
Association Between Workplace Gaslighting and Perceived Quality of Care, Patient Safety and Quiet Quitting: A Cross-Sectional Study Among Nurses in Greece

[Ioannis Moisoglou](#)*, [Aglaia Katsiroumpa](#), [Ioanna V. Papathanasiou](#), [Olympia Konstantakopoulou](#), [Aris Yfantis](#), [Aggeliki Katsapi](#), [Petros Galanis](#)

Posted Date: 31 December 2025

doi: 10.20944/preprints202512.2823.v1

Keywords: gaslighting; nurse; quiet quitting; patient; quality of care; safety; workplace



Preprints.org is a free multidisciplinary platform providing preprint service that is dedicated to making early versions of research outputs permanently available and citable. Preprints posted at Preprints.org appear in Web of Science, Crossref, Google Scholar, Scilit, Europe PMC.

Copyright: This open access article is published under a [Creative Commons CC BY 4.0 license](#), which permit the free download, distribution, and reuse, provided that the author and preprint are cited in any reuse.

Disclaimer/Publisher's Note: The statements, opinions, and data contained in all publications are solely those of the individual author(s) and contributor(s) and not of MDPI and/or the editor(s). MDPI and/or the editor(s) disclaim responsibility for any injury to people or property resulting from any ideas, methods, instructions, or products referred to in the content.

Article

Association Between Workplace Gaslighting and Perceived Quality of Care, Patient Safety and Quiet Quitting: A Cross-Sectional Study Among Nurses in Greece

Ioannis Moissoglou ^{1,*}, Aglaia Katsiroumpa ², Ioanna V. Papathanasiou ¹,
Olympia Konstantakopoulou ³, Aris Yfantis ⁴, Aggeliki Katsapi ⁵ and Petros Galanis ²

¹ Department of Nursing, University of Thessaly, 41500 Larissa, Greece

² Clinical Epidemiology Laboratory, Faculty of Nursing, National and Kapodistrian University of Athens, 11527, Athens, Greece

³ Center for Health Services Management and Evaluation, Faculty of Nursing, National and Kapodistrian University of Athens, 11527, Athens, Greece

⁴ Directorate of Secondary Education of Fthiotis, Special Vocational Education Laboratory of Fthiotis, 35100, Lamia, Greece

⁵ Euro-Mediterranean Institute for Quality and Safety in Health Services, 10678 Athens, Greece

* Correspondence: iomoysoglou@uth.gr

Abstract

Background: Patient safety is a top priority for healthcare organization leadership worldwide, as approximately one in ten patients experiences an adverse event, and nurses often report that the quality of the care they deliver is poor. **Objectives:** The present study aim was to examine the impact of work gaslighting on perceived quality of care, patient safety and quiet quitting on nursing staff. **Methods:** A cross-sectional study was conducted in Greece and data were collected using an online survey during October to November 2025, with 492 nurses. We used the Gaslighting at Work Scale (GWS) and the Quiet Quitting Scale to measure workplace gaslighting and quiet quitting. Perceived quality of care and perceived patient safety were measured with single items, representing the overall assessments in nurses' unit. **Results:** Nurses reported low to moderate levels of workplace gaslighting and quiet quitting, as well as almost half of the participants (52.0%, n=256) evaluated the quality of care in their unit as good, and 33.1% (n=163) of nurses perceived patient safety as good. In the univariate comparisons, greater workplace gaslighting was significantly associated with lower odds of reporting perceived quality of care to be good or excellent (OR = 0.650, 95% CI: 0.527–0.803; p < 0.001). This association was still statistically significant in the multivariable model after gender, years of work experience, working in shifts and working in an understaffed department were included (adjusted OR = 0.655; 95% CI: 0.529–0.810; p < 0.001). Workplace gaslighting was also strongly related to perceived patient safety. In the univariate analysis increased workplace gaslighting was associated with decreased odds of good-to-excellent patient safety (OR = 0.553, 95% CI: 0.445–0.686, p < 0.001). This association remained after controlling for the potential confounders (adjusted OR = 0.561, 95% CI: 0.450–0.700, p < 0.001). In the multivariable model, workplace gaslighting was significantly and positively associated with quiet quitting (adjusted beta = 0.224, 95% CI = 0.163 to 0.285, p < 0.001) after adjusted for demographic and work-related characteristics. **Conclusions:** The present study is the first that highlighted the significant association between workplace gaslighting and the quality and safety of care, as well as nurses' quiet quitting. A zero-tolerance stance by senior leadership, coupled with the establishment of clear policies and procedures that encourage staff to report such behaviors, is essential to dismantle the barriers created by psychological manipulation.

Keywords: gaslighting; nurse; quiet quitting; patient; quality of care; safety; workplace

1. Introduction

Patient safety constitutes the most critical dimension of the quality of healthcare services and has become a central priority for the leadership of healthcare organizations worldwide. The publication of the Institute of Medicine (US) report *“To Err is Human: Building a Safer Health System”* profoundly shook health systems worldwide, as it revealed that nearly 100,000 patients were dying each year in U.S. hospitals, not due to their underlying disease, but as a result of errors occurring during the delivery of care [1]. At the same time, this report catalyzed a systematic, concerted effort to reduce errors that lead to adverse patient events. It is estimated that 10–12% of hospitalized patients experience some form of adverse event, including healthcare-associated infections, medication errors, pressure ulcers, procedure-related complications, and falls. The consequences of adverse events for patients and healthcare organizations include emotional and physical harm, such as pain and disability, with a proportion resulting in patient death, as well as prolonged length of hospital stay, increased likelihood of readmission and increased costs of care [2–5]. The multidimensional consequences of adverse events also affect healthcare professionals, who may experience second victim syndrome, manifested through a wide range of symptoms including troubling memories, anxiety and concern, self-directed anger, regret and remorse, distress, fear of future errors, embarrassment, guilt, reduced self-confidence, and sleep disturbances [6]. Approximately one in five healthcare professionals requires up to one year to recover, and in some cases they may never fully recover [7]. Despite sustained efforts by healthcare organizations’ leadership and a reduction in the incidence of adverse events, these events continue to pose a threat to patients’ health status and lives, substantially undermining the quality of healthcare services [8].

The quality of care delivered is not, of course, confined to patient safety; rather, it is a multidimensional construct that health professionals conceptualize as holistic care. From nurses’ perspectives, care quality may encompass domains such as effective communication, teamwork, optimal patient outcomes, competence, knowledge, satisfaction, and meeting patients’ needs [9]. These needs may include treating patients with respect and dignity; acknowledging and supporting their spiritual, cultural, religious, and sexual identity; supporting patients in making informed choices; effective pain management; adequate patient monitoring/surveillance; educating patients and/or family members; and preparing patients and families for discharge [10,11].

The Institute for Healthcare Improvement proposes a framework for establishing safe, reliable, and effective Care, which comprises two foundational domains: organizational culture and a learning system. Leadership constitutes the shared enabling factor required to ensure and sustain both domains [12]. The leadership style most consistently identified as pivotal to fostering a safety culture among nursing staff is transformational leadership [13,14]. Core attributes of transformational leadership, such as leveraging errors as opportunities for learning and improvement, establishing a blameless safety culture, promoting open multidisciplinary communication, and actively involving followers in decision-making constitute fundamental elements for cultivating a robust culture of safety [15]. In contrast to transformational leadership, toxic leadership represents a style that effectively undermines any effort to develop and sustain a safety culture [16]. Specifically, toxic behavior may encompass features such as narcissistic behavior, referring to patterns of extreme self-centeredness and an inflated sense of personal importance; self-promoting behavior, involving actions aimed at advancing one’s own interests, such as exploiting staff and exhibiting marked shifts in conduct when interacting with superiors; and humiliating behavior, which includes practices that shame or embarrass employees, demonstrate limited concern for personnel or the organization, and reflect a lack of respect or consideration, including disparaging feedback, inequitable treatment, and the imposition of excessive pressure on nursing staff [16]. Gaslighting is a behavioral pattern that closely resembles toxic conduct, functioning as a form of psychological manipulation and a manifestation of structural power. Its core features are inherently misaligned with the prerequisites

for cultivating a robust safety culture. In practice, perpetrators may fabricate information, undermine the target's perceptions and recollections, question emotional or cognitive responses, and/or manipulate contextual cues in ways that generate disorientation and a sense of unreality. Taken together, these tactics aim to destabilize the individual's confidence in their own judgment and affect, fostering self-doubt and progressively diminishing self-trust and self-esteem. Notably, gaslighters often repudiate objective facts even when confronted with credible, well-substantiated evidence [17]. This pattern of behavior is commonly rooted in motives of dominance and control, reinforced by personal insecurity, a compulsive need for correctness, and a drive for power [18]. Employees who are victims of gaslighting report higher levels of occupational burnout, greater turnover intention and quiet quitting, and lower work engagement, while also facing serious mental health issues, including anxiety and depression [19,20]. Gaslighting behaviors foster a work environment that acts as a barrier to the development of a patient safety culture.

A work-related behavior that first gained prominence in the business sector during the COVID-19 pandemic is quiet quitting [21]. In an effort to push back against a culture of relentless striving, often in the absence of meaningful organizational attention to employee well-being, and to achieve a better balance between work and personal life, employees may adopt quiet quitting. In practice, this involves deliberately scaling back discretionary effort, limiting performance to the minimum requirements of the role, refraining from going above and beyond, and focusing primarily on meeting the formal job description [21]. In the healthcare sector, an increasing number of health professionals, most notably nurses, are opting for quiet quitting [22]. Within nurses' exceptionally challenging work environment, often characterized as poor, with very high workloads and elevated turnover intention [23–25], factors that collectively contribute to the emergence of quiet quitting, this phenomenon appears to represent the Achilles' heel of health systems. Specifically, reduced discretionary effort may undermine any sustained attempt to continuously improve the quality of nursing care delivery.

To the best of our knowledge, the present study is the first to examine the impact of gaslighting on perceived quality of care, patient safety and quiet quitting on nursing staff.

2. Materials and Methods

2.1. Study Design

A cross-sectional study was conducted in Greece and data were collected using an online survey during October to November 2025. The questionnaire was administered via Google Forms and shared through nurses' media groups in Facebook, Instagram and LinkedIn. Nurses' networks represented institutional and professional association networks of nurses. This process yielded a convenience sample. Participants: a) had to be clinical nurses working in hospitals, (b) should have been subordinates, not supervisors of other nurses, with at least one year of work experience in their position and c) had to provide their consent to be eligible to complete the study questionnaire. The study adhered to the Strengthening the Reporting of Observational studies in Epidemiology (STROBE) guideline [26].

We used G*Power v.3.1.9.2 for sample size determination. In our models, we adjusted for five confounders (gender, age, years of work experience, working in shifts and working in an understaffed department). Therefore, for an expected effect size of 0.03 between our predictor (workplace gaslighting) and outcomes (perceived quality of care, perceived patient safety, quiet quitting), statistical power of 95%, and a marginal error of 5%, the sample size was calculated at a total of 436 nurses.

2.2. Measurements

Demographic data included: gender (male/female), age (continuous variable), years of work experience (continuous variable), working in shifts (yes/no), and working in an understaffed department (yes/no).

The Gaslighting at Work Scale (GWS) was used to evaluate workplace gaslighting among nurses [27]. It consists of two factors: “loss of self-trust” (five items) and “abuse of power” (six items). The items are rated on a 5-point Likert scale ranging from 1 (never) to 5 (always). Total and subscale scores are calculated as an average of all responses (1–5), with higher scores indicating more frequent behaviors of supervisor gaslighting. The GWS version in the Greek language was used [28], yielding a Cronbach’s alpha value of 0.948. The Cronbach’s alpha values for “loss of self-trust” and “abuse of power” were 0.924 and 0.913, respectively.

To assess quiet quitting among nurses, we used the 9-item Quiet Quitting Scale [29]. Answers were recorded on a 5-point Likert scale from one (strongly disagree/never) to five (strongly agree/always). It consists of three factors: “detachment” (four items), “lack of initiative” (three items) and “lack of motivation” (two items). Score for each factor was derived by calculating the average value of the responses to items, ranging from 1 to 5. Higher scores are associated with higher levels of quiet quitting. The validated version of the Quiet Quitting Scale in Greek was used [22]. In our study, Reliability/internal consistency for the QQS was 0.814 (Cronbach’s alpha), (Cronbach’s alpha) 0.737 for “detachment”, 0.693 for “lack of initiative” and 0.810 for “lack of motivation”.

Perceived quality of care and perceived patient safety were measured with single items, representing the overall assessments in nurses’ unit. Quality of care was assessed with the question: “How would you rate the quality of the nursing care provided in your unit?” with answers in a 4-point Likert scale; poor, fair, good and excellent. This question constitutes a reliable approach for assessing the quality of nursing care delivery and is used internationally [30].

Patient safety was measured by the following question: “How would you assess patient safety in your unit?” with answers in a 5-point Likert scale; poor, fair, good, very good and excellent. This item was dichotomized for analysis (0=poor/fair and 1=good/very good/excellent) as literature suggest [31]. Increased values reflect increased ratings for perceived quality of care and patient safety.

2.3. Ethical Issues

Our study was conducted in accordance with the guidelines of the Declaration of Helsinki [32]. Our study protocol was approved by the Ethics Committee of the Faculty of Nursing, National and Kapodistrian University of Athens (approval number: 08, 23 September 2025). Data was collected in an anonymous and voluntary manner. Participants were informed about the purpose and design of the study and provided researchers with their consent.

2.4. Statistical Analysis

Continuous variables are described using mean, standard deviation (SD), median, and interquartile range, and categorical variables are presented as numbers and percentages. The distribution of continuous variables, which were normally distributed, was assessed using the Kolmogorov–Smirnov test and Q-Q plots. Workplace gaslighting was the predictor, and perceived quality of care, perceived patient safety and quiet quitting were the outcomes. Demographic variables (gender, age, years of work experience, working in shifts, and working in an understaffed department) were considered as confounding factors.

Univariate and multivariable logistic regression analyses were used to explore associations between workplace gaslighting, perceived quality of care and perceived patient safety. Univariate logistic regression analyses were initially carried out to evaluate crude associations of workplace gaslighting with each outcome. Final multivariable logistic regression models were thereafter built to determine the independent effect of workplace gaslighting, after adjustment for confounding. Age was highly correlated with years of work experience (Pearson’s correlation coefficient = 0.912, $p < 0.001$) suggesting multicollinearity issues, thus we added one of these two variables into the final multivariable models (work experience instead of age). The findings are reported as crude and adjusted odds ratios (ORs) with 95% confidence intervals (CIs) and p-values.

Univariate and multivariable linear regression analyses were performed to detect the association between workplace gaslighting and quiet quitting. Univariate linear regression analysis was initially

conducted and then we built a final multivariable model. This model controlled for possible confounders to measure the independent effect of workplace gaslighting on quiet quitting. We present crude and adjusted betas, 95% CI, and p-values. Additionally, we evaluated multicollinearity in the multivariable models using variance inflation factors (VIFs). A VIF larger than 5 implied multicollinearity between the independent variables. We also explored histograms of the residuals to investigate for multivariable normality. We reviewed scatterplots of residuals versus predicted values to confirm homoscedasticity and linearity [33]. There was no missing data. A p-value < 0.05 was considered statistically significant. We performed statistical analyses with IBM SPSS 28.0 (IBM Corp. Released 2021. IBM SPSS Statistics for Windows, Version 28.0. Armonk, NY, USA: IBM Corp.).

3. Results

3.1. Demographic Characteristics

Participants' demographic and work-related characteristics are presented in Table 1 (n = 492). Women comprised 82.1% of respondents, the average age of nurses was 42.98 years (SD = 18.27), and the mean duration of work experience was 9.79 years (SD = 9.95). Most of the participants were involved in shift work (81.7%) and had been working at an understaffed department (85.2%).

Table 1. Demographic and work-related characteristics of nurses (n = 492).

| Characteristics | N | % |
|---------------------------------------|-------|-------|
| Gender | | |
| Males | 88 | 17.9 |
| Females | 404 | 82.1 |
| Age (years) ^a | 42.98 | 18.27 |
| Years of work experience ^a | 9.79 | 9.95 |
| Working in shifts | | |
| No | 90 | 18.3 |
| Yes | 402 | 81.7 |
| Working in an understaffed department | | |
| No | 73 | 14.8 |
| Yes | 419 | 85.2 |

^a mean, standard deviation.

3.2. Study Scales

Descriptive statistics for the study scales are presented in Table 2. A mean score of 1.78 (SD = 0.89) was reported on the Gaslighting at Work Scale, while abuse of power scored higher (mean = 1.93, SD = 1.00) than loss of self-trust (mean value = 1.59, SD = 0.86).

Quiet quitting levels were similarly low to moderate (mean value = 2.18, SD = 0.65). Lack of motivation had the highest mean score (mean value = 2.77, SD = 1.00), followed by lack of initiative (mean value = 2.12, SD = 0.84) and detachment (mean value = 1.93, SD = 0.73), implying that motivational disengagement was the most emphasized, in contrast to behavioral withdrawal or emotional detachment.

Table 2. Descriptive statistics for the study scales (n= 492).

| Scale | Mean | Standard Deviation | Median | Interquartile Range |
|---------------------------|------|--------------------|--------|---------------------|
| Gaslighting at Work Scale | 1.78 | 0.89 | 1.45 | 1.00 |
| Loss of self-trust | 1.59 | 0.86 | 1.20 | 1.00 |
| Abuse of power | 1.93 | 1.00 | 1.67 | 1.50 |
| Quiet Quitting Scale | 2.18 | 0.65 | 2.11 | 0.86 |

| | | | | |
|--------------------|------|------|------|------|
| Detachment | 1.93 | 0.73 | 1.88 | 0.75 |
| Lack of initiative | 2.12 | 0.84 | 2.00 | 1.33 |
| Lack of motivation | 2.77 | 1.00 | 2.50 | 1.50 |

Table 3 presents the Pearson correlation coefficients between study scales and their subscales. The Gaslighting at Work Scale had a highly positive relationship with its two subscales, loss of self-trust ($r = 0.938$, $p < 0.01$) and abuse of power ($r = 0.968$, $p < 0.01$), suggesting strong internal coherence. Workplace Gaslighting was significantly and positively associated with the QQS ($r = 0.305$, $p < 0.01$), and its subscales: detachment ($r = 0.221$, $p < 0.01$), lack of initiative ($r = 0.300$, $p < 0.01$) and lack of motivation ($r = 0.198$, $p < 0.01$).

Similarly, both workplace gaslighting subscales were significantly associated with quiet quitting and its sub-scales. Loss of self-trust was positively correlated with total quiet quitting score ($r = 0.268$, $p < 0.01$), detachment ($r = 0.233$, $p < 0.01$), lack of initiative ($r = 0.245$, $p < 0.01$), and lack of motivation ($r = 0.142$, $p < 0.01$). Abuse of power had similar or somewhat stronger associations with quiet quitting ($r = 0.308$, $p < 0.01$), detachment ($r = 0.195$, $p < 0.01$), lack of initiative ($r = 0.317$, $p < 0.01$), and lack of motivation ($r = 0.224$, $p < 0.01$).

These findings indicate that higher perceived workplace gaslighting, particularly experiences related to abuse of power and loss of self-trust, is associated with greater levels of quiet quitting and its subscales.

Table 3. Pearson's correlation coefficients for the study scales (n=492).

| Scale | 2 | 3 | 4 | 5 | 6 | 7 |
|------------------------------|---------|---------|---------|---------|---------|---------|
| 1. Gaslighting at Work Scale | 0.938** | 0.968** | 0.305** | 0.221** | 0.300** | 0.198** |
| 2. Loss of self-trust | | 0.820** | 0.268** | 0.233** | 0.245** | 0.142** |
| 3. Abuse of power | | | 0.308** | 0.195** | 0.317** | 0.224** |
| 4. Quiet Quitting Scale | | | | 0.822** | 0.836** | 0.695** |
| 5. Detachment | | | | | 0.510** | 0.322** |
| 6. Lack of initiative | | | | | | 0.460** |
| 7. Lack of motivation | | | | | | |

** p-value < 0.01.

3.3. Quality of Care and Patient Safety

Almost half of the participants (52.0%, n=256) evaluated the quality of care in their unit as good, while 23.6% (n=116) evaluated it as fair, 19.7% (n=97) as excellent and 4.7% as (n=4.7%) poor.

Moreover, 33.1% (n=163) of nurses perceived patient safety as good, 28.5% (n=140) as very good, 20.7% (n=102) as fair, 11.2% (n=55) as excellent and 6.5% (n=32) as poor.

3.4. Association Between Workplace Gaslighting and Perceived Quality of Care and Patient Safety

Table 4 presents the unadjusted and adjusted effects of workplace gaslighting on perceived quality of care and patient safety among nurses, based on univariate and multivariable logistic regression analyses.

In the univariate comparisons, greater workplace gaslighting was significantly associated with lower odds of reporting perceived quality of care to be good or excellent (OR = 0.650, 95% CI: 0.527–0.803; $p < 0.001$). This association was still statistically significant in the multivariable model after gender, years of work experience, working in shifts and working in an understaffed department were included (adjusted OR = 0.655; 95% CI: 0.529–0.810; $p < 0.001$).

Workplace gaslighting was also strongly related to perceived patient safety. In the univariate analysis increased workplace gaslighting was associated with decreased odds of good-to-excellent patient safety (OR = 0.553, 95% CI: 0.445–0.686, $p < 0.001$). This association remained after controlling for the potential confounders (adjusted OR = 0.561, 95% CI: 0.450–0.700, $p < 0.001$).

These results suggest that higher perceived workplace gaslighting was related to worse perceptions of quality care and patient safety, even after adjusting for key demographic/work-related variables.

Table 4. Logistic regression models with perceived quality of care and patient safety as the dependent variables (n = 492).

| Dependent variable Independent Variable | Univariate model | | | Multivariable model ^a | | |
|--|------------------|----------------|---------|----------------------------------|----------------|---------|
| | Unadjusted OR | 95% CI for OR | P-value | Adjusted OR | 95% CI for OR | P-value |
| Perceived quality of care | | | | | | |
| Workplace gaslighting | 0.650 | 0.527 to 0.803 | < 0.001 | 0.655 | 0.529 to 0.810 | < 0.001 |
| Perceived patient safety | | | | | | |
| Workplace gaslighting | 0.553 | 0.445 to 0.686 | < 0.001 | 0.561 | 0.450 to 0.700 | < 0.001 |

^a Multivariable models are adjusted for gender, years of work experience, working in shifts and working in an understaffed department. OR: Odds Ratio; CI: Confidence Interval.

3.5. Association Between Workplace Gaslighting and Quiet Quitting

Univariate and multivariable linear regression analyses for workplace gaslighting and quiet quitting are shown in Table 5. In the univariate analysis, workplace gaslighting was significantly and positively associated with quiet quitting (beta = 0.223, 95% CI = 0.161 to 0.284, p < .001), indicating that higher levels of workplace gaslighting were related to increased quiet quitting behaviors. This association was still significant even when gender, years of work experience, working in shifts and working in an understaffed department were considered (adjusted beta = 0.224, 95% CI = 0.163 to 0.285, p < 0.001). These results demonstrate that exposure to workplace gaslighting was independently related to greater tendency toward quiet quitting among nurses beyond demographic and work-related covariates. The multivariable model explained 13% of the variation in quiet quitting (R² = 13.0%) and was statistically significant (ANOVA p-value < 0.001). Figure S1 indicates multivariable normality for the multivariable model with quiet quitting as the dependent variable since the residuals followed a normal distribution. Figure S2 indicates homoscedasticity and linearity of the multivariable model, with quiet quitting as the dependent variable. VIF for the final multivariable model ranged from 1.006 to 1.247, indicating an absence of multicollinearity between independent variables.

Table 5. Linear regression models with quiet quitting as the dependent variable (n = 492).

| | Univariate models | | | Multivariable model ^a | | |
|-----------------------|-----------------------------|-----------------|---------|----------------------------------|-----------------|---------|
| | Unadjusted coefficient beta | 95% CI for beta | P-value | Adjusted coefficient beta | 95% CI for beta | P-value |
| Workplace gaslighting | 0.223 | 0.161 to 0.284 | <0.001 | 0.224 | 0.163 to 0.285 | <0.001 |

^a Multivariable model is adjusted for gender, years of work experience, working in shifts and working in an understaffed department. R² for the multivariable model = 13%, p-value for ANOVA < 0.001. CI: Confidence Interval.

4. Discussion

The present study is the first to investigate and highlight the significant association between workplace gaslighting and the quality and safety of care, as well as nurses' quiet quitting. Given the existing gap in the literature, the findings will be discussed in the context of gaslighting's impact on nurses' work-related behavior, which has, in turn, been empirically shown to influence the quality and safety of nursing care delivery.

Our finding regarding the effect of gaslighting on nurses' quiet quitting is consistent with evidence from study in employees outside the healthcare sector, where gaslighting has been associated not only with quiet quitting, but also with reduced work engagement and poorer mental health, including increased anxiety and depressive symptoms [20]. Quiet quitting among nurses often constitutes a precursor to their departure from the employing organization and, in some cases, from the profession altogether [23]. As nurses' turnover intention increases, the quality and safety of nursing care correspondingly decline [34,35]. Even when nurses wish to advance their careers and leave their current career trajectory, gaslighting constitutes a substantial barrier. Remaining "trapped" in a specific role and organization may also adversely affect the quality of care delivered [36]. Furthermore, gaslighting deprives nurses of the capacity to adapt rapidly and effectively to the continuously evolving healthcare environment [37], an adaptive capability through which they can enhance the safety of care [38]. Nurses who are subjected to gaslighting by their supervisors are more likely to develop occupational burnout [19]. Patients hospitalized in units where nurses experience burnout may be at increased risk of adverse events and report lower satisfaction with the care received; concurrently, burnout has been associated with lower nurse-assessed quality of care [39].

In contrast to gaslighting behaviors, where employees may be driven to doubt their own judgment, be portrayed as "crazy" when they voice their views, and consequently become stigmatized and socially isolated, fostering a safety culture requires leadership that encourages nurses to speak up, identify patient safety issues, address them effectively, and provide timely feedback within a learning-oriented environment that leverages errors as opportunities for improvement and cultivates psychological safety [40,41]. Such leadership is non-punitive, demonstrates trust in staff, and actively promotes collaboration across the team. Both nurse-to-nurse communication and interprofessional communication constitute essential prerequisites for ensuring patient safety [42,43]. Moreover, nurse managers who adopt these leadership practices enhance nurses' work engagement and reduce burnout, thereby creating conditions conducive to fewer errors and adverse events [40,41].

The present study has several limitations. First, its cross-sectional design precludes the establishment of causal relationships among the variables examined. In addition, the assessment of care quality and safety relied on self-reported measures, and no administrative data from patient records were used. Therefore, participants' responses may have been influenced by subjective appraisal and reporting bias. Finally, to our knowledge, this is the first study to investigate the association between workplace gaslighting and the quality and safety of care. Further studies in other countries are warranted to corroborate the present findings.

5. Conclusions

The quality and safety of nursing care delivery are central priorities across health systems worldwide. The consequences of adverse events are exceptionally serious and multifaceted, affecting patients, healthcare organizations, and health professionals alike. Although nurses working under demanding conditions require strong managerial support, they often instead become targets of abusive behaviors such as gaslighting, which undermines care quality and safety and may contribute to nurses' quiet quitting. The present study is the first that highlighted the significant association between workplace gaslighting and the quality and safety of care, as well as nurses' quiet quitting. A zero-tolerance stance by senior leadership, coupled with the establishment of clear policies and procedures that encourage staff to report such behaviors, is essential to dismantle the barriers created by psychological manipulation.

Supplementary Materials: The following supporting information can be downloaded at the website of this paper posted on Preprints.org.

Author Contributions: Conceptualization, I.M., A.K. (Aglaia Katsiroumpa) and P.G.; methodology, I.M., A.K. (Aglaia Katsiroumpa), I.V.P., O.K., and P.G.; software, P.G.; validation, I.M., A.K. (Aglaia Katsiroumpa), I.V.P., O.K., A.K. (Aggeliki Katsapi), AY., and P.G.; formal analysis, A.K. (Aglaia Katsiroumpa) and P.G.; investigation,

I.M., A.K. (Aglaia Katsiroumpa), I.V.P., O.K., AY, A.K. (Aggeliki Katsapi), and P.G.; resources, I.M., A.K. (Aglaia Katsiroumpa), I.V.P., O.K., AY., A.K. (Aggeliki Katsapi), and P.G.; data curation, P.G.; writing—original draft preparation, I.M., A.K. (Aglaia Katsiroumpa), I.V.P., O.K., AY., A.K. (Aggeliki Katsapi), and P.G.; writing—review and editing, I.M., A.K. (Aglaia Katsiroumpa), I.V.P., O.K., AY., A.K. (Aggeliki Katsapi), and P.G.; supervision, P.G.; project administration, I.M and P.G. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki, and approved by the Ethics Committee of the Faculty of Nursing, National and Kapodistrian University of Athens approved our study protocol (approval number: 08, 23 September 2025).

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: The data used in this study are openly available in Figshare at <https://doi.org/10.6084/m9.figshare.30972223>

Conflicts of Interest: The authors declare no conflicts of interest.

References

1. Institute of Medicine (US) Committee on Quality of Health Care in America *To Err Is Human: Building a Safer Health System*; Kohn, L.T., Corrigan, J.M., Donaldson, M.S., Eds.; National Academies Press (US): Washington (DC), 2000; ISBN 978-0-309-06837-6.
2. San Jose-Saras, D.; Valencia-Martín, J.L.; Vicente-Guijarro, J.; Moreno-Nunez, P.; Pardo-Hernández, A.; Aranaz-Andres, J.M. Adverse Events: An Expensive and Avoidable Hospital Problem. *Annals of Medicine* **2022**, *54*, 3156–3167, doi:10.1080/07853890.2022.2140450.
3. Valencia-Martín, J.L.; Vicente-Guijarro, J.; San Jose-Saras, D.; Moreno-Nunez, P.; Pardo-Hernández, A.; Aranaz-Andrés, J.M.; ESHMAD Director Group and external advisers Prevalence, Characteristics, and Impact of Adverse Events in 34 Madrid Hospitals. The ESHMAD Study. *European Journal of Clinical Investigation* **2022**, *52*, e13851, doi:10.1111/eci.13851.
4. Li, Z.; Lin, F.; Thalib, L.; Chaboyer, W. Global Prevalence and Incidence of Pressure Injuries in Hospitalised Adult Patients: A Systematic Review and Meta-Analysis. *International Journal of Nursing Studies* **2020**, *105*, 103546, doi:10.1016/j.ijnurstu.2020.103546.
5. Schwendimann, R.; Blatter, C.; Dhaini, S.; Simon, M.; Ausserhofer, D. The Occurrence, Types, Consequences and Preventability of in-Hospital Adverse Events – a Scoping Review. *BMC Health Serv Res* **2018**, *18*, 521, doi:10.1186/s12913-018-3335-z.
6. Busch, I.M.; Moretti, F.; Purgato, M.; Barbui, C.; Wu, A.W.; Rimondini, M. Psychological and Psychosomatic Symptoms of Second Victims of Adverse Events: A Systematic Review and Meta-Analysis. *J Patient Saf* **2020**, *16*, e61–e74, doi:10.1097/PTS.0000000000000589.
7. Naya, K.; Aikawa, G.; Ouchi, A.; Ikeda, M.; Fukushima, A.; Yamada, S.; Kamogawa, M.; Yoshihara, S.; Sakuramoto, H. Second Victim Syndrome in Intensive Care Unit Healthcare Workers: A Systematic Review and Meta-Analysis on Types, Prevalence, Risk Factors, and Recovery Time. *PLOS ONE* **2023**, *18*, e0292108, doi:10.1371/journal.pone.0292108.
8. Eldridge, N.; Wang, Y.; Metersky, M.; Eckenrode, S.; Mathew, J.; Sonnenfeld, N.; Perdue-Puli, J.; Hunt, D.; Brady, P.J.; McGann, P.; et al. Trends in Adverse Event Rates in Hospitalized Patients, 2010-2019. *JAMA* **2022**, *328*, 173–183, doi:10.1001/jama.2022.9600.
9. Stavropoulou, A.; Rovithis, M.; Kelesi, M.; Vasilopoulos, G.; Sigala, E.; Papageorgiou, D.; Moudatsou, M.; Koukouli, S. What Quality of Care Means? Exploring Clinical Nurses' Perceptions on the Concept of Quality Care: A Qualitative Study. *Clinics and Practice* **2022**, *12*, 468–481, doi:10.3390/clinpract12040051.
10. Cleland, J.; Hutchinson, C.; Khadka, J.; Milte, R.; Ratcliffe, J. What Defines Quality of Care for Older People in Aged Care? A Comprehensive Literature Review. *Geriatrics & Gerontology International* **2021**, *21*, 765–778, doi:10.1111/ggi.14231.

11. Ball, J.E.; Murrells, T.; Rafferty, A.M.; Morrow, E.; Griffiths, P. 'Care Left Undone' during Nursing Shifts: Associations with Workload and Perceived Quality of Care. *BMJ Qual Saf* **2014**, *23*, 116–125, doi:10.1136/bmjqs-2012-001767.
12. Frankel, A.; Haraden, C.; Federico, F.; Lenoci-Edwards, J. *A Framework for Safe, Reliable, and Effective Care*; Institute for Healthcare Improvement: Cambridge, 2017;
13. Merrill, K.C. Leadership Style and Patient Safety: Implications for Nurse Managers. *JONA: The Journal of Nursing Administration* **2015**, *45*, 319, doi:10.1097/NNA.000000000000207.
14. Seljemo, C.; Viksveen, P.; Ree, E. The Role of Transformational Leadership, Job Demands and Job Resources for Patient Safety Culture in Norwegian Nursing Homes: A Cross-Sectional Study. *BMC Health Serv Res* **2020**, *20*, 799, doi:10.1186/s12913-020-05671-y.
15. Murray, M.; Sundin, D.; Cope, V. The Nexus of Nursing Leadership and a Culture of Safer Patient Care. *Journal of Clinical Nursing* **2018**, *27*, 1287–1293, doi:10.1111/jocn.13980.
16. Labrague, L.J. Toxic Leadership and Its Relationship with Outcomes on the Nursing Workforce and Patient Safety: A Systematic Review. *Leadersh Health Serv (Bradf Engl)* **2023**, *37*, 192–214, doi:10.1108/LHS-06-2023-0047.
17. Darke, L.; Paterson, H.; van Golde, C. Illuminating Gaslighting: A Comprehensive Interdisciplinary Review of Gaslighting Literature. *J Fam Viol* **2025**, doi:10.1007/s10896-025-00805-4.
18. Klein, W.; Wood, S.; Bartz, J. A Historical Review of Gaslighting: Tracing Changing Conceptualizations Within Psychiatry and Psychology.; OSF, August 23 2023.
19. Moisoglou, I.; Katsiroumpa, A.; Konstantakopoulou, O.; Papathanasiou, I.V.; Katsapi, A.; Prasini, I.; Chatzi, M.; Galanis, P. Workplace Gaslighting Is Associated with Nurses' Job Burnout and Turnover Intention in Greece. *Healthcare* **2025**, *13*, 1574, doi:10.3390/healthcare13131574.
20. Moisoglou, I.; Katsiroumpa, A.; Konstantakopoulou, O.; Mangoulia, P.; Tsiachri, M.; Koinis, A.; Kyriakatis, G.M.; Galanis, P. Workplace Gaslighting: Implications for Employees' Mental Health and Work Life in Greece. *Healthcare* **2025**, *13*, 3255, doi:10.3390/healthcare13243255.
21. Harter, J. Is Quiet Quitting Real? Available online: <https://www.gallup.com/workplace/398306/quiet-quitting-real.aspx> (accessed on 10 December 2025).
22. Galanis, P.; Katsiroumpa, A.; Vraka, I.; Siskou, O.; Konstantakopoulou, O.; Katsoulas, T.; Moisoglou, I.; Gallos, P.; Kaitelidou, D. Nurses Quietly Quit Their Job More Often than Other Healthcare Workers: An Alarming Issue for Healthcare Services. *International Nursing Review* **2024**, *71*, 850–859, doi:10.1111/inr.12931.
23. Galanis, P.; Moisoglou, I.; Katsiroumpa, A.; Gallos, P.; Kalogeropoulou, M.; Meimeti, E.; Vraka, I. Workload Increases Nurses' Quiet Quitting, Turnover Intention, and Job Burnout: Evidence from Greece. *AIMS Public Health* **2025**, *12*, 44–55, doi:10.3934/publichealth.2025004.
24. Galanis, P.; Moisoglou, I.; Malliarou, M.; Papathanasiou, I.V.; Katsiroumpa, A.; Vraka, I.; Siskou, O.; Konstantakopoulou, O.; Kaitelidou, D. Quiet Quitting among Nurses Increases Their Turnover Intention: Evidence from Greece in the Post-COVID-19 Era. *Healthcare* **2024**, *12*, 79, doi:10.3390/healthcare12010079.
25. Moisoglou, I.; Katsiroumpa, A.; Katsapi, A.; Konstantakopoulou, O.; Galanis, P. Poor Nurses' Work Environment Increases Quiet Quitting and Reduces Work Engagement: A Cross-Sectional Study in Greece. *Nursing Reports* **2025**, *15*, 19, doi:10.3390/nursrep15010019.
26. Elm, E. von; Altman, D.G.; Egger, M.; Pocock, S.J.; Gøtzsche, P.C.; Vandenbroucke, J.P. The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) Statement: Guidelines for Reporting Observational Studies. *The Lancet* **2007**, *370*, 1453–1457, doi:10.1016/S0140-6736(07)61602-X.
27. Katsiroumpa, A.; Moisoglou, I.; Konstantakopoulou, O.; Tsiachri, M.; Kolisiati, A.; Galanis, P. The Gaslighting at Work Scale: Development and Initial Validation. *Journal of Workplace Behavioral Health* **2025**, *0*, 1–23, doi:10.1080/15555240.2025.2539157.
28. Katsiroumpa, A.; Moisoglou, I.; Tsiachri, M.; Lamprakopoulou, K.; Galani, O.; Tsakalaki, A.; Galanis, P. Gaslighting at Work Scale: Determination of an Optimal Cut-Off Point. *International Journal of Caring Sciences* **2025**, *18*, 614–621.

29. Galanis, P.; Katsiroumpa, A.; Vraka, I.; Siskou, O.; Konstantakopoulou, O.; Moisoglou, I.; Gallos, P.; Kaitelidou, D. The Quiet Quitting Scale: Development and Initial Validation. *AIMS Public Health* **2023**, *10*, 828–848, doi:10.3934/publichealth.2023055.
30. Muir, K.J.; Sloane, D.M.; Aiken, L.H.; Hovsepian, V.; McHugh, M.D. The Association of the Emergency Department Work Environment on Patient Care and Nurse Job Outcomes. *JACEP Open* **2023**, *4*, e13040, doi:10.1002/emp2.13040.
31. Lake, E.T.; Hallowell, S.G.; Kutney-Lee, A.; Hatfield, L.A.; Del Guidice, M.; Boxer, B.A.; Ellis, L.N.; Verica, L.; Aiken, L.H. Higher Quality of Care and Patient Safety Associated With Better NICU Work Environments. *Journal of Nursing Care Quality* **2016**, *31*, 24, doi:10.1097/NCQ.000000000000146.
32. World Medical Association World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects. *JAMA* **2013**, *310*, 2191–2194, doi:10.1001/jama.2013.281053.
33. Kim, J.H. Multicollinearity and Misleading Statistical Results. *Korean J Anesthesiol* **2019**, *72*, 558–569, doi:10.4097/kja.19087.
34. Zaheer, S.; Ginsburg, L.; Wong, H.J.; Thomson, K.; Bain, L.; Wulffhart, Z. Acute Care Nurses' Perceptions of Leadership, Teamwork, Turnover Intention and Patient Safety – a Mixed Methods Study. *BMC Nurs* **2021**, *20*, 134, doi:10.1186/s12912-021-00652-w.
35. Huang, T.-L.; Wong, M.-K.; Shyu, Y.-I.L.; Ho, L.-H.; Yeh, J.-R.; Teng, C.-I. Reducing Turnover Intention to Improve Care Outcome: A Two-Wave Study. *Journal of Advanced Nursing* **2021**, *77*, 3083–3092, doi:10.1111/jan.14831.
36. Atta, M.H.R.; Waheed Elzohairy, N.; Abd Elaleem, A.E.D.M.H.; Othman, A.A.; Hamzaa, H.G.; El-Sayed, A.A.I.; Zoromba, M.A. Comprehending the Disruptive Influence of Workplace Gaslighting Behaviours and Mobbing on Nurses' Career Entrenchment: A Multi-Centre Inquiry. *Journal of Advanced Nursing* **2025**, *81*, 1815–1828, doi:10.1111/jan.16368.
37. El-Sayed, A.A.I.; Alsenany, S.A.; Atta, M.H.R.; Othman, A.A.; Asal, M.G.R. Navigating Toxicity: Investigating the Interplay Between Workplace Gaslighting, Workaholism, and Agility Among Nurses. *Nursing Inquiry* **2025**, *32*, e12697, doi:10.1111/nin.12697.
38. Saleem, M.S.; Isha, A.S.N.; Mohd Yusop, Y.; Awan, M.I.; Naji, G.M.A. Agility and Safety Performance among Nurses: The Mediating Role of Mindful Organizing. *Nursing Reports* **2021**, *11*, 666–679, doi:10.3390/nursrep11030063.
39. Li, L.Z.; Yang, P.; Singer, S.J.; Pfeffer, J.; Mathur, M.B.; Shanafelt, T. Nurse Burnout and Patient Safety, Satisfaction, and Quality of Care: A Systematic Review and Meta-Analysis. *JAMA Netw Open* **2024**, *7*, e2443059, doi:10.1001/jamanetworkopen.2024.43059.
40. Sammer, C.E.; Lykens, K.; Singh, K.P.; Mains, D.A.; Lackan, N.A. What Is Patient Safety Culture? A Review of the Literature. *Journal of Nursing Scholarship* **2010**, *42*, 156–165, doi:10.1111/j.1547-5069.2009.01330.x.
41. Sexton, J.B.; Adair, K.C.; Leonard, M.W.; Frankel, T.C.; Proulx, J.; Watson, S.R.; Magnus, B.; Bogan, B.; Jamal, M.; Schwendimann, R.; et al. Providing Feedback Following Leadership WalkRounds Is Associated with Better Patient Safety Culture, Higher Employee Engagement and Lower Burnout. *BMJ Qual Saf* **2018**, *27*, 261–270, doi:10.1136/bmjqs-2016-006399.
42. Wieke Noviyanti, L.; Ahsan, A.; Sudartya, T.S. Exploring the Relationship between Nurses' Communication Satisfaction and Patient Safety Culture. *Journal of Public Health Research* **2021**, *10*, jphr.2021.2225, doi:10.4081/jphr.2021.2225.
43. Park, K.-O.; Park, S.-H.; Yu, M. Physicians' Experience of Communication with Nurses Related to Patient Safety: A Phenomenological Study Using the Colaizzi Method. *Asian Nursing Research* **2018**, *12*, 166–174, doi:10.1016/j.anr.2018.06.002.

Disclaimer/Publisher's Note: The statements, opinions and data contained in all publications are solely those of the individual author(s) and contributor(s) and not of MDPI and/or the editor(s). MDPI and/or the editor(s) disclaim responsibility for any injury to people or property resulting from any ideas, methods, instructions or products referred to in the content.