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**The impact of nurses' perfectionistic self-presentation
and toxic leadership of nurse managers on workplace
incivility: a cross-sectional study**

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Abstract

Background: Unlike overt bullying or violence, incivility refers to subtle and recurring behaviors that undermine others' dignity. As a pervasive yet frequently overlooked problem in nursing workplaces, incivility has been linked to nurses' well-being and the quality of patient care, underscoring the need to clarify its dynamics and antecedents. This study aimed to explore the impact of nurses' perfectionistic self-presentation and the toxic leadership of nurse managers on workplace incivility, from the perspectives of both the victim and the perpetrator, among nurses.

Methods: In this cross-sectional study, data from 319 hospital nurses were collected through an online survey from November 18 to December 6, 2024. Multiple regression analysis was performed to identify the impact of the perfectionistic self-presentation and nurse managers' toxic leadership on workplace incivility.

Results: Victim-related factors had the most significant impact on workplace incivility. These factors included nurse managers' toxic leadership, nurses' perfectionistic self-presentation, and working in an intensive care unit, listed in descending order of significance. The factors that significantly affected the perpetrator aspect of workplace incivility included the experience of being a victim of workplace incivility and nurses' perfectionistic self-presentation. Nurses' perfectionistic self-presentation and the toxic leadership of nurse managers were shown to affect both the victim and the perpetrator aspects of workplace incivility.

1 **Conclusions:** Proactive organizational interventions are required to
2 address workplace incivility. Emotional support should be provided to
3 help nurses recognize and manage perfectionistic self-presentation
4 tendencies related to both victim and perpetrator roles. Educational
5 programs must also be established to mitigate toxic leadership among
6 nurse managers. Additionally, senior executives should foster an
7 organizational culture that encourages mutual respect and positive
8 leadership among nurses.

9 **Keywords:** incivility, leadership, perfectionism, nurses, workplace

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Background

Nurses, who account for the greatest proportion of the healthcare workforce [1], are regarded as one of the most trustworthy professional groups [2]. However, workplace incivility is a notable issue in nursing [3], negatively affecting nurses' psychological well-being, job satisfaction, and turnover intention [3]. Furthermore, it can lead to increased medical errors [4], decreased patient satisfaction, and compromised patient safety [5]. Thus, workplace incivility is detrimental not only to nurses but also to organizational performance, highlighting the need for scholarly and practical attention as well as organizational-level interventions.

Workplace incivility encompasses mild forms of norm-violating behavior in organizations that occur without explicit intent to cause harm. Experiences of incivility can lead to uncivil behavior, and such interactions can develop into retaliatory actions and "spiral" into more serious conflicts [6]. Types of uncivil behavior in hospitals include gossip, negative remarks, hostile behavior and gaze, harsh or sarcastic tones of voice, and unequal workload and work assignment [7]. According to a systematic literature review of the predictors and triggers of incivility in healthcare teams [8], incivility is more prevalent within the same occupation (e.g., among nurses) than among different occupations.

Nurses working in hospitals face unique job demands where even minor mistakes may have fatal consequences for patients. This environment fosters heightened perfectionistic tendencies [9]. In particular, perfectionistic self-presentation—defined as the interpersonal

tendency to appear flawless to others [10]—has been linked to greater occupational stress and burnout among nurses [9]. Nurses can demonstrate highly perfectionistic tendencies such as repeated checks and reviews to prevent errors [9]. Those individuals with higher perfectionistic self-presentation may hesitate to seek professional help, as it becomes more difficult to reveal their errors and incompetence [11].

The concepts of perfectionism and perfectionistic self-presentation both arise from the individual's desire to be perfect and both are closely related to psychological issues and interpersonal difficulties [10]. On the one hand, perfectionism differs in that the tendency to pursue perfection is demonstrated by demanding high performance from oneself according to one's own standards and displaying extreme reactions if those standards are not met [12]. On the other hand, perfectionistic self-presentation is a method of interpersonal presentation centered on the desire to appear perfect to other people rather than actually being perfect [10] and it entails promoting behaviors deemed to be perfect, while concealing those deemed to be imperfect [11].

According to a recent systematic literature review and meta-analysis, perfectionistic self-presentation was found to be a transdiagnostic factor for psychopathological results such as social anxiety, depression, and narcissism [13]. Additionally, perfectionistic self-presentation was found to affect workplace bullying in a study on intensive care unit nurses [14]. Therefore, it is important to ensure that nurses' perfectionistic self-presentation does not harm their health or contribute to workplace

incivility. A recent study highlighting different predictors of workplace bullying victimization and perpetration revealed that perfectionistic self-presentation significantly predicted perpetration but not victimization [15]. Building on these findings, we conducted this study to investigate workplace incivility from both victim and perpetrator perspectives, focusing on the distinct roles of perfectionistic self-presentation in each.

Alongside this individual factor, organizational factors such as toxic leadership also play a crucial role in exacerbating workplace incivility, with negative leadership or the absence of leadership identified as a particularly powerful antecedent [8]. Because nurse managers play a central role in shaping the work climate, modeling norms of interaction, and allocating resources, their leadership style can either buffer staff from or expose them to uncivil behavior [16,17]. Moreover, leadership is a modifiable factor that can be directly targeted through educational and organizational policies, which makes it a meaningful focus for intervention-oriented research [18,19]. *Toxic leadership* is classified as a typical form of *negative leadership*, which also includes abusive supervision, tyrannical leadership, destructive leadership, workplace bullying, and laissez-faire leadership [20]. *Destructive leadership* is characterized by greater intensity and severity in certain disciplines or groups (e.g., female workers, workers in the early stages of their careers). Toxic leadership, which comprises aspects of both negative and destructive leadership, is characterized by narcissistic and self-promoting tendencies as well as unpredictable, abusive, and

authoritative behavior by leaders [21]. This form of supervision can be detrimental to the overall organization, as the leader's destructive behaviors manifest in a persistent and organized manner [22]. Toxic leaders can demonstrate toxicity at various times and in various forms, which affects how they are perceived by subordinates [23]. This perception is primarily determined by the leader's behavior, which is commonly characterized by bullying, denigrating, and intimidating subordinates.

Toxic leadership behavior places unnecessary stress and pressure on subordinates, which not only diminishes their performance but also results in various other negative effects [24]. The toxic leadership of nurse managers has been reported to potentially cause depression and anxiety [25], poorer psychological well-being and lower work engagement [26,27], and diminished confidence in the organization and greater turnover intention among nurses [28]. Considering that authority, the work environment, and managerial leadership play key roles in workplace incivility [29], examining the relationship between toxic leadership and incivility from both victim and perpetrator perspectives offers important implications for organizational management.

Based on the above, workplace incivility may be related to perfectionistic self-presentation tendencies and nurse managers' leadership styles. Andersson and Pearson [6] used the spiral model of incivility to explain its aggressive behavioral change, noting that

workplace incivility arises from the confluence of personal and organizational factors. However, most studies have focused on the consequences of workplace incivility [30], including the impacts on job satisfaction, turnover intention, and burnout [3]. Keller et al. [8] conducted a systematic review analyzing the predictors and triggers of incivility in healthcare teams but the findings on the personal characteristics of individuals subjected to incivility have been broadly inconsistent and centered on workplace bullying (i.e., the victim aspect). Further, few studies have analyzed the victim and perpetrator aspects of workplace incivility in tandem. Therefore, this study aimed to explore the impact of nurses' perfectionistic self-presentation and nurse managers' toxic leadership on workplace incivility, focusing on both victimization and perpetration among nurses working in general hospitals and higher-level institutions.

Based on the literature and aims of this study, we develop a theoretical model in which nurses' perfectionistic self-presentation (individual factor) and nurse managers' toxic leadership (organizational factor) are hypothesized to influence workplace incivility, conceptualized in terms of both victim and perpetrator aspects. Work unit characteristics (e.g., working in an intensive care unit) are also included as contextual predictors. In addition, the model assumes that experiences of workplace incivility as a victim may increase the likelihood of perpetrating incivility, reflecting the potential overlap between victim and perpetrator roles (Supplementary Figure 1).

1 **Methods**

2 Design

3 This study employed a cross-sectional design.

4 Participant and data collection

5 We sought to recruit nurses to participate in an online survey. The link to
6 the survey was distributed from November 18 to December 6, 2024 and
7 data were collected using an online community for nurses. The required
8 sample size for this study was calculated using G*Power 3.1.9.7. Based
9 on multiple regression analysis, the minimum sample size was 302
10 participants, with an effect size of $f^2 = 0.15$ (medium), a significance level
11 of .01, and a power of 0.99, with 13 predictors. Considering an online
12 survey attrition rate of 10%, the target sample size was set to 336
13 participants.

14 The inclusion criteria for participant selection were as follows:
15 registered nurses employed in general or tertiary hospitals, those whose
16 total work experience was six months or longer, those who directly
17 provided nursing care to patients, and those who understood the
18 objective of this study and agreed to participate. Participants were
19 excluded from the study if they were nurse managers at the charge nurse
20 level or higher. Responses from 319 nurses were used for the data
21 analysis after excluding 17 respondents—eight who did not meet the
22 inclusion criteria and nine whose responses included incomplete
23 answers.

Measurements

Perfectionistic self-presentation

The Perfectionistic Self-Presentation Scale - Korean Version (PSPS-K), developed by Hewitt et al. [10] and translated into Korean and validated by Ha [11], was used. This tool consists of 19 items, including three sub-factors: perfectionistic self-promotion (eight items), non-display of imperfection (five items), and non-disclosure of imperfection (six items). The tool is evaluated on a seven-point Likert scale ranging from one point for “never” to seven points for “always,” with higher scores indicating higher levels of perfectionistic self-presentation. The Cronbach’s α value—as an indicator of reliability—of the full scale in the study by Ha [11] was 0.85 and that of the tool in this study was 0.88.

Toxic leadership

The Toxic Leadership Behaviors of Nurse Managers (ToxBH-NM) scale, which was developed by Labrague et al. [31], was translated into Korean and used with the approval of the original authors. This tool comprises 30 items, including four behavior sub-factors: *intemperate* (15 items), *narcissistic* (nine items), self-promotional (three items), and *humiliating* (three items). The tool is evaluated on a four-point Likert scale ranging from one point for “not at all” to four points for “very much so,” with higher scores indicating greater toxic leadership tendencies. The Cronbach’s α value of the tool in the study by Labrague et al. [31] was 0.98 and that of the tool in this study was 0.97.

Workplace incivility (victim and perpetrator aspects)

The Workplace Incivility Scale (WIS), a workplace incivility experience tool developed by Cortina et al. [32] and translated into Korean and validated by Kim et al. [33], was used. This tool identifies both the victim and the perpetrator aspects of workplace incivility. It comprises 24 items, including 12 items each for the victim and perpetrator aspects. The tool is evaluated on a five-point Likert scale ranging from one point for “not at all” to five points for “often so,” with higher scores indicating more frequent experiences of workplace incivility (from both victim and perpetrator perspectives). The Cronbach’s α values of the tool at the time of development were 0.86 and 0.83 for the victim and perpetrator aspects, respectively. In this study, the Cronbach’s α value was 0.86 for the victim perspective of workplace incivility and 0.96 for the perpetrator perspective.

Data analysis

Data analyses were performed using SPSS version 30.0 software (IBM Corp, Armonk, NY, USA). The characteristics of the participants, perfectionistic self-presentation, toxic leadership of nurse managers, and workplace incivility were analyzed using descriptive statistics. The differences in workplace incivility based on the participants’ characteristics were identified using the independent t-test, one-way ANOVA, and Pearson’s correlation coefficients, while the post-hoc test was performed using the Scheffè test. The correlations among the participants’ perfectionistic self-presentation, nurse managers’ toxic leadership, and workplace incivility were identified using Pearson’s

correlation coefficients. Multiple regression analysis was used to identify the impact of the participants' perfectionistic self-presentation and nurse managers' toxic leadership on the participants' experiences of workplace incivility.

Ethical considerations

This study was approved by the Institutional Review Board at Chung-Ang University (No. 1041078-20240930-HR-277, approved on November 7, 2024) and was conducted in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Declaration of Helsinki and its later amendments. Before the survey, the participants received an explanation of the study, including its objectives, content, confidentiality terms, and their right to withdraw, to ensure their informed consent. In particular, the protection of nurses' personal privacy and autonomy was emphasized: participation was entirely voluntary, and the participants were informed that they could decline to answer any question or withdraw from the study at any time without penalty or adverse consequences. They were also assured that their responses would be used exclusively for research purposes, securely stored on a locked computer with access restricted to the research team, and retained for three years after the study's completion before disposal.

Results

Characteristics of the participants

As shown in Table 1, 319 nurses participated in this study. The average age of the participants was 32.04 (SD [standard deviation] 5.87) years. In terms of sex, 305 participants were female (95.6%). Regarding marital status, 203 participants (63.6%) were unmarried. In terms of the highest educational attainment, most respondents had a bachelor's degree (230, 72.1%). The distribution of participants regarding the types of hospitals was as follows: 162 (50.8%) worked in tertiary general hospitals and 157 (49.2%) worked in general hospitals. In terms of the current working unit, 204 participants (63.9%) worked in wards, 44 (13.8%) in intensive care units, 30 (9.4%) in the emergency department, and 14 (4.4%) in operating rooms. The participants' average work experience was 7.98 (SD 5.34) years and the average experience in their current working units was 4.46 (SD 3.55) years. In terms of position, most (256, 80.3%) were staff nurses. As for work style, most (285, 89.3%) were engaged in shift work.

The participants' average scores for perfectionistic self-presentation, nurse managers' toxic leadership, and workplace incivility (both victim and perpetrator aspects) were 4.77 (SD 0.73), 2.17 (SD 0.60), 1.97 (SD 0.99), and 1.67 (SD 0.82) points, respectively.

Differences in perfectionistic self-presentation, toxic leadership, and workplace incivility according to the participants' characteristics

Table 2 shows the differences between the victim and perpetrator aspects of workplace incivility depending on the participants' characteristics. Workplace incivility (victim aspect) differed significantly depending on the current working unit ($F = 3.20, p = .013$), with the highest score seen among operating room nurses. However, the result of the Scheffè test of the differences based on working unit was not statistically significant. Further, there were no differences in workplace incivility (perpetrator aspect) based on the participants' characteristics.

Correlations among perfectionistic self-presentation, toxic leadership, and workplace incivility

Table 3 shows the correlations among the variables. As workplace incivility (victim aspect) and toxic leadership pertain to managers in the participants' current working units, correlations in relation to their years of experience in their current working units were analyzed along with these variables. Perfectionistic self-presentation demonstrated a significant negative correlation ($r = -0.11, p = .045$) with years of experience in the current working unit but no significant correlations were found among any of the other variables. Toxic leadership demonstrated strong positive correlations with both the victim and the perpetrator aspects of workplace incivility ($r = 0.79, p < .001$ and $r = 0.51, p < .001$, respectively). Furthermore, a significant correlation ($r = 0.63, p < .001$) was found between workplace incivility (victim aspect) and workplace incivility (perpetrator aspect).

Factors influencing workplace incivility (victim aspect)

The variance inflation factors (VIFs) of all the variables were below 10, indicating no multicollinearity. The Durbin-Watson statistic was 1.98, suggesting no violation of the independence of errors. The results of the multiple regression analysis showed that perfectionistic self-presentation, nurse managers' toxic leadership, and the working unit significantly affected workplace incivility (victim aspect) ($F = 91.09$, $p < .001$).

The variable with the greatest effect on the victim aspect of workplace incivility was toxic leadership ($\beta = 0.78$, $p < .001$; 95% CI: 0.04 to 0.05), where a higher level of toxic leadership tended to increase workplace incivility. Perfectionistic self-presentation ($\beta = 0.07$, $p = .041$; 95% CI: 0.00 to 0.01) also had a significant effect, where higher levels of perfectionistic self-presentation increased workplace incivility. Nurses working in intensive care units had more workplace incivility (victim aspect) experiences than those working in wards, which was the reference group ($\beta = 0.08$, $p = .022$; 95% CI: 0.03 to 0.43). The explanatory power of the regression model was 64% (Table 4).

Factors influencing workplace incivility (perpetrator aspect)

The VIFs of all the variables were less than 10, confirming the absence of any multicollinearity. The Durbin-Watson statistic was 2.09, close to 2, confirming no violation of the independence of errors. The overall regression model, which included perfectionistic self-presentation and the victim aspect of workplace incivility, significantly predicted the

perpetrator aspect of workplace incivility ($F = 70.77, p < .001$). In this model, the victim aspect of workplace incivility emerged as a particularly strong predictor ($\beta = 0.62, p < .001$; 95% CI: 0.40 to 0.63), indicating that nurses who experienced incivility were more likely to engage in uncivil behavior themselves. Likewise, perfectionistic self-presentation significantly affected the perpetrator aspect of workplace incivility ($\beta = -0.09, p = .042$; 95% CI: -0.12 to -0.002). That is, a lower level of perfectionistic self-presentation tended to increase the likelihood of uncivil behavior. The explanatory power of the regression model was 40% (Table 5).

Discussion

In this study, toxic leadership (measured using the ToxBH-NM scale) and perfectionistic self-presentation (assessed with the PSPS-K) were examined as key factors. The analysis revealed that nurse managers' toxic leadership, nurses' perfectionistic self-presentation, and working in intensive care units influenced the victim aspect of workplace incivility in that order. Among these, toxic leadership exerted the strongest effect. That is, the higher the level of nurse managers' toxic leadership, the higher the likelihood that nurses would experience workplace incivility as victims. Negative leadership has been reported as a factor affecting workplace incivility [8]. In a study that explored the effect of tyrannical leadership, which is a type of negative leadership like toxic leadership, authoritative, autocratic, and derogatory tyrannical leadership types were reported to cause workplace incivility [34]. Additionally, the

presence of unsupportive and autocratic leaders has been shown to increase nurses' workplace bullying [35]. Moreover, Zhang et al. [36] found that abusive supervision induced various forms of workplace violence such as verbal and physical violence and harassment, while negative (passive-avoidant) leadership increased workplace cyberbullying [37]. Blackstock et al. [38] found that an increase in positive leadership led to a decrease in the workplace incivility (victim aspect) experienced by new nurses, while Jungert and Holm [29] showed that the leadership of managers plays a key role in workplace incivility (victim aspect).

These findings confirm that workplace incivility is affected by managers' leadership styles, which is consistent with the results of the current study showing that toxic leadership is a major factor affecting workplace incivility (victim aspect). Situational and cultural factors—including excessive workload, issues in communication or collaboration, and concerns about patient safety, a lack of support, and inadequate leadership—have all been found to increase the level of incivility [8]. Meanwhile, toxic leadership behavior reportedly increased with high work intensity or insufficient managerial experience [39]. Thus, to diminish workplace incivility, the work environment should be improved so that nurse managers can demonstrate leadership that positively affects the organization and its members. Additionally, senior executives should promote leadership development processes that consider managers' years of managerial experience.

Perfectionistic self-presentation was found to affect workplace incivility (victim aspect). That is, higher levels of perfectionistic self-presentation indicated more experiences of the victim aspect of workplace incivility. Individuals with high perfectionistic self-presentation tendencies seek to conceal their errors and flaws and may refuse to acknowledge their errors in order to appear perfect to other people [10]. Thus, nurses with high levels of perfectionistic self-presentation are likely to be sensitive to evaluations from others, meaning they perceive even minor criticism or neglect as personal attacks. Jang et al.'s [14] study on intensive care unit nurses found that the higher their perfectionistic self-presentation, the higher the workplace incivility (victim aspect), consistent with the findings of the current study. Furthermore, leaders with perfectionistic tendencies affect workplace incivility (victim aspect) [40] and perfectionistic personalities affect incivility toward colleagues [41]. A study on nursing students also found that perfectionistic tendencies affect incivility (victim aspect) [42], corroborating the findings of this study. Interventions that manage perfectionistic self-presentation have been reported to mitigate vulnerability to negative evaluations and criticism in nursing practice and aid in alleviating anxiety, depression, and vulnerable narcissism [13]. Hence, providing organizational interventions for nurses and fostering psychological safety by easing the culture of perfectionistic pressure can help reduce uncivil interactions among nurses.

1 In this study, nurses working in intensive care units experienced a
2 higher level of incivility than nurses working in general wards. Similarly,
3 previous studies have reported that nurses working in special units
4 experienced a higher level of incivility than those working in general
5 wards [43], that intensive care unit nurses experienced greater incivility
6 than nurses in other units [44], and that intensive care unit workers were
7 more often victims of bullying and violence than emergency department
8 workers [45]. These findings suggest that high-intensity and high-stress
9 work environments can induce or reinforce uncivil interactions,
10 indicating that workplace characteristics can affect incivility. However,
11 the relationship between the working units and workplace incivility was
12 not clearly identified in this study. Although operating room nurses
13 reported the highest workplace incivility (victim aspect) scores in the
14 Scheffè test of the differences based on working unit, the regression
15 analysis indicated that victim incivility was higher among intensive care
16 unit nurses than ward nurses. The findings of this study must thus be
17 interpreted with caution, as the samples for special units such as
18 operating rooms and intensive care units were small and the
19 distributions of samples for each unit were uneven.

20 The factors that affected the perpetrator aspect of workplace
21 incivility were the victim aspect of workplace incivility and perfectionistic
22 self-presentation in that order. In other words, the victim aspect of
23 workplace incivility had the greatest effect on the perpetrator aspect of
24 workplace incivility. This suggests the potential for a vicious cycle in

which being the victim of incivility can lead to becoming a perpetrator of incivility. Andersson and Pearson [6] proposed the concept of the “incivility spiral,” wherein not only can the experience of incivility lead to the perpetration of incivility but simply witnessing incivility can imbue one with the intent to be uncivil toward others and can even lead to the actual perpetration of incivility. In previous studies, increased incivility by managers was associated with an increase in incivility among colleagues six months later [46]. Further, employees who experienced incivility from patients were more likely to be uncivil not only to patients but also to their hospital colleagues [47]. In particular, those who had experienced incivility within their families were more likely to display incivility in the workplace [48,49].

These findings are consistent with those of this study, indicating that being a victim of incivility induces the perpetration of incivility, suggesting that workplace incivility is not an individual issue but can affect and spread throughout the organization. Therefore, it is important to improve the work environment and foster a positive organizational culture to mitigate such negative effects. Furthermore, to alleviate workplace incivility and minimize its spread, human resources strategies must be developed and implemented to adequately manage the perfectionistic self-presentation tendencies of nurses and reduce the toxic leadership of nurse managers.

Perfectionistic self-presentation was found to significantly affect both the victim and the perpetrator aspects of workplace incivility. While a

higher level of perfectionistic self-presentation was associated with more experiences of workplace incivility as a victim, a lower level of perfectionistic self-presentation was associated with a higher likelihood of workplace incivility as a perpetrator. These findings are similar to those of Jang et al. [14], who analyzed the relationship between perfectionistic self-presentation and workplace bullying (victim and perpetrator aspects) among intensive care unit nurses. Considering that perfectionistic self-presentation characteristics involve being concerned about how one appears to other people and striving to maintain one's image [10], this finding suggests that people with lower perfectionistic self-presentation are less sensitive to other people's appraisal and less aware of social norms, making them more likely to display uncivil or aggressive behavior. Overall, our findings highlight a tension: excessive concern with appearing flawless may heighten perceived victimization, whereas too little concern for others' views and workplace norms may increase the risk of acting uncivilly toward colleagues. Rather than treating perfectionism or non-perfectionism as inherently desirable, emotional and organizational support should help nurses distinguish healthy professional standards from rigid, defensive self-presentation and foster a balanced approach that combines high standards with self-compassion and civility. Therefore, emotional support and organizational-level support systems are needed to identify perfectionistic self-presentation tendencies in nurses and prevent them from being negatively reinforced.

1 This study has the following limitations. First, owing to its cross-
2 sectional design, no causal relationships among the variables could be
3 identified. Hence, longitudinal cohort studies that can confirm the causal
4 relationships among the variables or intervention effect verification
5 studies evaluating the changes in related variables are needed. Second,
6 the representativeness of the sample may be limited, as the participants
7 were recruited using convenience sampling and an online community for
8 nurses. Future studies could adopt samples that include diverse
9 characteristics in terms of region, institution, and hospital type to
10 enhance representativeness. Third, because all the variables were
11 assessed using self-reported questionnaires at a single time point, the
12 findings may be subject to common method bias and the key variables
13 may have been under- or overestimated owing to respondents' subjective
14 perceptions. Future studies could reduce this bias by using multiple data
15 sources or time points and incorporating third-party observations or in-
16 depth interviews. Fourth, this study had limitations in identifying the
17 characteristics of workplace incivility in the healthcare setting, as the
18 workplace incivility measurement tools used were not developed for
19 nurses. Future studies could develop and verify incivility measurement
20 tools that can capture the unique characteristics of healthcare
21 organizations.

22 Despite these limitations, this study is significant in that it analyzed
23 the dual structure of workplace incivility in nursing from both the victim
24 and the perpetrator perspectives and identified key influencing factors:

perfectionistic self-presentation as an individual characteristic of nurses and nurse managers' toxic leadership as an organizational characteristic. Building on these findings, concrete steps in nursing practice could include the provision of leadership training programs for nurse managers to curb incivility and promote respectful communication, as nurse leaders play a key role in shaping a civil work climate and can be supported through targeted education and development initiatives [18]. In addition, peer support or coaching initiatives aimed at helping nurses manage perfectionistic self-presentation and work-related stress in healthier ways are consistent with emerging evidence that peer and leadership support programs enhance resilience and well-being among nurses [50]. Overall, the results of this study may serve as reliable empirical data for designing and implementing such practical interventions to reduce workplace incivility and support safer, more respectful clinical practice in healthcare settings [51].

Conclusions

This study identified the key predictors of workplace incivility among nurses, revealing that perfectionistic self-presentation, toxic leadership, and intensive care unit environments significantly influence victimization patterns. Notably, perfectionistic self-presentation and prior victimization were primary factors in perpetrator behaviors, suggesting a cyclical relationship between experiencing and enacting incivility. These findings underscore the multifaceted nature of workplace incivility, encompassing both individual psychological traits and organizational contextual factors.

The perpetuation cycle in which victims become perpetrators highlights the critical need for comprehensive intervention strategies.

Relevance for clinical practice

Organizations should prioritize leadership development programs targeting toxic management behaviors while implementing unit-specific interventions in high-risk environments. Individual-level support for nurses with perfectionistic tendencies is essential to disrupt the victim/perpetrator cycle. A multilayered approach combining managerial training, psychological support, and organizational culture reform is necessary to establish respectful work environments and prevent workplace incivility in nursing practice.

List of abbreviations

PSPS-K: The Perfectionistic Self-Presentation Scale - Korean Version

ToxBH-NM: Toxic Leadership Behaviors of Nurse Managers

WIS: Workplace Incivility Scale

SD: standard deviation

VIFs: variance inflation factors

Declarations

Ethical approval and consent to participate

This study was approved by the Institutional Review Board at Chung-Ang University (No. 1041078-20240930-HR-277, approved on November 7, 2024) and was conducted in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Declaration of Helsinki and its later amendments. All participants were fully informed about the study and provided written informed consent prior to enrollment.

Consent for publication

Not applicable: this manuscript contains no individual person's data in any form

Availability of data and materials

The data presented in this study are available on request from the corresponding author and with permission of the Institutional Review Board of Chung-Ang University.

Competing interests

The authors have no conflicts of interest to declare.

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Authors' contributions

Yeon Hwa OH: Conceptualization, Methodology, Software, Validation, Formal analysis, Investigation, Data curation, Writing – original draft preparation, Writing – review and editing, Visualization, Project administration.

Youn-Jung SON: Conceptualization, Validation, Supervision, Writing – original draft preparation, Writing – review and editing.

Sun Joo JANG: Conceptualization, Methodology, Validation, Visualization, Supervision, Writing – original draft preparation, Writing – review and editing.

Haeyoung LEE: Conceptualization, Methodology, Validation, Visualization, Supervision, Writing – original draft preparation, Writing – review and editing, Project administration.

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1 Table 1. Participants' characteristics and main variables (N=319)

Characteristic	Category	n (%)	M (SD)
Age (years)			32.04(5.87)
Sex	Female	305(95.6)	
	Male	14(4.4)	
Marital status	Single	203(63.6)	
	Married	116(36.4)	
Highest educational attainment	3-year college	47(14.7)	
	Bachelor's degree	230(72.1)	
	Above master's degree	42(13.2)	
Hospital type	Tertiary general hospital	162(50.8)	
	General hospital	157(49.2)	
Working years (current unit)			4.46(3.55)
Total working years			7.98(5.34)
Current working unit	Ward	204(63.9)	
	Intensive care unit	44(13.8)	
	Operating room	14(4.4)	
	Emergency department	30(9.4)	
	Other*	27(8.5)	
Position	Staff nurse	256(80.3)	
	Charge nurse	63(19.7)	
Work style	Shift work	285(89.3)	
	Full-time work	34(10.7)	
Perfectionistic self-presentation			4.77(0.73)
Toxic leadership			2.17(0.60)
Workplace incivility (victim aspect)			1.97(0.99)

Workplace incivility (perpetrator aspect)	1.67(0.82)
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1 M: mean, SD: standard deviation

2 * Other: Outpatient department, Recovery room, Delivery room,

3 Hemodialysis unit, Home visit nursing

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Table 2. Differences in workplace incivility according to the participants' characteristics (N=319)

Characteristic	Category	n	Workplace incivility (victim aspect)			Workplace incivility (perpetrator aspect)		
			M (SD)	t/F	<i>p</i>	M (SD)	t/F	<i>p</i>
Sex	Female	305	1.97(0.99)	-0.10	.919	1.67(0.82)	0.23	.820
	Male	14	1.95(0.87)			1.72(0.75)		
Marital status	Single	203	1.98(0.99)	0.12	.907	1.66(0.77)	-0.29	.775
	Married	116	1.96(0.98)			1.69(0.89)		
Highest educational attainment	3-year college	47	2.02(1.07)	0.25	.780	1.71(1.01)	0.18	.836
	Bachelor's degree	230	1.98(0.99)			1.68(0.80)		
	Master's degree	42	1.88(0.85)			1.61(0.63)		
Hospital type	Tertiary general hospital	162	1.95(0.99)	0.47	.637	1.63(0.77)	0.97	.333
	General hospital	157	2.00(0.97)			1.72(0.86)		
Current working unit	Ward	204	1.98(0.95)	3.20	.013 [†]	1.68(0.81)	0.68	.604
	Intensive care unit	44	2.19(1.27)			1.77(1.00)		

	Operating room	14	2.51(1.01))			1.79(0.96)		
	Emergency department	30	1.58(0.67)			1.53(0.68)		
	Other*	27	1.76(0.80)			1.52(0.57)		
Position	Staff nurse	256	2.00(1.01)	0.83	.409	1.69(0.84)	1.00	.317
	Charge nurse	63	1.88(0.86)			1.58(0.71)		
Work style	Shift work	285	1.95(0.96)	-1.04	.301	1.66(0.80)	-0.56	.579
	Full-time work	34	2.14(1.13)			1.75(0.94)		

M: mean, SD: standard deviation

* Other: Outpatient department, Recovery room, Delivery room, Hemodialysis unit, Home visit nursing

† n.s. (not significant in the Scheffè test)

Table 3. Correlations among working years, perfectionistic self-presentation, toxic leadership, and workplace incivility (N=319)

Variable	Working years (current unit)	Perfectionistic self-presentation	Toxic leadership	Workplace incivility (victim aspect)	Workplace incivility (perpetrator aspect)
	$r(p)$	$r(p)$	$r(p)$	$r(p)$	$r(p)$

Working years (current unit)	1				
Perfectionistic self- presentation	-0.11(.045)	1			
Toxic leadership	0.08(.145)	0.06(.293)	1		
Workplace incivility (victim aspect)	0.05(.352)	0.11(.061)	0.79(<.001)	1	
Workplace incivility (perpetrator aspect)	0.10(.067)	-0.02(.681)	0.51(<.001)	0.63(<.001)	1

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4 Table 4. Factors influencing workplace incivility (victim aspect) (N=319)

Variable	B	SE	β	t	<i>p</i>	VIF	95% confidence interval	
							Lower	Upper
(Constant)	-1.29	0.26		-5.04	<.001		-1.79	-0.79
Perfectionistic self-presentation	0.01	0.01	0.07	2.05	.041	1.03	0.00	0.01
Toxic leadership	0.04	0.01	0.78	22.39	<.001	1.03	0.04	0.05
Current working unit [†]								
Intensive care unit	0.23	0.10	0.08	2.30	.022	1.06	0.03	0.43
Operating room	0.28	0.17	0.06	1.70	.090	1.04	-0.05	0.61
Emergency department	-0.01	0.12	-0.01	-0.04	.970	1.07	-0.24	0.23
Other	-0.10	0.12	-0.03	-0.78	.435	1.04	-0.34	0.15
Adjusted R ² =0.64, F=91.09 (<i>p</i> <.001), Durbin-Watson's d=1.98								

5 [†] Dummy variable (Reference): Current working unit (Ward)

6 Note. SE: standard error, VIF: variance inflation factor

Table 5. Factors influencing workplace incivility (perpetrator aspect)
(N=319)

Variable	B	SE	β	t	p	VIF	95% confidence interval	
							Lower	Upper
(Constant)	12.71	3.25		3.91	<.001		6.31	19.11
Perfectionistic self-presentation	-0.06	0.03	-0.09	-2.04	.042	1.01	-0.12	-0.002
Toxic leadership	0.02	0.04	0.03	0.38	.706	2.65	-0.06	0.09
Workplace incivility (victim aspect)	0.51	0.06	0.62	8.65	<.001	2.67	0.40	0.63
Adjusted $R^2=0.40$, $F=70.77$ ($p<.001$), Durbin-Watson's $d=2.09$								

Note. SE: standard error, VIF: variance inflation factor