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Authentic Leadership and Organizational Identification: Its Relation to Organizational Silence and Cynicism among staff nurses

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Abstract:

Background: Authentic leadership, as the key component of productive leadership, which is necessary to create healthier workplace. These actions are concordant with innately held nursing values to demonstrate trust and independence, reflecting staff identification with their organization and diminishing negative behaviors such as silence and cynicism for organizational efficiency. **The study aimed** to assess authentic leadership and organizational identification and its relation to organizational silence and cynicism among staff nurses. **Research design:** A descriptive correlational design was used. **Setting:** All the Critical Care units of Benha University Hospital were used for conducting the study. **Subjects:** A simple random sample of (275) staff nurses who met the criteria for inclusion. **Tools:** There four tools were used for data collection 1) Authentic Leadership Questionnaire (ALQ), 2) Organizational Identification Questionnaire (QIQ), 3) Organizational Silence Scale & 4) Organizational Cynicism Scale (OCS). **Results:** The majority (90.6% and 73.5%) of staff nurses reported high perceived authenticity levels and organizational identification levels were high respectively, while about two-thirds and the majority (62.9% and 82.6%) of them had low levels respectively for organizational silence and cynicism at the studied setting. **Conclusion:** There was a highly positive statistically significant correlation between (authentic leadership and organizational identification), also, between (organizational silence and cynicism) among staff nurses at (P value < 0.01). There was a highly negative statistically significant correlation among authentic leadership, organizational identification, organizational silence and cynicism. **Recommendation:** strengthen their competitive edge by attracting and retaining leaders who act on their own to complete their tasks and assist other staff. Adopt an open-door policy to overcome work problems.

Keywords: Authentic Leadership, Organizational Identification, Organizational Silence & Organizational Cynicism.

Introduction

Organizations have greater expectations of their staff, and staff has greater expectations of their organizations. First-line managers must show trust and independence to nurses in order to fulfill these expectations that are shared by organizations and personnel **(Bulinska-Stangrecka & Bagienska, 2021)**. The fundamental element of effective leadership required to create healthier work environments has been identified as authentic leadership. This is because these behaviors align with the core values of nursing and determine the organizational behaviors that staff nurses display and how they can positively or negatively influence the organization's success **(Tuna, Bacaksz & Seren, 2019)**.

Authentic leadership has been characterized as a paradigm of leadership behavior to promote better self-awareness, an internalized moral perspective, and balanced information processing. The central elements of authentic leadership are self-aware, relational transparency, a balanced approach to information processing, and moral/ethical ideals **(Yadav & Dixit, 2017)**. Self-awareness is the state of understanding and accepting one's intentions, feelings, desires, and other facts. Relational transparency refers to being authentic in relationships and entails information sharing by leaders. Gathering and analyzing all information about oneself involves balanced processing, whether the information is positive or bad **(George, 2016)**.

Authentic leadership is a calling to use one's position of privilege to assist and serve others. An individual is highly aware of their principles and ideas, as well as in what manner they perform and are viewed by others, which is what an authentic leader means. Since they cannot make choices for the nurses, they are more concerned with enhancing their skills and giving them more freedom to do their duties **(Baron & Parent, 2015)**.

Authentic leadership is required to increase nurses' ability to express their concerns and help them plan strategies. Therefore, authentic leadership positions impact the nursing workforce, profession, healthcare delivery system, and community **(Labrague et al., 2018)**. This behavioral pattern could help nurses

maintain their identity and make it simpler to share their principles, values, and ethics **(Yeboah-Appiagyei et al., 2018)**.

As a result, organizational identification is a metaphor for how organizational staff view, feel, and think about their organization. One of the crucial requirements for the organization's effectiveness is organizational identification (OID) **(Eger, 2021)**. Organizational identification (OID) is the outcome of social construction processes in which nursing staff define themselves regarding their organizational membership. Staff identification with their organization reflects value congruence with the organization and communication **(Myers et al., 2016).** Organizational identification is a broad aspect that refers to the uniformity between an organization's staff members' behaviors, ideas, and affiliation with that organization. In addition, an organization partner may feel an unreasonable reliance on and a contractual obligation to that organization **(Li et al., 2021)**.

Three interrelated trends, loyalty, resemblance, and membership, combine to generate the idea of organizational identification. Individuals' commitment to the organization, support, and favorable attitudes toward its goals and tasks exemplify loyalty. The ability to convey shared traits between oneself and one's organization and to understand and accept the organizational ideals and culture is referred to as similarity. Membership symbolizes an individual's emotional connection to a group; they view the group as their home, treasure any emotional ties they have formed, and are extremely proud of their membership. **(Miller et al., 2000; Haslam, 2014 & Callea et al., 2016).**

Organizational identification has importance pouring at the end into the organization's interest to achieve its goals efficiently and effectively and into the staff interest himself as it develops the spirit of belonging, loyalty, and sincerity in the staff. Consequently, it develops creativity, innovation, and cooperation **(Toivanen, 2021)**.

The more staff identify with their organization, the more their values, goals, and norms are included in the staff self-concept. When organizations are unfair to their staff, the staff gets the impression that the organization does not value or care about their loyalty and retention, which could lead to silence and cynicism **(He et al., 2015 & Finch et al., 2018).**

In management literature, employee silence is a synonym for organizational silence. When employees purposefully keep their concerns and suggestions regarding organizational issues to themselves rather than communicating them to the management, this is known as organizational silence **(Labrague & Santos, 2020)**. Silence has a devastating effect on healthcare organizations because it reduces their capacity for change and decision-making, eliminates the mitigating effect of feedback, and impairs their ability to recognize and correct mistakes and undesirable consequences **(Çaylak & Altuntas, 2017)**.

There are five components of organizational silence (**Brinsfield, 2009)**. Firstly, top management support may significantly contribute to a climate of silence; the administration may label staff discussing labor disputes as troublemakers. Secondly, there is a lack of communication opportunities; the involvement and appearance of ideas on workplace issues increase as connection chances inside the business increase. Thirdly, when working under a powerful supervisor, the ability to voice opposing views may be constrained due to the supervisor's encouragement for silence (**Alheet, 2019)**.

Fourth, heads typically keep quiet because they suppose that their ideas are insignificant and that their position is what gives them official authority. Fifth, personnel may fear discussing workplace issues out of fear of losing their jobs due to their superiors' fear of bad reactions. Organizational silence is generally bad for staff and organizations because it causes stress, dissatisfaction, and cynicism (**Creese et al., 2021)**.

Being cynical means having a negative outlook on other people. Cynical nursing personnel can impact the entire business and prevent it from achieving its objectives. Cynical employees think their coworkers are self-centered and selfish **(Karadag, 2014).**

Organizational cynicism refers to a staff nurse's behavior in response to challenging circumstances at work. Additionally, it is an attitude of resentment toward the organization because of management's lack of honesty, justice, and transparency, which results in aloofness, dissatisfaction, lack of confidence, misery, rage, and distrust of parties, societies, or human beings **(Ozgur, 2017)**.

The basic components of organizational cynicism are: Cognitive, affective, and behavioral. Cognitively illustrates the organization's lack of justice, sincerity, and honesty. Cognitive cynicism is possible when nurses believe their company does not value their efforts or care about each of them. Nurses who experience cognitive cynicism believe morality is frequently abandoned in favor of convenience **(Dean & Singh, 2018).**

The term "affective cynicism" describes sentimental and emotional responses toward an organization and includes psychological responses like an annoyance, tension, anxiety, and discomfort. Arrogance often goes hand in hand with affective cynicism because cynical nurses think they possess exceptional knowledge and a superior understanding of the world. Criticism and pessimism are often used in organizations and are referred to as "behavioral cynicism." Cynical nurses often act mockingly and sarcastically, criticizing their employer

publicly **(Rehan et al., 2017 & Erarslan et al., 2018**).

Commonly, distrusting others and their organization signifies organizational cynicism. A nurse cynic has a prejudicial mistrust of the goodness and sincerity of nurses' intentions and actions; this non an inherent character feature; instead, it is brought on by situations like mistrust of superiors, unfavorable working conditions like long hours, and excessive workload, role conflicts at work, inequality, and poor leadership **(Mohamed et al., 2022)**.

Significance of the Study

Healthcare professionals should be permitted to share their ideas and thoughts in today's ever-changing and volatile world to promote better flexibility **(Creese et al., 2021)**. So, nursing research has paid attention to the use of different strategies for nurses, such as organizational identification and effective leadership styles as authentic leadership because it has human-centered standards as its foundation, which are essential to nursing, that inspire positive behaviors that significantly influence the nurse's performance **(Alilyyani, Wong and Cummings, 2018; Cummings et al., 2018; Gerpott, Van Quaquebeke, Schlamp & Voelpel, 2019).** Because nurses who exhibit negative behaviors in organizations related to their identity and leadership style lead to silence and cynicism, which directly inhibit the improvement of organizational efficiency **(Helvaci & Kiliçoğlu, 2018)**. Organizational silence and cynicism threaten organizational norms and welfare. Also, causes the loss of trained and skilled nurses, resulting in decreased healthcare organization productivity **(Labrague & Santos, 2020)**.

Aim of the study

The current research aimed to assess authentic leadership and organizational identification and its relation to organizational silence and cynicism among staff nurses.

Research Questions

1. What is the perceived level of authentic leadership as reported by the studied staff nurses?
2. What is the organizational identification level from staff nurses' perspectives?
3. What is the organizational silence level as reported by the studied staff nurses?
4. What is the organizational cynicism exposure level as reported by the studied staff nurses?
5. Is there a relation among authentic leadership, organizational identification, organizational silence and cynicism?

Subjects and Method

Research design: A descriptive correlational design was utilized to achieve the current study aim.

Setting: The study was executed in all Critical Care Units at Benha University Hospital, Qaluobyia Governorate, Egypt. It offers free and financial services with various ambulant care facilities.

Subjects:

Subject Size

A simple random sample of (**275** staff nurses) out from (total population 475) who had "at least a year of experience in the previously indicated context, willing to participate, and were available at the time of data collection" was included in the study.

Using the **Epi Info** statistical software, version 4 (CDC Manufacture, USA), the sample size was estimated with a power of 80% and a value of 2.5 as the permissible limit of accuracy (D) at a 95% confidence level with an expected prevalence of 10. Thus, (**275** staff nurses) were included as study participants from total population (475 staff nurses).

Tools of data collection

A self-administered questionnaire with five sections was used to gather the data. They are as follows:

Section (1): The personal data of staff nurses: It was developed by the researchers and included (code, age, gender, marital status, educational qualification levels, work shift, and experience years).

Section (2): Authentic Leadership Questionnaire (ALQ):

It was developed by **Walumbwa et al. (2008)**, and modified by the researchers to the perceived level of authentic leadership as reported by staff nurses. It consisted of (16 items) categorized into four dimensions: Self-awareness "4 items", relational transparency "4 items", balanced processing of information "3 items", and moral/ ethical values "5 items".

Scoring System: Responses were valued by using a 5-point Likert scale, ranging from strongly disagree to strongly agree (1-5), which transformed into 3- points for presentation; staff nurses' response for each item was scored as follows; "agree" (3), "neutral which denotation cannot reply or resolute" (2), and "disagree" (1). The total score for each dimension, which ranged from 16 to 48 percent, was calculated. The threshold was set at 60% = 29. Accordingly, the level of perceived authenticity of the leader was classified as "High level" if the percent was greater than 75%, which equals 36:48 points, "Moderate level" if it was between 60% and less than 75%, which equals 29:35 points, and "Low level" if it was below 60%, which equals 16:28 points.

Section (3): Organizational Identification Questionnaire (QIQ):

It was developed by researchers based on **(Cheney, 1983; Cheney and Tompkins, 1987; Barge and Schlueter, 1988 and Mael and Ashforth, 1992)** to evaluate organizational identification levels from staff nurses' perspectives. It involved (12 items) grouped under three domains which are: Loyalty "6 items", similarity "3 items", and membership "3 items".

Scoring System: The rate of points in each item was on a 3-points Likert scale ranging from agreeing to disagreeing (3-1). The score of each domain was summed up and converted to percent and ranged from 12 to 36, and the cutoff point was made at 60% = 22.

The level of organizational identification is categorized into the following:

- High-level "if the percent ≥ 75%" ranged from 27 to 36 points.
- The moderate level, "from 60% to less than 75%," ranged from 22 to 26 points.
- Low level "< 60 %", those ranged from 12 to 21 points.

Section (4): Organizational Silence Scale:

It was adapted from **Schechtman (2008) & Brinsfield (2009),** to assess the level of organizational silence from staff nurses' perspectives. It comprised (27 items) which were disseminated as five dimensions: support of the top management for silence (5 items), lack of communication opportunities (6 items), support of supervisor for silence (5 items), official authority (5 items) and subordinate's fear of negative reactions (6 items).

Scoring System: The subject's answer was measured on a 5-point Likert scale for each statement, ranging from (1) "very ineffective," (2) "ineffective," (3) "neither effective nor ineffective," (4) "effective," and (5) "very effective," which converted into 3- points as follow; "effective" (3), "neutral which meaning neither effective nor ineffective" (2) and "ineffective" (1). The score ranged from 27 to 81; the cutoff point was 60% = 49.

The level of organizational silence is categorized into the following:

- High level "if the percent ≥ 75%" ranged from 61 to 81 points.
- The moderate level, "from 60% to less than 75%" ranged from 49 to 60 points.
- Low level "< 60 %", those ranged from 27 to 48 points.

Section (5): Organizational Cynicism Scale (OCS):

It was developed by **Brandes, Dharwadkar & Dean (1999)** to measure the level of exposure to organizational cynicism as reported by staff. It consisted of (13 items) within three subscales: cognitive (5 items), affective (4 items), and behavioral (4 items).

Scoring System: The response for each item was on a 5-points Likert type scale ranging from completely disagree to completely agree (1-5), which is converted into 3- points as follows; Agree (3), Neutral (2), and Disagree (1). The overall score ranged from 13 to 39, and the cutoff point was made at 60% = 24.

The level of organizational cynicism is categorized into the following:

- High-level "if the percent ≥ 75%" ranged from 29 to 39 points.
- Moderate level "from > 60% to less than 75%", that ranged from 24 to 28 points.
- Low level "< 60 %", those ranged from 13 to 23 points.

Data Collection Procedure

Administrative Approval

The Director of Benha University Hospital was given formal permission by the Dean of the Nursing Faculty at Benha University to obtain the official authorization for data gathering to carry out the present study. The hospital administration will be sent a copy of the study's findings and recommendations for consideration. The hospital administration will get the study findings and recommendations for potential implementation.

Operational design

The operational design included the preparatory phase, the pilot study, and the fieldwork starting in November 2021 and ending in April 2022.

Preparatory phase

The preparatory phase started from November 2021 January 2022, covering three months and including the following: Examining the most recent national and worldwide related literature using journals, publications, periodicals, textbooks, the internet and theoretical understanding of the different components relating to the study's subject. The content of the tools was created, translated into Arabic and evaluated for face and content validity and reliability.

Ethical Consideration

Before conducting the study, informal approval was obtained from the whole study subjects. Meetings between the researchers and the staff nurses were held to clarify the nature and goal of the study, that participation is entirely voluntary, that they can leave the study at any moment without incurring any consequences, and that there will be no negative impacts from the study procedures on participants. Workflow won't be hampered, and patient care won't be in jeopardy. The questionnaire sheets were coded to ensure complete anonymity and confidentiality of the data gathered. The length of data collection was set with their agreement, considering their perspectives and workload.

Tool Validity and Reliability

The tools' contents were created, evaluated for content validity, and presented to a panel of five nursing administration professionals from various faculties. The tools' validity was intended to be evaluated for language clarity, comprehensiveness, relevance, simplicity, and accuracy through reviewing and testing the content validity. Jury comments were also obtained on the tools' format, layout, components, and scoring system. Minor changes were made to several things following their suggestions, and the researchers created the tools' final validated form.

Face Validity

Jury opinions were elicited regarding the tools' format, layout, and clarity of parts.

Content Validity

The content was conducted to determine the appropriateness of each item in the questionnaire sheet. Minor modifications were done based on the jury's recommendations.

Reliability

The study tools were tested for reliability by measuring the internal consistency of items using Cronbach's Alpha Coefficient Test. The tools were proved reliable, where Cronbach's Alphas were (α= 0.80, 0.86, 0.90 & 0.92) for Authentic Leadership, Organizational Identification, Organizational Silence, and Organizational Cynicism, respectively, which reflect accepted internal consistency of the tools done during January 2022.

Pilot Study

In February 2022, before collecting data, the revised questionnaires were piloted by the researcher with (10%) of the total subjects (27 staff nurses) to test the clarity, relevance, and applicability of the study questionnaires to determine obstacles that may be encountered during data collection and to evaluate the feasibility and effectiveness of the proposed tools to be easily understood through the final version which proposed for distributing to the staff nurses. In addition, to estimate the time needed to fill questionnaire sheets. No modifications were made, and nursing staff included in the pilot study were included in the main study subjects.

Fieldwork

The actual data collection took about two months, started from the beginning of March 2022 to the end of April 2022; before beginning to collect data from the study subjects, the researchers met with the nursing director of the hospital to determine a suitable time to collect the data and confirm the days and times. The researchers collected data from staff nurses before and between their work hours according to their availability three days per week (Saturday, Monday and Wednesday) from 9.00 AM. to 2.00 PM. (Morning Shifts).

The average number of filled sheets was between (11 to 12 sheets). The time required to fill the questionnaire sheets ranged from 25:30 minutes. The filled forms were collected in time and revised to check their completeness to avoid any missing data. Finally, the researchers thanked the participants for their cooperation.

Data collection:

The study participants were approached through self-administered questionnaires during their work shifts at break time. The researchers provided the needed instructions before the distribution of the questionnaire. Then questionnaires were completed in the presence of the researchers to ensure the objectivity of staff nurses' responses and check that all items were answered.

Statistical analysis:

The collected data were verified before computerized entry using the Statistical Package for Social Sciences (SPSS version 32.0 Inc. Chicago, IL, USA) for that purpose, followed by data analysis and tabulation. Data were presented using descriptive statistics in the form of frequencies and percentages for describing personal characteristics. Arithmetic mean and standard deviation (SD) were used as central tendency and dispersion measures for quantifying the study's variables. Pearson correlation coefficients (r) analysis was used to test the nature of the relationship between the study variables. A significant level value was considered $p \leq 0.05$, and a highly significant level value was considered $p \leq 0.001$.

Results

Table (1): Distribution of staff nurses according to their personal data (n=275)

Personal data	No.	%
Age (years)		
< 25	84	30.5
25: < 35	176	**64.0**
≥ 35	15	5.5
M±SD	**29.30±5.70 years**	
Gender		
Female	263	**95.6**
Male	12	4.4
Marital status		
Single	41	14.9
Married	229	**83.3**
Others	5	1.8
Educational qualification		
Nursing diploma	26	9.5
Associated degree of nursing	35	12.7
Bachelor of nursing science	198	**72.0**
Others	16	5.8
Years of experience in working units		
< 5	54	19.6
5: <15 years	126	**45.8**
≥ 15	95	34.5
M±SD	**11.55±4.89 years**	
Working shift		
Morning (6 Hours)	27	9.8
Night/ day (12 hours)	6	2.2
Rotating (Morning, Evening, Night)	242	**88.0**

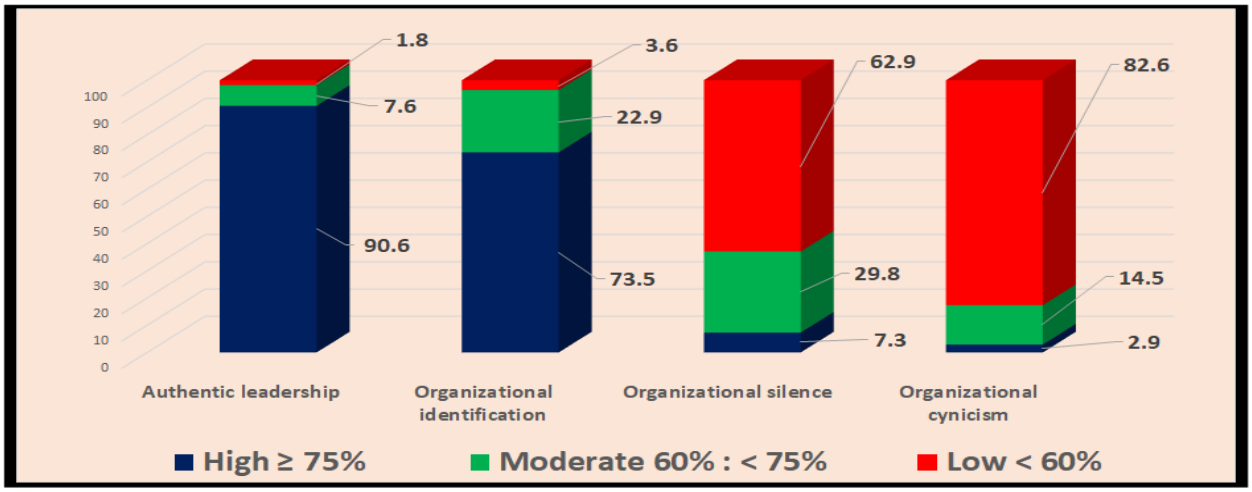

Figure (1): Total levels of authentic leadership, organizational identification, silence and cynicism as perceived by staff nurses

Table (2): Total mean scores of authentic leadership, organizational identification, silence and cynicism from staff nurses' viewpoints (n=275)

Variables	Maximum Score	Range	Mean±SD	Mean%
Total authentic leadership	**48**	**18**	**42.93±3.43**	
Self-awareness	12	6	10.42±1.58	86.8
Relational transparency	12	6	11.29±1.20	94.1
Balanced processing of information	9	6	7.89±1.22	87.7
Moral/ ethical values	15	5	13.33±1.44	88.9
Total organizational identification	**36**	**18**	**27.39±3.16**	
Loyalty	18	10	13.92±2.09	77.3
Similarity	9	5	6.38±1.45	70.9
Membership	9	5	7.58±1.21	84.2
Total organizational silence	**81**	**30**	**46.47±6.33**	
Support of the top management for silence	15	6	8.32±1.31	**55.5**
lack of communication opportunities	18	8	11.59±1.56	**64.4**
Support of supervisor for silence	15	8	7.51±1.87	**50.1**
Official authority	15	5	9.01±1.22	**60.1**
Subordinate's fear of negative reactions	18	5	10.04±1.50	**55.8**
Total organizational cynicism	**39**	**20**	**24.15±2.56**	
Cognitive	15	10	10.20±2.56	**68.0**
Affective	12	8	7.58±2.30	**63.2**
Behavioral	12	8	6.37±1.73	**53.1**

Table (3): Correlation matrix between authentic leadership, organizational identification, silence and cynicism among staff nurses (n=275)

Variables		Total authentic leadership	Total organizational identification	Total organizational silence	Total organization cynicism
Total authentic leadership	**r**	**1**	**.281****	**-.383****	**-.616****
	P value	**--**	**.000**	**.000**	**.000**
Total organizational identification	**r**	**.281****	**1**	**-.173****	**-.169****
	P value	**.000**	**--**	**.004**	**.005**
Total organizational silence	**r**	**-.383****	**-.173****	**1**	**.231****
	P value	**.000**	**.004**	**--**	**.000**
Total organization cynicism	**r**	**-.616****	**-.169****	**.231****	**1**
	P value	**.000**	**.005**	**.000**	**--**

***highly significant at P<0.01* *r: Pearson coefficient*

Table (1): Represented that the mean age of staff nurses was (29.30±5.70), about two-thirds (64.0%) of them were aged between 25 to less than 35 years, and the highest percentage of them (95.6% and 83.3%) were female and married, respectively. Regarding educational qualification, nearly three quarters (72.0%) of staff nurses had a Bachelor of nursing science. For years of experience in working units, their total mean was (11.55±4.89), and 45.8% of them had 5 to less than10 years of experience. Regarding working shifts, the highest percentage of staff nurses (88.0%) were working rotating shifts in the study setting.

Figure (1): It is evident from that the majority (90.6% and 73.5%) of staff nurses reported that the authentic leadership and organizational identification levels were high, respectively, while about two-thirds and the majority (62.9 % and 82.6%) of them had low levels respectively for organizational silence and cynicism at the studied setting.

Table (2): Explained that the total mean score of authentic leadership among staff nurses was 42.93±3.43, the highest mean authentic leadership dimension was related to relational transparency, 11.29±1.20, while the lowest mean score was 10.42±1.58 related to self-awareness. As for organizational identification, the total mean score was 27.39±3.16, and the highest mean score was 7.58±1.21, related to the membership domain.

Otherwise, the lowest mean score was 6.38±1.45 related to the similarity domain. Also, for organizational silence, the total mean score was 46.47±6.33, and the highest

mean score was 11.59±1.56, related to the lack of communication opportunities dimension, while the lowest mean score was 7.51±1.87 related to the support of the supervisor for silence dimension. As for organizational cynicism, the total mean score was 24.15±2.56, and the highest mean score was 10.20±2.56 related to the cognitive subscale; otherwise, the lowest mean score was 6.37±1.73 related to the behavioral subscale.

Table (3): Illustrated that there was a highly positive statistically significant correlation between authentic leadership and organizational identification and between organizational silence and cynicism among staff nurses at p-value <.01. While there was a highly negative statistically significant correlation among authentic leadership, organizational identification, organizational silence and cynicism. There were means when authentic leadership and organizational identification increased; there was a simultaneous decrease in organizational silence and cynicism.

Discussion:

Nurses are very important human recourses for any health organization, especially for gaining a competitive advantage worldwide. They are considered a strategic asset of every healthcare organization. Nurses' emotions can affect organizational effectiveness and efficiency **(Munyon et al., 2021)**. Nurses who do not perceive enough organizational identification may also exhibit negative emotions against overall healthcare organizations, such as organizational cynicism and organizational silence, which is a consequence of the nurses' believability that organizations lack authenticity **(Aly et al., 2016)**.

Thus, the standing study sought to shed insight on the authentic leadership and organizational identification and its relation to organizational silence and cynicism among nurses, as well as the correlations and regressions between them.

Authentic leadership is an essential and highly promising leadership perception **(Munyon et al., 2021)**. Authentic leadership can produce excellent leaders who realize their true selves, strengths, and weaknesses, show their real emotions and enthuses followers to focus on ending their tasks and inspire to engage in the organization's accomplishments. Authentic leadership skills positively affect and form positive working relationships between leaders and followers and enforce trust in the workplace to recognize and express their true selves and feelings toward others which improve work effectiveness **(Wei, 2016 and Hsieh & Wang, 2015).**

The present study demonstrated that, there is high perceived authenticity of the leader among the staff nurses, and the highest mean score of authentic leadership dimensions was connected to relational transparency, while the lowest mean score was related to self-awareness. Similar to the study of **Al-Romeedy & Ozbek (2022)**, they emphasized the high level of acceptance of authentic leadership style among travel agents in Egypt and Turkey.

A study handled by **Safwat, Maher & Abo-Elgheit (2022)**, they provided a clearer understanding may be learned, they reported that, in their study, which aimed at evaluating the impact of adopting authentic leadership in Egyptian travel agencies on work engagement among employees in these companies, it was found that, there is a high level of adopting authentic leadership within travel agencies. In light of this respect, **Munyon et al. (2021)** displayed a bound relationship between authentic leadership and important organizational and follower outcomes.

Regarding organizational identification which is a psychological condition in which individuals perceive they are a fragment of a greater whole **(Steffens et al., 2021).** It denotes the way the individual and organization goals are mutually attained, creating a more unified and integrated structure **(Cornwell et al., 2018 & Besharov, 2014).** It arises when persons' organizational beliefs become self-expressive or self-defining, or when they assimilate those organizational ideas with their own identities **(Chen et al., 2019).** Individuals psychologically practice a sense of participation with their organization through organizational identification **(Atalay, Aydemir and Acuner, 2022 & Cornwell et al., 2018).**

The present study demonstrated a high perceived organizational identification among the staff nurses. Also, as for organizational identification, the highest mean score was associated to the membership domain; otherwise, the lowest mean score was interrelated to the similarity domain. In this respect, the study result of health employees accomplished by **Terzioglu et al. (2016) & Santas et al. (2016)** established that, the organizational identification level was moderate among the studied subjects.

Concerning the association between authentic leadership and organizational identification, our study proved a highly positive, statistically significant correlation between authentic leadership and organizational identification. The reason may be that authentic leadership behavior with the followers in the workplace will inspire organizational identification inside the staff and result in a positive effect on the organization.

This result coincided with **Valsania et al. (2016)**, in prior works that authentic leadership behaviors are positively associated with members' organizational identification. This finding intervenes with a study established with Turkish companies, **Çeri-Booms (2012),** who stated that organizational identification

among followers is fostered as a result of the trust that leaders create and a characteristic authentic leadership.

These results support the original model based on the argument of the authentic leadership model **(Luthans; Avolio, 2003 & Avolio et al., 2004),** which proposed that, organizational identification is a fundamental method by which authentic leaders raise follower self-efficacy, commitment, and performance. Several studies have presented that leader characteristics such as openness and integrity, typical traits of authentic leadership, are positively associated with the organizational identification of the followers (**De Cremer et al., 2008; Sluss & Ashforth et al., 2008)**. Other fundamental traits of authentic leadership include ethical behaviors which have been found to positively predict followers' organizational identification (**Walumbwa et al., 2011)**.

According to **Al-Hamdan & Bani Issa (2021),** stated that nursing is is the cornerstone and backbone of the healthcare field and it is an essential career for the health and well-being of all populations. The majority of healthcare providers are nurses, and the effective management of healthcare systems depends heavily on their professional competences **(Said & Chiang, 2020)**. In order for nurses to provide more efficient and competent services within the healthcare system, it is crucial for healthcare facilities to prevent or diminish negative problematic conditions such as organizational silence and cynicism **(Sungur et al., 2019)**.

Concerning organizational silence it highlights how unable staff member to voice their ideas and refrain from bringing up difficulties and problems at work. On the other side, organizational silence may be a sign of a lack of experience, as well as stress and dread of others' reactions **(Alheet, 2019)**. Moreover, Organizational silence is the behavioral decision that has the power to either promote or diminish the performance **(Beheshtifar et al., 2012),** which refers to the intentional blocking of knowledge, inquiries, suggestions, and judgments of situations or work that are relevant to employment **(Deniz et al., 2013)**.

The existing study proved low perceived organizational silence among the nurses. This outcome may be attributed to nurses' use of silence, in which they choose not to voice their opinions about the existing condition or difficult at hand in order to avoid punishment. Furthermore, the "Lack of communication opportunities dimension" had the greatest mean score, while the "Support of supervisor for silence dimension." had the lowest mean score.

There was moderate organizational silence among Chinese nurses, according to a study conducted by **Yang, Yang & Wang (2022),** which provided a deeper understanding of the situation.

This outcome is supported by a study by **Doo & Kim (2020)**, who confirmed that, there was an average score of organizational silence, but found that it was lower than that of nurses working in a Turkish national university hospital, supports this conclusion. According to prior studies conducted in private hospitals in South Korean studies **Elçi et al. (2014),** and public hospitals in Istanbul **Harmanci-Seren et al. (2018),** which showed that nurses in public hospitals in two Turkish studies had a greater tendency toward organizational silence than those in private hospitals, this finding confirmed in expressions of the type of hospital establishment **(Kılınç & Ulusoy, 2014).**

De los Santos et al. (2020), found the opposite results, showed that, there organizational silence scores were higher among nurses with less than ten years of experience in the nursing field and were employed in rural hospitals. They came to the conclusion that few individual and organizational factors predicted organizational silence.

This result is similar to that of **Harmanci Seren et al. (2018),** who discovered that young nurses opted to remain silent out of concern for endangering their professional relationships and job security. Also, in the same contrast, **Elhanafy & Ebrahim (2022),** reported that one of the major issues facing healthcare professionals is organizational silence, which inhibits staff members from openly sharing their ideas and concerns about the organization's issues. **Bayn (2015)** made a similar discovery when discovered that; the majority of the studied nurses had organizational silence. Additionally, more than three-quarters of the nurses experienced organizational silence, according to **Yurdakul et al. (2016)**.

Organizational cynicism refers to an employee's behavioral response to unfavorable conditions in the workplace and a sensation of dissatisfaction with the party **(Helvaci & Kiliçoglu, 2018)**. Organizational cynicism negatively affects nurses and the overall healthcare facility **(Karadag et al., 2014)**.

The present study demonstrated a low perceived organizational cynicism level among the studied staff nurses. The highest mean score was connected to cognitive cynicism; otherwise, the lowest mean score was related to behavioral cynicism. This result may be due to the organizational practices slightly lacking justice, honesty, and sincerity among staff members and tiny embarrassing, humiliating attitudes.

Moreover, the studied nurses suffer from intense workloads, the absence of orientation programs developed for new nurses at the hospital, and non-constructive feedback systems on their performance. Also, this result can be defensible by nurses' conviction that their hospital claims one way but speaks another. When employees consider their hospital intensely

negative mental predispositions, tension and annoyance overtake their ideas, decisions, and judgments.

The study of **Mahmoud & Shaheen (2022),** supports this finding they found that, the most of nurses perceived a low level of hospital cynicism at Tanta Main Hospital, compared to more than half of nurses at El-Mahalla General Hospital perceived a moderate level. Along in the same line, the study conducted by **Sungura (2019),** who explored those nurses' perceptions of organizational cynicism were low.

In addition, **El-liethiey & Atalla (2021),** who demonstrated that nurses were perceived to moderate organizational cynicism. Moreover, the highest mean percent score of organizational cynicism as perceived by the studied nurses was connected to cognitive cynicism. And the same result of a study by **Mohamed et al. (2022)** showed that, half of studied nurses had moderate organizational cynicism. Also**, Bacaksız et al. (2018),** explained that, the level of organizational cynicism of employees was moderate in a study conducted with hospital subordinates.

Conversely, this result is contradicted by **Archimi et al. (2018),** surprising that, the highest mean percent score of organizational cynicism as perceived by the examined employees was connected to behavioral cynicism, while the lowest mean percent score of organizational cynicism was connected to affective cynicism. According to **Aly et al. (2016),** the nurses in the study had higher levels of organizational cynicism and the scored higher on the affective (emotional) dimension than the behavioral and cognitive dimensions of organizational cynicism.

In addition, **Volpe et al. (2014),** found that, there were higher levels of cynicism among nurses. In symmetrical with **Kahar (2019),** who exemplified that, the perception of organizational cynicism is relatively higher among senior Staff employees. This study is also incompatible with Mahdy and **Elsayed-ElAraby (2021),** who explained that, slightly more than half of the studied nursing staff reported high organizational cynicism.

Regarding the association between the nurses' silence and cynicism, our study proved a highly positive, statistically significant correlation between organizational silence and cynicism among staff nurses. The reason may be due to high-stress levels caused by work overload, low salaries, stressful working environments, rotating shifts, long hours, and lack of flexibility in the work schedules, including weekends and vacations, and verbal communication abuse by patients' relatives. So, silence is considered intentional behavior, which can be liberated by appealing to cynical behavior.

In this respect, **Elhanafy & Ebrahim (2022),** discovered a significant association between the nurses' silence and cynicism in this regard. In the same vein **Aboramadan et al. (2021),** they stated that, employee silence was denoted to have a positive effect on behavioral cynicism, which suggested that employees with high levels of silence are more likely to adopt unfavorable attitudes and behaviors like cynicism.

Conclusion:

This study adds to the body of knowledge literature by concluding that, there was a highly positive statistically significant correlation between (authentic leadership and organizational identification), also, between (organizational silence and cynicism) among staff nurses at (P value < 0.01). Whereas there was a highly negative statistically significant correlation between authentic leadership, organizational identification, organizational silence and cynicism. This implies that when authentic leadership and organizational identification grow, the organizational silence and cynicism decline simultaneously.

Recommendations:

This study highlighted in the light of the results some commendations as follows:

Hospitals' administrators should:

- Strengthen their competitive edge by attracting and retaining leaders who act on their own to complete their tasks and assist other staff.
- Adopt an open-door policy to overcome work problems.
- Build an atmosphere of confidence, a culture of organizational identifications, loyalty, similarity, and membership among nurses by fostering, adopting the fair practices like operating in an environment of openness and honesty, stressing a conflict-free workplace, and encouraging a sense of justice among all employees.
- Improve the organizational reputation and competitiveness by considering an effective leadership style.
- Contribute more actively and significantly in preventing cynicism.
- Conduct effective communication and promote cooperation among all nursing staff, leaders, and management, to help decrease organizational silence and cynicism.
- Address the root causes of organizational silence and cynicism by finding suitable workable solutions.
- Conduct frequent meetings with staff nurses who have problems in their job to decrease organizational silence and cynicism and its negative effects threatening the overall health care organization and its efficiency and success.
- Formulate plans to overcome the organizational silence issue and tendency to display cynical behavior to raise their morale and performance.

- Build an effective internal discipline system and adopt a policy of punishing cynical people to protect staff nurses from the negative consequences of organizational cynicism.
- Conduct an in-service training program to help staff identify with their organization.
- Enable staff nurses to feel like a part of their organization and value and appreciate them.
- Conduct activities that increase the nurse's performance and give them encouragement, recognition, and enforcement.
- Create a motivating work climate and work environment to build a positive work experience.
- Recognize the importance of job satisfaction, intrinsic motivation, and rewards.
- Offer regular and fair performance appraisals.
- Entirely accept the necessity of a healthy workplace, honestly live it, and include others in achieving it.
- Provide an efficient training program on time and stress management to help reduce organizational cynicism and cope with stressful situations to improve staff nurses' performance.

Future Research:

- Replicate further studies in a wider context of diverse healthcare organizations on different populations and samples addressing the same study problem to examine the resultant authentic leadership measure.
- Conduct further studies to provide a comparative design between private and public hospitals and facilitate the generalization of the study findings.

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