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Psychopathological effects of Work Place Harassment

- Jose Luis Gonzalez-de-Rivera, MD, FRCP(C)[1],
Dept. of Psychiatry, Fundación Jimenez-Diaz, Universidad Autonoma de Madrid, Spain
- Manuel Rodriguez-Abuin, PhD
Institute of Psychotherapy and Psychosomatic Research, Madrid, Spain

ABSTRACT

194 subjects (72 males and 122 females) complaining of Work Place Harassment (WPH) were evaluated with the Spanish version of Derogatis´ 90 symptoms Check-List Revised (SCL 90 R). A group of 311 ambulatory psychiatric patients of similar demographic characteristics were used as a comparison group. The harassed workers had significant higher scores than the mixed psychiatric sample in the Total of Positive symptoms (PST): 59.42 vs. 52.79 ($p < 0.001$) and in the symptom dimensions of paranoid ideation (1.67 vs. 1.30, $p<0.0001$), obsession-compulsion (1.88 vs. 1.64, $p<0.01$), hostility (1.42 vs. 1.16, $p<0.01$) and depression (2.06 vs. 1.89 $p< 0.05$). Those with lower job status had higher General Symptom Index than those with medium-high job status (GSI= 1, 74 vs. 1, 44 $p<0.05$). Women had higher somatisation index than men (1, 74 vs. 1, 35, $p<0.01$). There were no significant differences related to civil status.

Mobbing. Adult Bullying. Work Place Harassment SCL90R LIPT60

[1] Adress for correspondence: Avenida de Filipinas, 52 – 28003 Madrid, Spain. psy@terra.es

Work place harassment is referred to as “adult bullying” in the U.K. and in the U.S.A. and as “mobbing” in the European mainland and in Canada. Although we will use both terms interchangeably, there is a fine distinction to be made: *Bullying*, the adult version of school harassment, implies the action of a *bully*, an agent more powerful than the victim, who may act alone or with willing accomplices. *Mobbing* is a collective activity, often sustained by peers and even inferiors. *Bossing* is a specific instance of bullying, in which the direct superior is the bully. *Institutional harassment* is a specific instance of mobbing, in which the whole of the organization gangs up or shuns upon a target. The former kind of harassment seems to be more prevalent in individualistic cultures, while the second is so in more socialistic countries. In any event, we recommend the use of the wider term Workplace Harassment (WPH) when no clear distinctions among nuances are made. The study and prevention of WPH has been declared a priority in the European Union, were it has been estimated to affect seriously at least 12 % of workers (1). Health-care workers seem to be at increased risk, and alarms have been sounded to further investigate the problem (2). According to a survey in a National Health Service community trust in England, 38% of employees report suffering one or more types of bullying in the previous year (3). Life time prevalence in the U.K. has been estimated as 50 % (4). Harassed workers show higher scores of depression, anxiety and stress than non-harassed workers (3), as well as irritability, increased arousal, sleep difficulties and nightmares, difficulty in concentration, work-related obsessions, phobic avoidance of the work place and job issues (5, 6, 7) and “focalised thought pressure” or need to talk about work difficulties even if the context is inappropriate (7).

An operational definition of mobbing has to exclude occasional instances of confrontation, conflict, hardship or rudeness, as well as the stress produced by demanding or difficult occupations. All of those situations may be causes of work stress in their own right, but are not bullying. In our studies, we define mobbing as a psychosocial disorder, developed by the abusive interaction of a bully and its victim, in an environment that tolerates or cooperates with this abuse. A given experience has to meet five criteria to be defined as mobbing: a) Unfair psychological pressure or mistreatment; b) persistent and repetitive c) without possibility of escape or defense d) that takes place in an unsympathetic environment, e) with the aim of eliminating the worker or destroying his/her health and abilities (8).

Method

We have applied the Spanish version of Derogatis´ SCL90R questionnaire (9) to 194 consecutive complainants registered by the Spanish Association against Psychological Harassment at the Workplace. All the subjects had been previously tested with the LIPT-60 (Spanish version of the Leymann Inventory of Psychological Terrorization – 60 items) (9) and interviewed by psychological trained officers of the Association, who excluded those who did not fit our operational definition. We compared the measurements obtained in the SCL90R with the normalised values found in the general population and in ambulatory psychiatric patients in Spain, described elsewhere (10). For statistical analysis we applied the SPSS-13 to perform the two-tailed Student test for two samples.

RESULTS

Of the 194 subjects, 72 were males and 122 females. The mean of age was 43 (SD = 10· 1), with a range from 18 to 67. As for the job status, we classified 91 as low-medium (clerical, blue collar, unqualified workers…) and 103 as medium-high (professionals, specialists, executives…). Marital status shows an excess of singles (95) over married subjects (80), the reverse of what is found in the general population of similar age. The number of divorced (13) and widows (6) are similar to the expected in the general population (table 1). The general scores and all the dimensions of psychopathology were significantly higher in the harassed workers than in the general population (table 2 and fig. 1). In addition, the scores for the dimensions of Paranoid Ideation, Hostility, Depression and Obsession-compulsion were significantly higher in the harassed workers than in the sample of ambulatory psychiatric patients (table 2 and fig. 2). Comparison by sex in the harassed workers sample show higher scores for somatisation in females (mean score 1.74 s.d. 0.97 vs mean score 1.35 s.d. 0.85 in males; $p<0.01$), with no significant differences in the remaining symptomatic dimensions (table 3, fig. 3). When compared by job level (see table 4, fig. 4), those with lower job status scored significantly higher in all general indexes of distress (GSI = 1.74 s.d. 0.75 vs 1.44 sd 0.74; PST= 63, s.d. 17.95 vs 56.41, s.d. 19.69; PSDI = 2.38, sd 0.61 vs 2.18, sd 0.6) and in the symptomatic dimensions of somatisation (1.86 sd 0.95 vs 1.37 sd 0.85), obsessionality (1.99 sd 0.92 vs 1.66, sd 0.91), anxiety (1.87 sd 0.93 vs 1.57 sd 0.9) and phobic anxiety (1.18 sd 0.92 vs 0.71 sd 0.93). There were no significant differences

related to marital status, albeit there is a definite trend to more psychopathology in widowed and separated workers.

DISCUSSION

Our findings confirm the widespread observation that mobbing, adult bullying or, as we prefer to term it, work place harassment, is related to the production of severe psychopathology. The characteristic symptoms profile clearly differentiates this population from the bulk of ambulatory psychiatric patients, mostly neurotics with mixed anxiety / depression symptoms. There is, however, a point of caution in the interpretation of our results: The high scores in paranoidism and hostility may reflect a previous tendency to misinterpret and to overreact to environmental cues. On the other hand, the structure of the psychometric instrument applied is such that whoever feels mistreated and persecuted will rate highly in paranoidism, regardless of the degree in which those feelings are grounded on reality. Longitudinal studies are needed to further elucidate the cause-effect relationship of this finding. The higher levels of psychopathology found in workers in lower status jobs is in agreement with the worse self-perceived health status and physical symptoms found by epidemiological studies in subjects in lower status jobs (11). The higher than expected presence of single subjects, compensated by the lower than expected presence of married subjects, in our sample needs further verification. The lack of significant differences in psychopathology related to marital status (table 5) may be due to the insufficient size of our sample to illustrate the effect of marital status. The definite trend to more psychopathology in widowed and separated workers makes sense in view of the current concepts on the protective effects of social support. Unfortunately, our sample is not big enough to discard that those differences are due to chance. We conclude that permanence in a hostile or persecutory environment in the workplace produces severe reactive psychopathology and facilitates the development of depression and a retaliatory attitude. Harassed workers show high scores in paranoid ideation, hostility, obsession-compulsion and depression. Job status shows inverse relation with severity of psychopathology.

Table 1. Marital status in the General Population and in Mobbing targets

	SINGLE	MARRIED
GENERAL POPUL		
Observed frequency	154	349
Expected frequency	184,7	318,3
MOBBING TARG		
Observed frequency	95	80
Expected frequency	64,3	110,7

Chi^2: = 31,2
Contingency coefficient = 0,77

Table 2. Dimensions of psychopathology in victims of WPH, normal population and ambulatory psychiatric patients.

	Harassed subjects at workplace (n= 194) Mean and sd	**Ambulatory Psychiatric norm (n= 303) Mean and sd**	**General population norm (n= 530) Mean and sd**
SOM	1, 60 (0,94)	1,53 (0,97)	0,56 (0,55)**
OBS	1,88 (0,93)	1,64 (0,99) **	0,60 (0,51)**
INT S	1,49 (0,85)	1,40 (0,96)	0,46 (0,44)**
DEP	2,06 (0,96)	1,88 (0,95)*	0,72 (0,55)**
ANX	1,73 (0,94)	1,61 (0,99)	0,51 (0,48)**
HOST	1,42 (1,07)	1,16 (1,01)**	0,46 (0,53)**
FOB	0,92 (0,96)	1,01 (1,02)	0,25 (0,37)**
PAR	1,67 (0,93)	1,30 (0,98)**	0,47(0,50)**
PSY	0,99(0,76)	1,02 (0,88)	0,22(0,30)**
GSI	1,59 (0,77)	1,47 (0,80)	0,51 (0,36)**
PST	59,43 (19,28)	52,79 (19,77)**	25,32 (14,30)**
PSDI	2,29 (0,61)	2,35 (0,65)	1,73 (0,48)**

* P<0·05
** P<0·01
(In relation to the sample of harassed subjects)

Table 3. Dimensions of psychopathology in victims of WPH by sex.

	MALES (n=72) Mean and sd	FEMALES (n=122) Mean and sd
SOM **	1,35 (0,85)	1,74 (0,97)
OBS	1,89 (0,92)	1,88 (0,93)
INT S	1,47 (0,87)	1,51 (0,84)
DEP	1,98 (0,98)	2,11 (0,95)
ANX	1,65 (0,93)	1,78 (0,94)
HOST	1,44 (1,12)	1,41 (1,04)
FOB	0,84 (1,04)	0,97 (0,91)
PAR	1,51 (0,91)	1,77(0,92)
PSY	0,97(0,83)	1 (0,71)
GSI	1,53 (0,77)	1,64 (0,78)
PST	59,12 (18,48)	59,60 (19,82)
PSDI	2,21 (0,63)	2,35 (0,59)

* P<0·05
** P<0·01

Table 4. Dimensions of psychopathology in mobbing victims by job level

	LOW-MEDIUM (n= 91) Mean and sd	MEDIUM-HIGH (n=103) Mean and sd
SOM **	1·86 (0·95)	1·37 (0·85)
OBS*	1·99 (0·92)	1·66 (0·91)
INT S	1·57 (1·42)	1·42 (0·81)
DEP	2·15 (0·91)	1·94 (1·01)
ANX*	1·87 (0·93)	1·57(0·90)
HOST	1·54 (1·06)	1·25 (1·01)
FOB**	1·18 (0·92)	0·71 (0·93)
PAR	1·79 (0·92)	1·61 (0·88)
PSY	1·1 (0·78)	0·88 (0·71)
GSI*	1·74 (0·75)	1·44 (0·74)
PST*	63 (17·95)	56·41 (19·69)
PSDI*	2·38 (0·61)	2·18 (0·60)

* P<0·05
** P<0·01

Table 5. Dimensions of Psychopathology in mobbing victims by marital status

	SINGLE (n= 95)	MARRIED (n=80)	DIVORCED (n=13)	WIDOW (n=6)
	Mean (sd)	-		
SOM	1,60 (0,90)	1,55 (0,98)	1,57 (0,81)	1,95 (1,24)
OBS	1,80 (0,90)	1,79 (0,92)	1,71 (1,01)	2,28 (1,37)
INT S	1,51 (0,84)	1,44 (0,83)	1,69 (0,65)	1,47 (0,86)
DEP	2,05 (0,94)	1,95 (0,96)	2,23 (0,94)	2,37 (1,67)
ANX	1,73 (0,87)	1,63 (1,02)	1,78 (0,81)	2,18 (1,08)
HOST	1,33 (0,95)	1,42 (1,07)	1,36 (1,28)	1,53 (1,88)
FOB	0,87 (0,81)	0,99 (1,14)	0,9 (0,79)	1,31 (1,18)
PAR	1,75 (0,94)	1,51 (0,88)	1,95 (0,58)	2,27 (0,72)
PSY	1,01 (0,77)	0,94 (0,72)	1,06 (0,91)	1,11 (0,77)
GSI	1,57 (0,74)	1,53 (0,79)	1,68 (0,66)	1,88 (1,04)
PST	59,59 (19,95)	59,10 (18,86)	61 (18,26)	55 (22,17)
PSDI	2,26 (0,56)	2,21 (0,64)	2,45 (0,70)	2,87 (0,64)

FIGURE 1

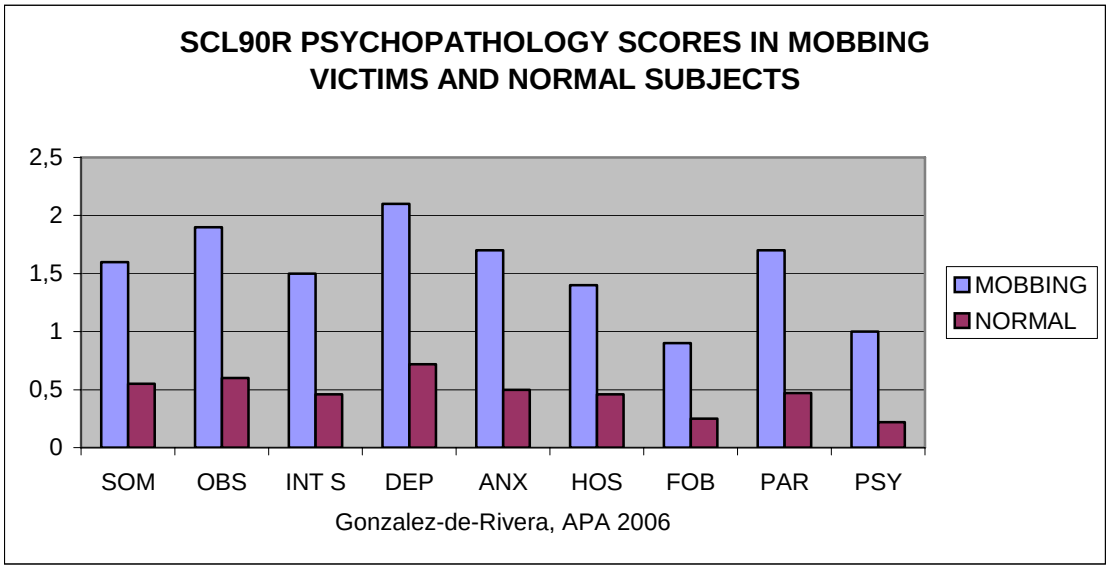


FIGURE 2

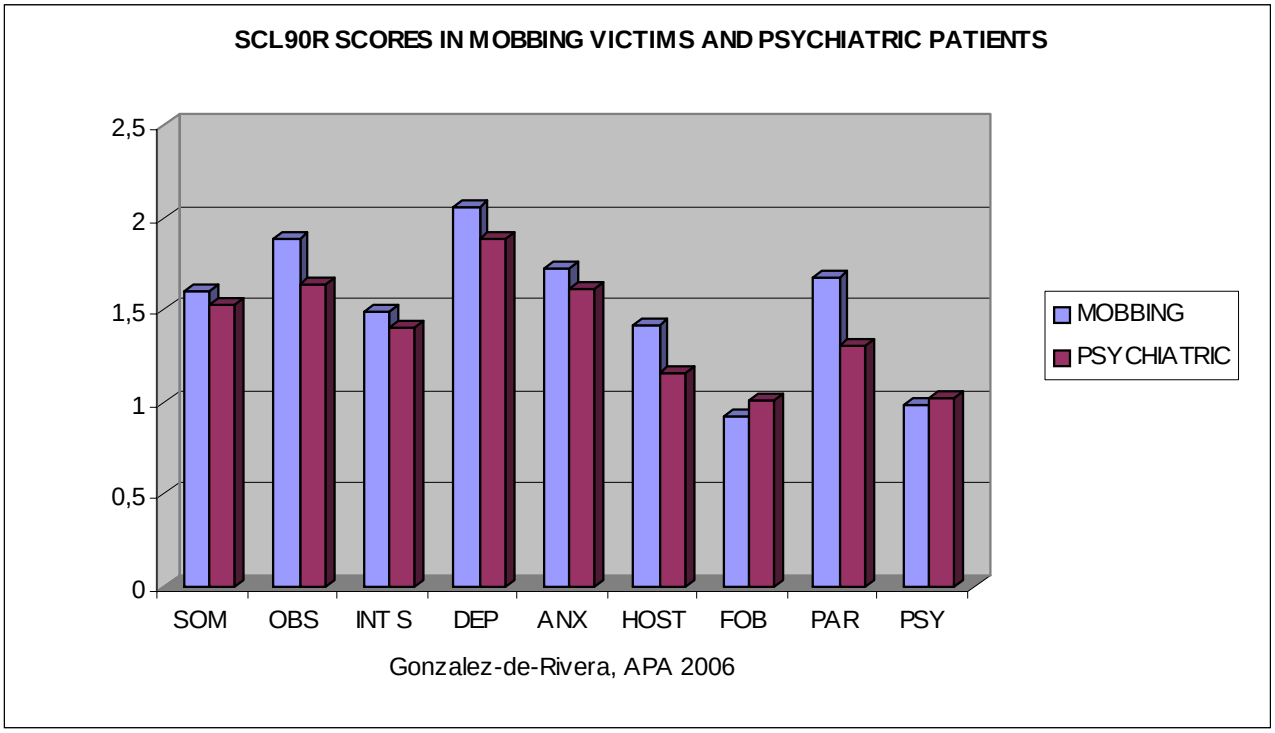


FIGURE 3

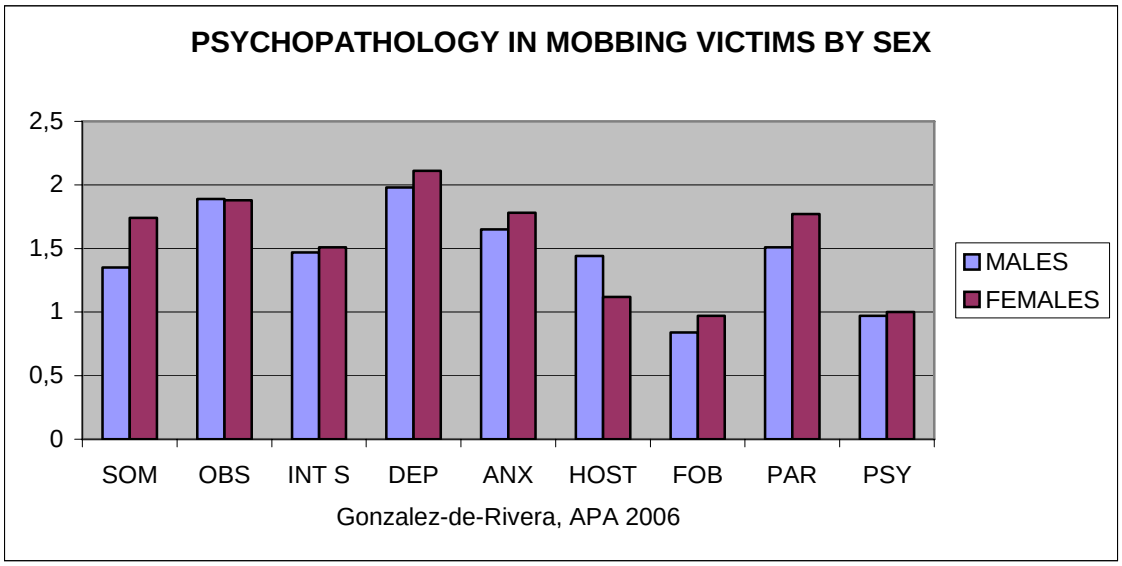
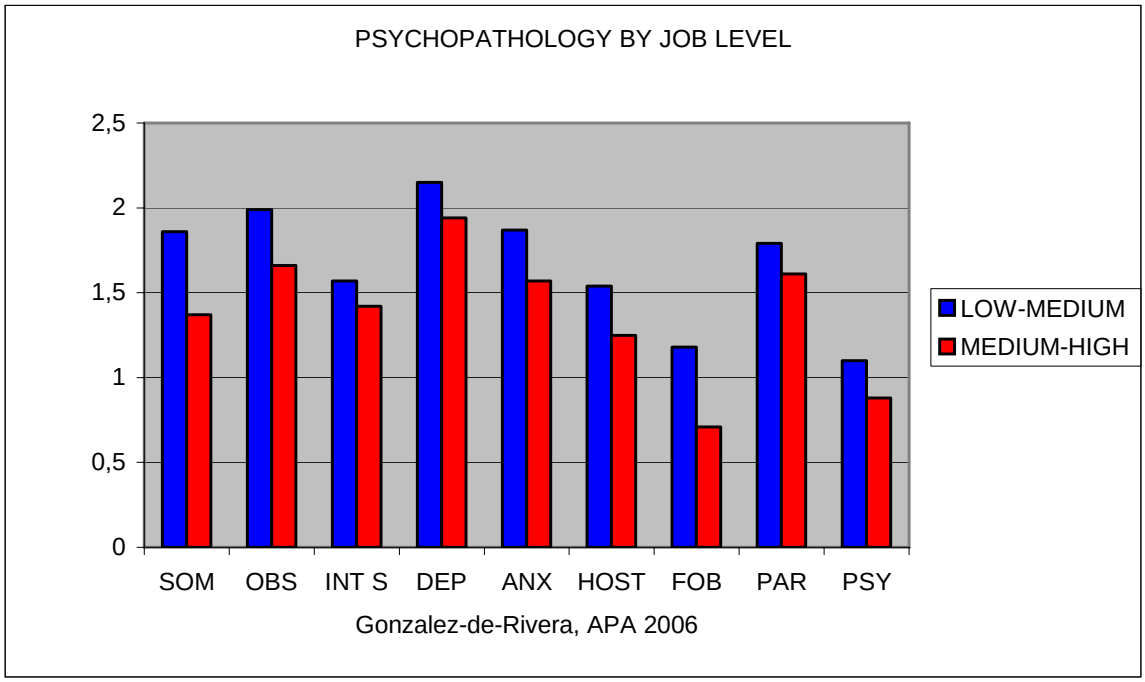


FIGURE 4



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