.5
Married	113	56.8	Day	47	23.6
Education status			Alternating	143	71.9
Health Vocational High School	13	6.5	Psychiatry service preference		
Associate degree	34	17.1	Yes	75	37.7
Bacheolar degree	130	65.3	No	124	62.3
Postgraduate	22	11.1	Status of receiving conflict management training		
Income status			Yes	80	40.2
Income less than expenses	34	17.1	No	119	59.8
Income equal to expenses	126	63.3			
Income more than expenses	39	19.6			

Table 2. The rahim organizational inventory-ii and perceived stress scale scores (n=199)

ROCI-II and perceived stress scale subscales	Number of items	n	$\bar{X}$±SD	Min	Max
Integration	6	199	2.50±0.90	1.00	5.00
Obliging	5	199	3.03±0.74	1.20	5.00
Dominating	5	199	2.92±0.85	1.00	5.00
Avoiding	6	199	2.98±0.66	1.33	5.00
Compromising	6	199	2.61±0.83	1.00	5.00
Perceived stress scale	8	199	13.78±4.74	3.00	30.00
Perceived stress	5	199	4.49±2.04	2.00	12.00
Perceived coping	3	199	9.30±3.45	2.00	12.00

ROCI-II: Rahim Organizational Conflict Inventory–II; $\bar{X}$: Mean; SD: Standard deviation.

years of professional experience. The majority of the nurses (71.9%) worked in rotating shifts. A total of 62.3% did not prefer the psychiatry service as a priority, and 59.8% had not received any course/seminar/training on conflict management.

The Rahim Organizational Inventory–II Scale and Perceived Stress Scale subscale scores are shown in Table 2.

When the participants' Conflict Management Strategies Scale subscale scores are ranked from highest to lowest: obliging 3.03±0.74, avoiding 2.98±0.66, dominating 2.92±0.85, compromising 2.61±0.83, and integration 2.50±0.90. The mean score of the perceived stress subscale was 13.78±4.75, and the mean score of the perceived coping subscale was 9.30±3.45.

Participants' The Rahim Organizational Inventory–II Scale subscale scores were compared according to demographic characteristics, and the findings are presented in Table 3.

Statistically significant differences were found between the three subscale scores of Conflict Management Strategies according to the age variable. Integration, obliging, and compromising subdimension scores of the 26–35 age group (19.03±5.31; 13.92±3.68; and 18.97±5.32, respectively) were significantly higher than those of the 18–25 age group (integration 22.31±4.50; obliging 15.62±3.54; compromising 21.80±4.25) and the 56 and over age group (integration 22.60±6.11; obliging 17.80±5.12; compromising 24.20±6.34)

Table 3. Comparison of the rahim organizational inventory-ii scale subscale scores of nurses according to demographic variables (n=199)

	Integration $\bar{X}$±SD	Obliging $\bar{X}$±SD	Dominating $\bar{X}$±SD	Avoiding $\bar{X}$±SD	Compromising $\bar{X}$±SD
Gender					
Male	20.00±5.34	14.81±3.46	15.73±4.44	18.62±3.60	19.88±4.73
Female	21.10±5.41	14.82±3.78	15.29±4.28	18.01±4.04	20.64±5.04
Z	-1.099	-0.103	-0.258	-0.660	-0.720
p	0.272	0.918	0.796	0.509	0.471
Age					
18–25[a]	22.31±4.50	15.62±3.54	15.45±4.55	18.49±4.64	21.80±4.25
26–35[b]	19.03±5.31	13.92±3.68	16.14±4.04	17.71±3.94	18.97±5.32
36–45[c]	22.15±5.12	15.26±3.54	14.11±4.44	18.04±3.49	21.43±4.46
46–55[d]	19.15±6.26	13.60±3.80	15.90±3.39	17.60±3.20	18.85±5.24
56 and above[e]	25.60±6.11	17.80±5.12	15.20±4.71	21.20±4.38	24.20±6.34
X^2	**21.427**	**10.284**	62.07	3.760	**14.988**
p	**0.001**	**0.036**	0.184	0.439	**0.005**
	b<a-e	**b<a-e**			**b<a-e**
Marital status					
Single	21.30±5.31	14.85±4.00	15.43±4.55	18.12±4.66	20.97±5.15
Married	20.70±5.48	14.80±3.53	15.29±4.10	18.07±3.41	20.21±4.88
Z	-1.116	-0.487	-0.087	-0.318	-1.369
p	0.264	0.626	0.931	0.751	0.171
Education status					
Health Vocational High School	18.62±5.08	13.00±3.63	14.92±3.30	16.77±3.47	18.85±4.06
Associate degree	21.53±5.71	14.88±3.96	16.35±4.47	19.03±3.61	20.41±5.98
Bachelor degree	21.23±5.16	15.05±3.61	14.90±4.33	17.98±3.96	20.90±4.62
Post graduate	19.86±6.29	14.41±4.09	16.73±3.93	18.05±4.86	19.59±5.91
X^2	4.797	3.392	5.578	3.996	3.412
p	0.187	0.335	0.134	0.262	0.332
Income status					
Income less than expenses	20.41±6.76	14.29±4.67	16.03±5.21	18.12±4.36	19.59±5.94
Income equal to expenses	20.74±5.26	14.75±3.59	15.25±4.10	18.15±3.83	20.44±4.98
Income more than expenses	22.15±4.40	15.49±3.24	15.10±4.06	17.87±4.24	21.67±3.97
X^2	1.226	1.221	0.958	0.639	2.651
p	0.542	0.543	0.619	0.726	0.266

Tests were conducted based on rank averages and arithmetic averages of the sample are given in the table. $\bar{X}$: Mean; SD: Standard deviation.

(p<0.01; p<0.05; p<0.01, respectively). There was no statistically significant difference between the dominating and avoiding subscale scores (p>0.05).

The scores obtained by the participants from the subdimensions of the Conflict Management Strategies Scale did not show a statistically significant difference according to gender, marital status, educational status, and income status (p>0.05).

The subscale scores of The Rahim Organizational Inventory–II Scale were compared according to the participants' working characteristics variables, and the findings are presented in Table 4.

Statistically significant differences were observed between the subscale scores of the participants according to their working experience and training on conflict management.

According to the working experience variable, it was found that the mean score of the integration subdimension among employees with 1–5 years of working experience (21.34±5.09) was statistically significantly higher than those with 6–10 years of experience (18.70±5.14) (p<0.05), while no difference was found between the other subscale mean scores (p>0.05).

The scores obtained from the integration, obliging, and compromising subdimensions (19.03±5.31, 13.92±3.68, and 18.97±5.32, respectively) of the nurses who received training on conflict management were higher than those of the participants who did not receive such training (p<0.01; p<0.05; and p<0.05, respectively). The scores obtained from

Table 4. Comparison of nurses' the rahim organizational inventory-ii scale subscale scores according to the variables of working characteristics (n=199)

Integration	Obliging $\bar{X}$±SD	Dominating $\bar{X}$±SD	Avoiding $\bar{X}$±SD	Compromising $\bar{X}$±SD	Hospital type $\bar{X}$±SD
Public Hospital Type	20.81±4.98	14.83±3.44	15.49±3.76	18.27±3.45	20.37±4.43
Education and Research Hospital (private-foundation)	27.50±3.54	18.00±2.83	13.50±3.54	21.50±2.12	27.50±2.12
Education and Research Hospital (public)	20.43±5.86	14.47±4.02	14.71±4.67	17.73±4.34	20.04±5.46
X^2	6.337	3.48	4.412	2.835	7.669
p	0.096	0.323	0.220	0.418	0.053
Working experience					
1–5 years[a]	21.34±5.09	15.22±3.73	15.75±4.36	18.49±4.35	21.04±4.97
6–10 years[b]	18.70±5.14	13.45±3.34	15.70±4.28	17.18±4.14	18.64±4.66
11–20 years[c]	21.50±5.47	14.75±3.49	14.96±3.77	17.50±4.33	20.57±5.29
21–30 years[d]	21.12±5.34	14.88±3.82	14.70±4.59	17.93±2.59	20.72±4.35
31 years and above[e]	23.00±7.56	15.80±4.76	14.70±4.03	20.00±3.77	21.70±7.20
X^2	9.656	7.387	1.919	5.22	8.558
p	0.047	0.117	0.751	0.265	0.073
	a>b				
Shift					
Alternating	20.71±5.47	14.73±3.85	15.56±4.38	17.96±3.85	20.49±5.12
Day	21.56±5.19	15.06±3.42	14.88±4.01	18.35±4.23	20.65±4.67
Night	21.67±5.70	14.89±3.86	14.56±4.42	18.78±5.07	20.78±5.29
X^2	1.424	0.138	1.18	0.830	0.982
p	0.479	0.933	0.554	0.660	0.612
Was the psychiatric unit your primary choice?					
Yes	21.51±5.67	15.35±3.75	14.87±4.33	17.89±4.23	20.64±5.05
No	20.63±5.23	14.50±3.70	15.65±4.26	18.21±3.84	20.48±4.98
Z	-1.566	-1.712	-1.477	-0.593	-0.682
p	0.117	0.087	0.140	0.553	0.495
Have you received any courses/seminars/ training on conflict management?					
Yes	22.31±4.56	15.68±3.26	14.78±4.08	18.59±3.76	21.54±4.45
No	20.05 ± 5.74	14.24±3.93	15.74±4.40	17.76±4.11	19.87±5.24
Z	-2.696	-2.459	-1.611	-1.213	-2.213
p	**0.007**	**0.014**	0.107	0.225	**0.021**

Tests were conducted based on rank averages and arithmetic averages of the sample are given in the table. $\bar{X}$: Mean; SD: Standard deviation.

the dominating and avoiding subdimensions did not show a statistically significant difference (p>0.05).

The subscale scores of the Conflict Management Strategies Scale did not show a statistically significant difference according to the type of hospital, shift schedule, or psychiatry service being the primary working preference (p>0.05).

Participants' Perceived Stress Scale subscale scores were compared according to demographic characteristics, and the results are presented in Table 5.

Statistically significant differences were found between the subscale scores of the Perceived Stress Scale according to age, marital status, and income status variables.

While it was observed that the mean perceived stress subscale score of the participants aged 56 years and over (2.20±1.30) was statistically significantly lower than that of other age groups (p<0.05), no difference was found in the perceptions of coping with stress (p>0.05).

According to the marital status variable, it was observed that the mean perceived stress and coping scores of single participants (4.90±2.13; 9.99±3.40, respectively) were significantly higher than those of married participants (4.18±1.92; 8.77±3.42, respectively) (p<0.05).

No difference was observed in the perceived stress levels of nurses according to the income status variable (p>0.05).

Table 5. Comparison of participants' perceived stress scale subscale scores according to demographic characteristics (n=199)

	Perceived stress $\bar{X}$±SD	Perceived coping $\bar{X}$±SD
Gender		
Female	4.44±2.04	9.40±3.56
Male	4.81±2.10	8.62±2.56
Z	-0.633	-0.936
p	0.527	0.349
Age		
18–25[a]	4.67±2.23	9.93±3.68
26–35[b]	4.86±2.03	9.82±3.09
36–45[c]	4.24±1.95	8.31±3.25
46–55[d]	4.00±1.45	9.00±4.13
56 and above[e]	2.20±1.30	7.40±2.51
X^2	10.574	8.553
p	**0.032**	0.073
	e<a-b-c-d	
Marital status		
Single	4.90±2.13	9.99±3.40
Married	4.18±1.92	8.77±3.42
z	-2.405	-2.150
p	**0.016**	**0.032**
Education status		
Health Vocational High School	4.15±1.68	9.62±2.99
Associate degree	5.21±2.53	10.15±3.84
Bachelor degree	4.34±1.94	8.89±3.28
Post graduate	4.45±1.84	10.18±3.91
X^2	4.013	3.618
p	0.260	0.306
Income status		
Income less than expenses[a]	4.68±2.08	10.94±3.92
Income equal to expenses[b]	4.55±1.99	9.21±2.99
Income more than expenses[c]	4.13±2.19	8.15±3.96
X^2	1.711	9.685
p	0.425	**0.008**
		c<a

Tests were conducted based on rank averages and arithmetic averages of the sample are given in the table. $\bar{X}$: Mean; SD: Standard deviation.

However, the mean score of coping with perceived stress among nurses whose income was higher than their expenses (8.15±3.96) was statistically significantly lower than that of nurses whose income was lower than their expenses (10.94±3.92) (p<0.01).

The scores obtained by the participants from the subdimensions of the Perceived Stress Scale did not show a statistically significant difference according to gender and educational status variables (p>0.05).

Table 6. Comparison of participants' perceived stress scale subscale scores according to working characteristics variables (n=199)

	Perceived stress $\bar{X}$±SD	Perceived coping $\bar{X}$±SD
Hospital type		
Private Hospital	4.41±1.94	9.10±2.93
Public Hospital	4.21±1.78	9.16±3.30
Education and Research Hospital (private-foundation)	4.50±0.71	8.00±1.41
Education and Research Hospital (public)	4.82±2.34	9.56±3.84
X^2	4.425	1.078
p	0.219	0.782
Working experience		
1–5 years[a]	4.96±2.15	9.89±3.68
6–10 years[b]	4.27±1.91	9.64±2.09
11–20 years[c]	4.54±2.24	9.64±3.44
21–30 years[d]	4.02±1.61	8.0 0±3.49
31 years and above[e]	3.00±1.63	7.70±3.65
X^2	12.413	12.484
p	**0.015**	**0.014**
	e<a-b-c-d	**e<a-b-c-d**
Shift		
Alternating[a]	4.45±2.09	9.37±3.27
Day[b]	4.33±1.89	8.60±3.52
Night[c]	5.89±1.76	11.78±4.89
X^2	-2.163	-1.372
p	**0.031**	0.170
	c>a-b	
Was the psychiatric unit your primary choice?		
Yes	3.95±1.87	8.77±3.15
No	4.81±2.08	9.61±3.60
z	-2.614	-1.588
p	**0.009**	0.112
Have you received any courses/ seminars/training on conflict management?		
Yes	4.32±2.26	4.60±1.88
No	8.95±3.50	9.53±3.42
z	-1.517	-0.941
p	0.129	0.347

Tests were conducted based on rank averages and arithmetic averages of the sample are given in the table.

Participants' Perceived Stress Scale subscale scores were compared according to their working characteristics, and the results are presented in Table 6.

Statistically significant differences were found between the subscale scores of the Perceived Stress Scale according to the variables of working experience, shift pattern, and preference for psychiatry service.

Table 7. The relationship between the rahim organizational inventory-ii scale subscale scores and perceived stress scale subscale scores (n=199)

	ROC II	Integration	Obliging	Dominating	Avoiding	Compromising	Perceived stress scale	Perceived stress
Integration								
r	0.791							
p	**0.001**							
Obliging								
r	0.876	0.750						
p	**0.001**	**0.001**						
Dominating								
r	-0.235	-0.596	-0.383					
p	**0.001**	**0.001**	**0.001**					
Avoiding								
r	0.624	0.247	0.458	-0.040				
p	**0.001**	**0.001**	**0.001**	0.572				
Compromising								
r	0.824	0.890	0.780	-0.547	0.273			
p	**0.001**	**0.001**	**0.001**	**0.001**	**0.001**			
Perceived stress scale								
r	-0.197	-0.304	-0.202	0.254	0.019	-0.323		
p	**0.005**	**0.001**	**0.004**	**0.001**	0.786	**0.001**		
Perceived stress								
r	-0.114	-0.232	-0.119	0.195	0.106	-0.255	0.738	
p	0.108	**0.001**	0.094	**0.006**	0.137	**0.001**	**0.001**	
Perceived coping								
r	-0.197	-0.280	-0.197	0.232	-0.021	-0.288	0.902	0.415
p	**0.005**	**0.001**	**0.005**	**0.001**	0.771	**0.001**	**0.001**	**0.001**

ROCI-II: Rahim Organizational Conflict Inventory–II.

Participants with 31 or more years of work experience had significantly lower mean scores of perceived stress and coping with perceived stress (3.00±1.63; 7.70±3.65, respectively) compared to other participants ($p<0.05$).

It was observed that the perceived stress subscale scores (5.89±1.76) of participants who always worked night shifts were statistically significantly higher than those of the other shift groups ($p<0.01$). The scores of the participants on the perceived coping subscale did not show a statistically significant difference according to the shift variable ($p>0.05$).

It was found that the perceived stress subscale scores of participants who did not prefer to work in the psychiatric service (4.81±2.08) were statistically significantly higher than the scores of participants who preferred to work in the psychiatric service (3.95±1.87) ($p<0.01$). The scores obtained from the perceived coping subscale did not show a statistically significant difference according to the variable of preferring psychiatric service ($p>0.05$).

The scores obtained by the participants from the subdimensions of the Perceived Stress Scale did not show a statistically significant difference according to the variable of hospital of employment and conflict management training ($p>0.05$).

The relationship between the participants' The Rahim Organizational Inventory–II Scale subscale scores and Perceived Stress Scale subscale scores is presented in Table 7.

A significant positive relationship was found between the integration subscale and the obliging and compromising subdimensions ($r=0.750$; $p<0.001$ and $r=0.890$; $p<0.001$, respectively), and a weak positive relationship was found with the avoiding subscale ($r=0.247$; $p<0.001$). There was a positive and weakly significant relationship between the avoiding subscale and the compromising subdimension ($r=0.273$; $p<0.001$).

A significant positive relationship was found between the obliging subscale and the compromising subscale at a high level ($r=0.780$; $p<0.001$), and a significant positive relationship was found with the avoiding subscale at a moderate level ($r=0.458$; $p<0.001$).

There was a moderate negative relationship between the dominating subscale and the integration and compromising subdimensions ($r=-0.596$; $p<0.001$ and $r=-0.547$; $p<0.001$, respectively).

There was a significant positive relationship between perceived stress and perceived coping subscale scores ($r=0.415$; $p<0.001$).

There was a significant relationship between the perceived stress subscale and the dominating subscale at a weak positive level (r=0.195; p<0.001), while there was a significant relationship with the compromising and integration subdimensions at a weak negative level (r=-0.255; p<0.001 and r=-0.232; p<0.001, respectively).

A significant relationship was found between the perceived coping subscale and the integration, obliging, and compromising subdimensions in a weak negative direction (r=-0.280; p<0.001; r=-0.197; p<0.001; and r=-0.288; p<0.001, respectively).

Discussion

All health fields and services are of great importance in terms of sustaining human life and increasing the quality of life. As a part of quality healthcare, health professionals should provide support, trust, respect, and understanding regarding the health status of the patient who will use the service. However, while managing the service to be provided in this sense, effective performance is expected from the manager towards healthcare professionals.[26,27] An important component of effective performance is conflict management.

The nursing profession has an important role in terms of providing accurate and uninterrupted healthcare services. Nursing is the professional group that is in contact with the patient the most. This situation has imposed important roles and responsibilities on the nursing profession. Proper management of conflicts that nurses face in the hospital environment is important for increasing work efficiency and reducing stress levels. Psychiatry services have special importance in terms of working conditions. In psychiatry wards, patients' risk of aggression, working in a closed-door system, and communication difficulties affect nurses' stress levels.[28] This study was conducted to determine the relationship between the opinions of nurses working in psychiatry wards regarding their managers' conflict management styles and their self-perceived stress levels.

One of the most important factors that create conflict is communication problems between managers and nurses. Conflicts arising from this affect the quantity, quality, and organization of health service provision and are reflected in the health status of the people receiving the service.[29] Therefore, it is important to examine the conflict management styles of managers from the nurses' perspective in this study. The original aspect of the study is that it was aimed at psychiatric nurses, and the relationship between conflict management styles and perceived stress conditions was examined.

When evaluated according to the scale score ranges, it was found that, according to the perceptions of the nurses, their managers used the compromising style "occasionally" and the integration style "rarely." Similarly, in Çınar and Baykal's study, it was determined that nurses used the integration style at a "very low" level;[30] in Başoğul and Özgür's study, at a "low" level;[31] and as in our study, these scores were the lowest scores compared to other subdimensions. Many studies have been conducted on this subject; however, in those studies, employees were generally asked how they manage conflict themselves. In this study, subordinates evaluated their managers. When the literature was examined, different results were obtained, which are thought to be due to this reason. Alan, Gül, and Baykal,[32] Assi et al.,[33] and Curus[32–34] determined the integration style as the most frequently used conflict management style. Similarly, Çal and Çavuşoğlu[35] found that all methods except the dominating style were used above the medium level. These differences may be due to the fact that the opinions of subordinates were taken into account, unlike in other studies as mentioned above. In addition, while nurses working throughout the hospital were included in the sample group in other studies, only psychiatry nurses were examined in this study. Nurse managers in psychiatry clinics may have thought that they could support their subordinates working under intense stress and uncertain conditions by making concessions. The obliging style has the purpose of softening and calming.[9]

In this study, there was a difference in the frequency of use of integration and obliging styles according to the age variable. Those in the 26–35 age group stated that their managers used integration and obliging styles more frequently than those in the 18–25 and 56 and over age groups. No difference was observed between the 26–35 age group and the 36–45 and 46–55 age groups. While Çal and Çavuşoğlu[35] and Başoğul and Özgür found no difference according to the age variable, Cevizci[31] found that the avoidance score decreased with increasing age. In Curus's study,[34] it was found that integration, obliging, and compromising styles were used more frequently in the group aged 36 years and over. The difference in the results is thought to be due to differences in the classification of age groups in the studies.

When the conflict management styles perceived by the participants in their managers were compared according to the working experience variable, nurses with 1–5 years of working experience stated that their managers used the integration style more frequently than nurses with 6–10 years of working experience. Çal and Çavuşoğlu,[35] in their study on nursing students, found that first-year students used the integration style more than upperclassmen. This result supports our study. Similarly, in Yılmaz's study, although the styles used by nurses differed according to the duration of professional experience, it was observed that those with 5 years or less of experience used the obliging style more frequently.[36] For less experienced employees, communication with the manager and the manager's guidance are very important.[37] This may have caused less experienced psychiatric nurses to make a more positive evaluation of their superiors.

Nurses who received training on conflict management stated that their managers used integration, obliging, and compromising styles more frequently than others. Integration is a win-win method that involves problem solving, where the views of both parties are taken into consideration.[38] In the compromising style, mutual sacrifice is involved.[8] The fact that nurses who received conflict management training exhibited more problem-solving and compromise-oriented approaches shows that the trainings had a positive effect on conflict resolution. Similar to this study, Bozkurt and Beydağ found that nurses who had previously received conflict training had higher conciliatory approach scores.[39] In contrast to this study, Turgut et al.[40] provided training on conflict management to healthcare workers in a mental health hospital and found no difference in Conflict Resolution Scale scores. Differences in study results may be due to variations in the content, quality, and duration of the trainings. Education is a process of changing desired behavior,[41] so an effective education should be expected to make a difference in conflict management. Well-planned trainings may contribute to helping nurses manage conflicts in a more constructive and cooperative way.

Within the scope of the study, the perceived stress and coping levels of the participants were examined. It was observed that the participants' scale total score was average, and their perceived coping scores were above average. The scale total score explains the perceived stress level. A high total and subdimension score is a negative situation.[25] In other words, the level of stress perceived by nurses is moderate, and their level of perceiving themselves as adequate in coping is low. In Camcı and Kavuran's study, the scale and subscale scores were found to be at a moderate level,[42] and similarly, the total score was found to be at a moderate level in Altınel and Karaman's study. These results support our study. Psychiatric nurses are exposed to occupational stress due to unpredictable patient behaviors, workload, patients with suicidal thoughts, communication problems, and inadequate training. In a study on community mental health nurses, it was reported that nurses endeavored to provide quality care but could not provide the care they wanted to deliver.[28] This situation may create stress in psychiatric nurses and a sense of inadequacy in coping with stress.

When the perceived stress level was compared according to the age variable, it was found that the perceived stress level of the participants aged 56 years and over was lower than that of participants aged 18–55 years. There are many studies in the literature that support our findings. In Camcı and Kavuran's study, it was found that the perceived stress levels of nurses aged 36 years and over were statistically significantly lower compared to younger nurses.[42] In Aslan and Pekinci's study, it was reported that the perceived stress levels of nursing students aged 21 and over were lower than those of younger students.[43] Similarly, in Fidan and Çalışkan's study on nurses, it was found that the age group of 29 years and younger had higher stress levels than other age groups.[44] In addition, in the study of Öztürk et al.,[45] it was observed that the depression score decreased with increasing age among health personnel. In contrast, in the studies of Durna, Çetin, and Filiz and Yıldız and Babaoğlu, no significant difference was found.[46,47] Age and work experience in nurses may enable them to make quick decisions in emergency situations, to manage the care process more effectively, and to approach events more calmly.[42] This may explain the decrease in the perceived stress levels of psychiatric nurses with increasing age.

In this study, when the subscale scores in the Perceived Stress Scale were compared according to the marital status variable, it was observed that single participants had higher stress levels and higher perceptions of inadequacy in coping with stress than married participants. Similar to this study, Şanlıtürk and Ardıç and Karaman and Altınel found that the stress perceived by single nurses was higher, and Demiray and Polattimur found that single healthcare workers had higher levels of general work stress than married health workers.[48–50] Additionally, in a study conducted in a mental health hospital in Egypt, a significant difference was observed between the subjective well-being levels of nurses according to marital status.[51] In contrast, in the studies of Hacimusalar et al.,[52] Özdemir et al.,[53] and Sakaoğlu et al.,[54] it was found that married healthcare workers had higher levels of stress and anxiety. In the study of Hamaideh et al.,[55] no significant difference was found according to marital status. The fact that some of the mentioned studies were conducted during the pandemic period and the role of cultural factors may explain these differences. Having children is also thought to have a stress-reducing effect, as it can strengthen family bonds.[49] Evli concluded that social support had a positive effect on the anxiety, depression, and stress levels of healthcare personnel.[56] It can be said that the social support received by married psychiatric nurses from their families positively affects their perceived stress levels.

It was observed that participants whose income was higher than their expenses perceived themselves as more adequate in coping with stress. There are many studies supporting this result. Güçlüel stated that those with less income than expenses adopted a more helpless approach in coping with stress,[57] and Çamkerten et al.[58] reported that the group with poor income levels reported high levels of work stress and general stress. It can be said that a high income level enables individuals to access resources to cope with stress and to focus more effectively on their work life.

In this study, when the subscale scores of the participants in the Perceived Stress Scale were compared according to the working time variable, it was determined that the stress levels of nurses with 31 years or more of working experience

were lower. The group with the highest perceived stress score was nurses with 1–5 years of working experience. Similarly, in Camcı and Kavuran's study, although a difference was observed according to the working time variable, the lowest stress level was found among nurses with 0–3 years of working experience.[42] Additionally, in the study of Evli, it was found that healthcare workers with longer working hours had higher normal depression scores.[56] In contrast to our findings, no difference was observed according to working time in the studies of Durna, Filiz, and Çetin,[46] Çınar et al.,[59] and Yıldız and Babaoğlu.[47] As can be seen, there are studies that both support and do not support our findings. It is thought that the difference in results is due to the fact that this study was conducted specifically in psychiatry services. Çokdinçer stated that nurses working in psychiatric wards encountered more aggressive patient behaviors compared to nurses in other units, and that this may lead to increased compassion fatigue and moral distress.[60] It can be said that encountering such challenging working conditions, especially in the early years of the profession, may cause nurses to have higher stress levels.

In our study, when the subscale scores of the participants in the Perceived Stress Scale were compared according to the shift variable, based on the nurses' perceptions, it was determined that the stress levels of participants who always worked the night shift were higher than those working in other shifts. Numerous studies in the literature support our findings. Bumin et al.[61] found that the stress levels of individuals working night shifts were higher than those in the daytime full-time group. Fidan determined that the perceived stress level of nurses working in a mixed (day–night) shift system was higher.[44] Similarly, in the study of Geniş et al.,[62] it was observed that depression, anxiety disorder, sleep disturbance, burnout, and stress perception were higher in shift workers. It is thought that the decrease in both sleep quality and duration in nurses working night shifts has a negative effect on perceived stress levels.

According to the findings of the study, it was determined that the stress levels of nurses who primarily preferred the psychiatry service were lower than those who did not. In Doğan and Yıldırım's study, the stress score of intern nurses working in a field they disliked was found to be higher.[63] The fact that healthcare personnel work in the department they prefer has a positive effect on their willingness to do their job and on job satisfaction.[64] It is thought that nurses who prioritized the psychiatry service worked more willingly in this field, which contributed to this result.

According to the relationship between the subscale scores of The Rahim Organizational Inventory–II Scale, a highly significant positive relationship was found between the integration subdimension and the obliging and compromising subdimensions, and a moderately significant positive relationship was found with the avoiding subdimension. In Bucak's study, a very strong and significant positive relationship was found between integration and obliging strategy, and between avoiding and compromising strategies.[64] Accordingly, as the integration score increases, obliging, avoidance, and compromising scores also increase. The increase in these strategies along with integration may indicate flexibility in conflict management and the use of strategies suited to different situations. These results are consistent with other studies in the literature and may suggest that leaders or managers employ multidimensional strategies for effective conflict resolution.

In this study, a moderately significant negative relationship was found between the dominating subdimension and the integration and compromising subdimensions. While the dominating style involves competition and prioritization of self, the compromising style requires mutual concession.[8,11] It is thought that this result was obtained because these two styles involve opposing approaches.

According to the nurses' statements, in the present study, the perceived stress level increased as managers' preference for the dominating style increased, and the stress level decreased as the preference for obliging, compromising, and integration styles increased. Tabak and Koprak found a negative relationship between stress and integration and dominating styles, and a positive relationship between obliging and avoiding methods.[65] Özkan found no significant relationship between job stress levels and the conflict management styles of nurse managers.[66] Managers who use the dominating style are individuals with a strong desire to win and who therefore do not value others' feelings and opinions.[64] In our study, it was observed that the dominating style adopted by managers increased the stress levels of employees. This may be explained by the fact that authoritarian management reduces employee participation in decision-making processes and increases perceived pressure.

There are a limited number of studies in the literature examining the relationship between conflict management styles and stress level, and those focus on general stress levels. No study has directly examined the relationship between conflict management styles and the perception of coping with stress. In this study, it was observed that as the preference for the dominating style increased, the perception of inadequacy in coping with stress also increased. In contrast, the use of integration, obliging, and compromising styles had a positive effect on coping perception, while a high perceived stress level had a negative effect. Similarly, in Evli's study, it was found that a one-unit increase in stress level caused a 0.564-unit decrease in coping perception.[56] Likewise, in Hancıoğlu's study

on university students, it was found that as perceived stress increased, coping ability decreased. It was also observed that psychiatric nurses tended to use submissive and helpless approaches in coping.[67] It can be said that psychiatric nurses have difficulties coping effectively as stress levels increase due to the use of the dominating style.

When the findings of the study are evaluated as a whole, it is seen that the conflict management styles used by managers are related to both the stress levels and coping skills of psychiatric nurses. The literature also shows that effective and constructive resolution of conflicts is crucial for healthcare professionals. Constructive conflict resolution reduces stress levels, promotes an effective working environment, and increases job satisfaction. If conflict is resolved destructively, it lays the groundwork for new conflicts and causes an increase in stress levels.[17,18] It is thought that the results of this study will raise awareness regarding conflict management among nurse managers working in psychiatric clinics and encourage the adoption of conciliatory and integration-based approaches.

Limitations and Generalizability of the Study

The limitations of this study include the fact that some psychiatric nurses did not agree to participate in the study, and that an online survey was conducted over the internet due to the Covid-19 pandemic. Another limitation is that the data are based on the self-reports of the nurses who participated in the study. Therefore, the results are limited to the responses provided by the nurses included in the research. The findings of this study can be generalized to nurses working in psychiatric wards in İstanbul.

Conclusion

As a result, according to psychiatric nurses, their managers use the obliging style most frequently and the integration style least frequently in conflict management. As the preference for compromising and integration styles increases, stress levels decrease; conversely, as the preference for the dominating style increases, perceived stress levels increase. Conflict management styles perceived by nurses vary by age, working time, and training on conflict management. Nurses' perceptions of stress and coping with stress vary according to age, marital status, working time, shift worked, and preference for working in a psychiatry clinic.

To reduce the stress levels of psychiatric nurses and ensure their competence in coping with stress, both nurses and managers should be supported with training programs that promote a conciliatory approach. Studies should be conducted to explore why nurse managers prefer the conflict management styles they frequently use. Both nurse managers and their subordinates should receive training in conflict management, which will also enable subordinates to evaluate their managers more effectively. The causes of stress among less experienced and younger nurses should be investigated. In psychiatry services, nurses who prefer to work in this field should be prioritized for employment. In psychiatric clinics, nurses should not be assigned to night shifts for extended periods.

It is recommended to conduct research on the conflict management styles perceived by nurses in hospitals outside of İstanbul. Nurse managers should initiate studies to determine the causes of nurses' stress and assess the impact of conflict management styles on stress. Psychiatric nurses should be trained in stress coping methods. Appropriate and effective communication skills should be adopted by the entire healthcare team, especially by managers. Additionally, group meetings can be held to identify training needs in conflict management skills.

Moreover, training programs should be implemented across hospitals to guide conflict toward constructive outcomes, and institutional policies should be established to provide sustainable solutions. Finally, it is recommended to conduct qualitative studies on this topic specifically for psychiatric nurses.

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