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**Bullying in Hospital Settings:
The Nature of Bullying, Prevalence Rates and
Occupational Health Outcomes**

Brynja Bragadóttir
Centre for Research in Health Behaviour
Department of Psychology



This thesis is submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy in the Faculty of Social Sciences at the University of Kent at Canterbury, December 2003.

F 185505

DX 229320



ABSTRACT

This thesis deals with the issue of bullying at work. The bullying concept refers to situations where a person is persistently and over time exposed to hostile and demeaning behaviours at work. Whether the bullying is deliberate or not, it is likely to cause humiliation, offence and distress in the target person. In the thesis, the focus is on two aspects of bullying at work – namely prevalence rates and occupational health outcomes. In recent years, attention has been paid to bullying and harassment among health care professionals. Findings from several countries suggest that health professionals are frequently exposed to various kinds of bullying behaviours or acts. Indeed, the two studies reported in this thesis point to high levels of bullying in the health sector.

The studies took place in two hospital trusts, one located in Scotland and the other in Iceland. Questionnaires were used to assess the prevalence and nature of bullying experiences in these trusts. The study samples were large and randomly generated. Two key methods were used to assess prevalence levels. The first method focused on persistent exposure to undesirable behaviour at work. The second method focused on subjective experiences of bullying at work. An interesting disparity in findings appeared, depending on the method used. Results from the first method consistently pointed to higher prevalence rates than results from the second method.

Apart from studying local prevalence rates, the project aimed at comparing the rates from the two countries. The results from this cross-cultural comparison pointed consistently to higher levels of bullying in Scotland than in Iceland. However, both studies showed that people were most likely to report work-related negative acts and personal derogation or isolation. This accords with the notion that rational-appearing aggression and other forms of covert aggression are more frequently used in the workplace than are overt forms of aggression.

In Scotland, cross-sectional data were used to assess the link between bullying and occupational health outcomes. Results showed that staff who had experienced one or more types of bullying acts in the past year were more likely than other staff to be dissatisfied in their job, to contemplate leaving and to have higher levels of anxiety and depression. They also reported poorer health and taking more days off work for sickness in the past year. In the Icelandic study, longitudinal data were used to assess the link between patterns of bullying experiences and health outcomes. In regression analyses, it was found that chronic exposure to bullying and recent onset predicted anxiety and depression levels. Moreover, three patterns of bullying (chronicity, remission and onset) predicted levels of psychosomatic complaints.

What mainly distinguishes the current project from other projects in the field is the methodology used to test the relationship between bullying and health outcomes. Specifically, the methodology used in the project enabled the author to study whether bullying at work is mainly a cause of adverse health outcomes or whether the relationship between bullying and health outcomes is more complex. Whilst most current knowledge suggests that bullying at work leads to outcomes such as increased levels of anxiety and depression, it is quite possible that other causal mechanisms (e.g. reverse causal mechanisms) are also at work. Indeed, the results reported in the thesis suggest that reverse causation is also possible. Specifically, that psychological distress (reflected in depressive symptoms) places people at more risk of being bullied at work. Whilst this finding is certainly important in its own right, it is also important in practical sense – for instance, when it comes to preventive actions. In order to effectively deal with the problem, it seems essential to look for ways to help and support vulnerable groups of employees. In particular, groups who suffer symptoms of depression.

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CHAPTER 1

THE NATURE OF WORKPLACE BULLYING

Introduction

In the past two decades, the concept of workplace bullying has received considerable attention in Continental Europe, the UK, Australia and the US. A number of definitions have appeared during this time, and researchers have used various labels to describe the same concept. For example, researchers in Germany, Austria, and Sweden tend to use the word “mobbing” (e.g. Leymann, 1990, 1996; Niedl, 1996; Zapf, Knorz & Kulla, 1996), whilst researchers in the UK, Ireland and Australia usually talk about “bullying” (e.g. Lewis, 1999; O’Moore, Seigne, McQuire & Smith, 1998; Quine, 1999; Rayner, 1997; Sheenan, Barker & Rayner, 1999). In the US, still other labels are used, such as workplace harassment (Brodsky, 1976), employee abuse (Bassman, 1992), workplace victimisation (Aquino, Grover, Bradfield & Allen, 1999), workplace incivility (Anderson & Pearson, 1999), and emotional abuse (Keashly, 1998). In general, these labels refer to the same kind of situation – namely, the situation where an employee is repeatedly and persistently exposed to negative acts on the part of one or more individuals.

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In a recent review article on workplace bullying, Ståle Einarsen (2000) cites several authors (e.g. Adams, 1992a; Leymann, 1990; Randall, 1992) who claim that a hostile environment, where offensive remarks, persistent criticism, and emotional or physical abuse prevail, is a reality for many employees in both private and public organisations. Empirical findings from various countries also support this view (e.g. Einarsen & Skogstad, 1996; Hoel, Cooper & Faragher, 2001; Leymann, 1992a, 1996; Mikkelsen & Einarsen, 2001; Quine, 1999). The severity of the problem has also been discussed in various papers (see, for example, Einarsen & Raknes, 1997a). It has been argued that aggression, threats and serious interpersonal problems at work may have more negative effects on the individual than aggression and interactional problems in other settings (Bolger, DeLongis, Kessler & Schilling, 1989). There are mainly four reasons for this.

Firstly, aggression at work is embedded in a situation with potential formal and informal power and status inequalities between parties, and with formal superior-subordinate relationships. Such settings make it possible to justify power abuses, threats and coercion as “necessary” actions, in the sense of duties and privileges of firm management. Second, attendance at work is required on a daily basis and therefore, it is an unavoidable setting. Third, people’s experiences at work affect the quality of their private lives and their overall life satisfaction (Burke & Greenglass, 1987). Fourth, work seems to be important in shaping people’s self-respect, self-images and identities (Kile, 1990a). These

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arguments taken together suggest that the workplace is a setting where people are especially vulnerable when faced with aggression, interpersonal problems, coercion, threats and general harassment.

So far, the concept of bullying has only been described briefly. The aim of this first chapter is to describe the various parameters that make up the concept. Following this description, the nature of workplace bullying will be discussed in some detail. The chapter will then finish with a brief outline of the current thesis.

The concept of bullying at work

As previously noted, researchers in the field of workplace bullying have provided various definitions of the concept. However, most of these definitions share some basic aspects or features. In a recent review article, Hoel and colleagues give an outline of four such features (Hoel, Rayner & Cooper, 1999; see also Einarsen, Hoel, Zapf & Cooper, 2003). These are: frequency and duration of negative acts, reaction of the target, balance of power between target and perpetrator, and intent of perpetrator.

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Frequency and duration of negative acts

Most definitions stress frequency and duration as critical features of the bullying concept. Using these two features, researchers describe workplace bullying as the situation where an employee is exposed *repeatedly* and *over a period of time* to negative acts on the part of one or more individuals (see, for example, Björkqvist, Österman & Hjelt-Bäck, 1994; Einarsen, Raknes, Matthiesen & Hellesøj, 1994; Leymann, 1990, 1996; Vartia, 1996).

As well as being critical features of bullying, frequency and duration are seen as essential in separating bullying from other concepts, such as workplace violence. Whilst workplace bullying consists of repeated and enduring negative acts, workplace violence comprises “one-off” incidents of trauma and/or multiple incidents of harassment from different individuals (see Cox & Leather, 1994; LaBar, 1994; Mantell, 1994).

Even though frequency and duration are seen as basic features of bullying, there are no set rules as to how workplace bullying is best examined. Therefore, operational definitions vary considerably in the field. However, in most studies, people are seen as victims of bullying if they report repeated negative acts (e.g. “every week”, “several times a month”, “now and then”) over a period of six months (e.g. Einarsen & Skogstad, 1996; Leymann, 1992c; Mikkelsen & Einarsen, 2001) or a year (e.g. Björkqvist et al, 1994a; Quine, 1999).

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Reaction to negative acts

In common with racial and sexual harassment, definitions of workplace bullying usually extend to the reaction of the person exposed to the negative acts. In order for bullying to occur, the target of negative acts *must feel harassed* and their work be affected (Rayner & Hoel, 1997). For instance, the target may experience the negative acts as hostile, offensive, intimidating, degrading, and unreasonable.

According to Rayner, Hoel and Cooper (2002), there are indeed several factors around this issue, such as the nature of the negative reactions (see examples above), the degree of reaction, and the severity of the effects of the reaction. The authors note however that while this is a wide spectrum of potential response, from being annoyed by the actions of others through to psychological breakdown, it is entirely negative in nature and effect (Rayner et al, 2002).

Given this perspective, researchers often rely on self-reports when studying workplace bullying (e.g. Einarsen et al, 1994b; Rayner, 1997; Vartia, 1996). In these studies, respondents are presented with a description of bullying, which comprises negative reactions, such as feeling abused or powerless, and asked if they think of themselves as being targets of bullying. Accordingly, the occurrence of bullying is decided on the basis of people's self-labelling.

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However, there are some researchers (e.g. Leymann, 1993, 1996) who deliberately exclude target's reactions in their definitions of bullying. Instead, these researchers rely on people's reports of negative acts, and use fixed criteria of frequency and/or duration of such acts, e.g. once a week over a period of six months, to determine the occurrence of bullying. In other words, the feature of target's reactions is not always considered as critical aspect of definition.

The imbalance of power between parties

Researches in Scandinavia (e.g. Björkqvist et al, 1994a; Leymann, 1996; Einarsen & Skogstad, 1996), as well as in Austria and Germany (e.g. Niedl, 1995, 1996; Zapf et al, 1996), have stressed the imbalance of power between the parties (targets and perpetrators). The argument provided is that targets of bullying must have difficulties in defending themselves. What follows is that serious conflict between parties of "equal strength" does not fall into definition of bullying.

Well-known definitions of bullying in school context (Olweus, 1978, 1991, 1993) also stress that bullying and harassment imply a difference in actual or perceived power and strength between parties. In addition, imbalance of power is usually emphasised in definitions of sexual harassment (Kreps, 1993).

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In the context of workplace bullying, power can emanate from many sources. Yet, Rayner and colleagues (2002) have made a useful distinction between formal and informal power. That is, between power stemming from status and position and power derived from sources such as previous experience, personal contacts, ability to influence others etc.

Imbalance of power may also be reflected in the target's dependence on the perpetrator(s), whether it is of a social, physical, economic or psychological nature (Niedl, 1995). An employee will in most cases be more dependent on his supervisor than vice versa. A single person will also be more dependent on the work group than the other way around. It has also been argued (e.g. Brodsky, 1976; Einarsen, 1999; Einarsen et al, 2003) that knowledge of someone's "weak point" may become a source of power in a conflict situation. According to this view, perpetrator(s) of bullying tend to exploit the experienced inadequacies of the target's personality or work performance, which in itself indicates powerlessness on the part of the target.

The intent of the perpetrator

Some definitions of workplace bullying also take into account the intent on the part of the perpetrator. Whilst some authors (e.g. Randall, 1997) talk explicitly about the intent of the perpetrator, others (e.g. Björkqvist et al, 1994a; Keashly, Trott & MacLean, 1994; Leymann, 1990) talk implicitly about this issue. Björkqvist et al (1994a), for example, define

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workplace harassment in the following way: “repeated activities, *with the aim* of bringing mental (but sometimes also physical) pain, and directed toward one or more individuals...” (p. 173). Some definitions in school contexts also include intent of the perpetrator (e.g. Besag, 1989; Tattum & Lane, 1988).

However, Rayner et al (2002) have argued that intent is not necessarily present when people behave negatively to others: “Their focus may be exclusively on getting a job achieved or they may be simply unaware that their behaviour is experienced as bullying” (Rayner et al, 2002, p. 13). The Norwegians, (e.g. Einarsen & Raknes, 1997a, 1997b) have also defined workplace bullying as repeated actions that are directed to one or more employees, which may be done deliberately *or* unconsciously, but still cause humiliation, offence and distress.

The issue of intent is also problematic in the sense that it is normally not possible to verify the presence of intent (see, for example, Hoel et al, 1999). It is indeed for this reason that intent is usually excluded from most definitions of sexual harassment (e.g. Fitzgerald & Shullman, 1993). However, whereas intent may be a controversial feature of bullying, there is no doubt that perception of intent is important as to whether a person decides to label his or her experience as bullying or not (Einarsen et al, 2003).

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The effects of bullying

In addition to the four features mentioned above (frequency and duration of acts, target's reaction to the acts, imbalance of power between parties, and intent of perpetrator), potential health effects are sometimes included in definitions of bullying. For example, Lyons, Tivey and Ball (1995) define bullying as "persistent, offensive, abusive, intimidating, malicious or insulting behaviour...which makes the recipient feel upset, threatened, humiliated or vulnerable, which undermines their self-confidence and *which may cause them to suffer stress*" (p. 3).

Existent anecdotal and clinical accounts of bullying and harassment at work also underscore the adverse effects of persistent harassment on the targets' psychological and physical health (e.g. Adams, 1992a, 1992b, Brodsky, 1976; Kile, 1990b; Leymann, 1988, 1990; Thylefors, 1987). According to Leymann, persistent bullying also affects the targets' abilities to retain communication skills, social contacts and the respect of others. Leymann's clinical accounts (e.g. Leymann, 1992a, 1993) emphasise still other effects of bullying, such as the effects on work and life situations and the effects on physical health.

The nature of behaviours involved

Given the central elements of the bullying concept, it must be noted that the concept is ultimately about behaviours. The range of behaviours involved in bullying is quite extensive. However, some attempts have been made to describe the nature of these acts. In the related literature of workplace aggression (see, for example, Baron & Neuman, 1996), aggressive behaviours are commonly categorised in terms of three dichotomies: verbal-physical, direct-indirect, and passive-active (a categorisation based on Buss's (1961, 1995) theoretical framework). According to Buss (1961), verbal aggression creates harm through words, whereas physical aggression inflicts harms through deeds or acts. Direct forms of aggression are ones in which harm is delivered directly to the target, whilst indirect forms involve the delivery of harm "via the negative reactions of others" (Buss, 1961, p. 8). Often, indirect aggression is a kind of social manipulation, like spreading rumours about the target person or trying to persuade others not to associate with him or her (Lagerspetz, Björkqvist & Peltonen, 1988). Finally, active aggression produces harm through the performance of some behaviour, whilst passive aggression delivers harm through the withholding of some action.

Some authors (e.g. Keashly, 1998) have applied this categorisation in the context of workplace bullying. Based on an extensive literature review, Keashly (1998) concludes that the behaviours involved in

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bullying are mostly of verbal nature. Baron and Neuman (1996) also claim that in workplace aggression, verbal, passive and indirect forms of behaviours are more common than the other forms. Moreover, Björkqvist and colleagues (e.g. Björkqvist, Lagerspetz & Kaukiainen, 1992; Björkqvist, Österman & Lagerspetz, 1994; Kaukiainen et al, 2001) have argued that covert (or verbal, indirect and passive) forms of aggression are more frequent in workplaces than overt forms (i.e. physical, active and direct) of aggression. The reason for this, according to Björkqvist et al, is that human adults often prefer to maximise what is known as “the effect/danger ratio” when aggressing against others (e.g. Björkqvist et al, 1994b). Specifically, people prefer to maximise the harm done to the target while at the same time minimising the danger to themselves. This tendency leads to a preference for actions that produce harm, but are disguised and subtle in nature. For instance, actions that allow the person to disguise their identity and motives, and even leave the target unsure of whether the actions were intentional or not (Björkqvist et al 1992a). The aggressor may also be likely to strive for actions that minimise the overall risk of social condemnation.

It has been argued (e.g. Leymann, 1990) that the behaviours involved in bullying may in fact be quite common in everyday life. Yet, they are likely to cause much harm and humiliation when occurring on a regular basis. Hence, it may not be the nature of the conduct itself that makes the target suffer. The frequency of the acts, situational factors relating to power differences, or the target’s attributions about the offender’s

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intentions may cause just as much anxiety, misery and suffering as does the actual behaviour involved (Einarsen et al, 1994b). Niedl (1995) claims that a target will experience repeated aggressive or unwanted behaviour as bullying if the behaviour is perceived as being hostile, directed towards oneself and conducted in an inescapable situation where the target is unable to defend him or herself.

According to Leymann's (1990) theoretical model, behaviours involved in bullying and psychological terror at work can be of five different forms. These are: manipulation of the target's reputation (through rumours, ridicule etc.); manipulation of the target's possibilities of communicating with co-workers; social exclusion and isolation of the target; manipulation of the target's possibilities to perform work tasks (e.g. no work given, target given humiliating or meaningless work tasks); and violence and/or threats of violence.

Other contributors have proposed somewhat different categories of bullying behaviours. According to Rayner and Hoel (1997), bullying behaviours can be grouped into the following five categories: threat to professional status (e.g. belittling opinion, public professional humiliation, accusation regarding lack of effort); threat to personal standing (e.g. name-calling, insults, intimidation); isolation (physical or social); overwork (e.g. undue work pressure, impossible deadlines); and destabilization (e.g. meaningless tasks, removal of responsibility).

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Empirical evidence also suggests that the behaviours involved in bullying can be divided into different categories. However, the categories identified vary somewhat between studies. Based on factor analyses of the LIPT questionnaire¹, Niedl (1995) identified seven forms of bullying: attacking a person's integrity, isolation, direct and indirect critique, sanction by certain tasks, threats, sexual encroachment, and attacking a person's private sphere. In a prior study, Leymann (1992a) had identified five classes of bullying behaviour: negative communication, humiliating behaviour, isolating behaviour, frequent changes of tasks to punish someone, and violence or threat of violence.

Zapf et al (1996) also used LIPT in their study, but discovered seven bullying [mobbing] factors: attacking the victim with organisational measures (e.g. refusal to assign work tasks or assigning senseless/degrading tasks), attacking the victim's social relationships with social isolation, attacking the victim's private life (e.g. criticizing a person's private life, making fun of a person's private life), physical violence, attacking the victim's attitudes, verbal aggression (e.g. shouting/cursing at a person, verbal threats), and rumours.

In studies using other questionnaires, such as the negative acts questionnaire (NAQ), still other categories have been identified. Einarsen and Raknes (1997a) used this scale in their study and discovered four bullying factors: attacking the private person, social

¹ LIPT stands for "the Leymann Inventory of Psychological Terrorization" (Leymann, 1989).

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isolation, work-related measures, and physical violence. Finally, Vartia (1993) found six main forms of bullying [mobbing]: slander, gossips or rumours spread about a person, social exclusion, giving the person too few or overly simple tasks, continuous criticism of the person's work and results, physical violence or threat of such violence, and insinuations about the person's mental health.

Despite some variations in empirical findings, most of the studies suggest that bullying acts can be divided into five broad categories: (1) Work-related bullying, (2) Social isolation, (3) Personal attacks and attacks on the person's private life, (4) Verbal abuse, and (5) Physical violence or threats of such violence. According to Zapf et al (1996) and others (e.g. Einarsen et al, 1994b), the most common strategies of bullying are those of social isolation, personal attacks/attacks on the person's private life and work-related bullying. Compared to these three categories, physical violence seems to occur only occasionally in the context of bullying at work (Einarsen et al, 1994b; Zapf et al, 1996).

Bullying as a process

A common way of examining bullying at work is using the survey method, which constitutes a static approach to the topic. However, some authors have treated bullying in more dynamic way, describing bullying as an escalating process (e.g. Björkqvist, 1992; Kile, 1990a; Leymann,

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1988, 1990, 1996; Thylefors, 1987). Björkqvist (1992, cf. Einarsen, 2000) suggested a three-phase model of bullying with a focus on the intensity of bullying behaviours. In the first phase, indirect/discrete strategies of bullying, such as spreading rumours or persistently interrupting the victim, are used aiming at degrading the victim. In the second phase, more direct acts of aggression appear. The victim is, for instance, isolated and humiliated in public. In the third phase, extreme forms of direct aggression and power abuse are used. Examples of behaviours here are: the victim is accused of being psychologically ill, he or she is blackmailed, and threats to distribute intimate knowledge is put forward.

Empirical evidence also suggests that victims of long-lasting harassment are attacked more frequently than victims with a short history of bullying. In a study of Norwegian workers, Einarsen and Skogstad (1996) describe the bullying process in this way: In the early phases, victims seem to be attacked only now and then. As the bullying escalates, the frequency of attacks increases and after some time the victims are attacked on a weekly and even daily basis (Einarsen & Skogstad, 1996, p. 197). In a study of German bullying victims, Zapf and Gross (2001), found that three out of five bullying strategies – work-related bullying, attacking the private sphere, and rumours – occurred more frequently among victims of long-lasting harassment, “indicating that bullying is escalating in the course of time” (p. 515).

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Leymann (1990, 1996) also suggested a theoretical model, which describes a typical process of bullying. This model of Leymann shows parallels with escalation models in conflict research (as noted by Zapf and Gross, 2001). In the model, Leymann distinguishes between “four critical incident phases”. The triggering situation is most often a work-related conflict. Hypothetically, this first phase (which according to Leymann is not yet bullying) may be very short. However, not much is known about what exactly causes the conflict to develop into a bullying situation.

In the second phase, one of the conflicting parties (the person who acquires a disadvantaged position in the conflict) is exposed to repeated and enduring aggressive acts. In other words, the disadvantaged person becomes a victim of bullying. As seen above, the bullying activities may comprise quite a number of behaviours. According to Leymann, these activities are used with the aim of humiliating, intimidating, frightening or punishing the victim. The stigmatising effects of these activities, and their escalating frequency and intensity, make the victim constantly less able to cope with his or her daily tasks and the co-operation requirements of the job. Therefore, the victim continually becomes more vulnerable and “a deserving target” of aggressive acts.

In the third phase, the management steps in and the case becomes “official” in the organisation. The previous stigmatisation of the victim makes it easy to misjudge the situation and to blame the victim for his or

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her misfortune. In Leymann's view, management, union representatives, and the personnel administration representatives often tend to accept and legitimize the position of the bully and his/her negative view of the victim. The most common strategy of conflict management, according to Leymann, is therefore to try and get rid of the cause of the trouble – namely, the victim. In this phase, the victim ultimately becomes marked and stigmatised.

The final phase of bullying is expulsion from the organisation (be it long-term sick leave, no work provided, (but still employed), relocation to degrading tasks, or a plain notice). When the process has reached this phase, many victims are seriously ill and are often sent for psychiatric treatment. According to Leymann (1996) and others (e.g. Groeblinghoff & Becker, 1996), the threat of becoming expelled is responsible for the development of serious illnesses (regarding this issue, see also Leymann & Gustafsson, 1996). Leymann notes that many victims are "incorrectly" diagnosed with paranoia, manic depression and character disturbance. In the recent years, Leymann has added this misdiagnosis as an extra phase in his model (Leymann, 1996).

Empirical support for Leymann's dynamic model of bullying is still lacking. However, Einarsen (2000) notes that an interview study of Norwegian bullying victims seems to support the four critical incidents identified in the model (Einarsen et al, 1994b).

Definition of bullying at work

In view of the various features of bullying at work, described on the previous pages, a generally agreed definition of the concept goes as follows:

Bullying at work means harassing, offending, socially excluding someone or negatively affecting someone's work tasks. In order for the label bullying (or mobbing) to be applied to a particular activity, interaction or process it has to occur repeatedly and regularly and over a period of time. Bullying is an escalating process in the course of which the person confronted ends up in an inferior position and becomes the target of systematic negative social acts. A conflict cannot be called bullying if the incident is an isolated event or if two parties of approximately equal "strength" are in conflict.

(cf. Einarsen et al, 2003, p. 15)

Interpersonal vs. organisational bullying

Bullying at work is normally conceived as an interpersonal phenomenon. That is, bullying is exhibited by one or more persons, directed towards another person, and perceived and reacted to by that person. However, Liefhooge and Mackenzie Davey (2001) have argued that the concept may also refer to events of what may be called "organisational bullying" or "structural mobbing" (Neuberger, 1999).

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Organisational bullying refers to situations where organisational practices and procedures perceived as being oppressive, intimidating and humiliating are employed, so that many employees feel victimised by them. As previously, the definition refers to persistent negative events and behaviours that wear down and frustrate employees. In these situations however, managers enforce organisational structures and procedures that may torment, abuse or even exploit the employees. Hence, bullying in this context does not strictly refer to interpersonal interactions, but more to indirect interactions between the employee and management.

This use of the bullying concept has been debated though, especially due to the general view of the concept as an interpersonal phenomenon. Some authors have also warned against misuse of the term bullying (e.g. Einarsen et al, 2003), as may possibly be the case when management practices are at issue.

Outline of thesis

This thesis is concerned with workplace bullying in hospital settings. In recent years, attention has been paid to problems of bullying and harassment among health care professionals. Research findings from the UK suggest that health professionals working in community services are frequently exposed to various kinds of bullying behaviours or acts

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(e.g. Quine, 1999). Findings from other countries, such as Austria (Niedl, 1995), also suggest that bullying among health care professionals is a serious problem (cf. Einarsen, 2000). However, there still seems to be a need for research into bullying in this occupational sector.

The studies reported in the thesis took place in two hospital trusts, one located in Scotland and the other in Iceland. A basic aim of the two studies was to assess the prevalence of bullying among trust employees. A second aim of the studies was to examine the effects of bullying on employee health and well-being. The literature related to these two aims will be reviewed in the next two chapters. That is, previous findings on the prevalence of workplace bullying will be reviewed (Chapter 2) and the effects of bullying on occupational health outcomes (e.g. psychological health complaints, sickness absence, job satisfaction, and propensity to leave) thoroughly examined (Chapter 3). Chapter 2 also deals with some methodological issues that have been raised in the sphere of workplace bullying and the apparent cross-cultural variations in prevalence rates.

Following these chapters, the two studies mentioned above will be systematically reported. First, the study conducted in Scotland will be described. In Chapter 4, the issue of prevalence rates will be thoroughly addressed. Then in the following chapter (Chapter 5), the focus will be on bullying and occupational health outcomes. The next two chapters (Chapters 6 & 7) will be similar in structure. In these chapters, the

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Icelandic study will be reported. The former chapter (Chapter 6) will concentrate on prevalence rates, whilst the latter chapter (Chapter 7) will focus on bullying and psychological health outcomes. Once the two studies have been described and the key findings reported and assessed, the thesis will finish with a summary of these findings (Chapter 8). Along with the summary, implications for theory and future research will be raised and discussed.

CHAPTER 2

PREVALENCE OF WORKPLACE BULLYING: A REVIEW OF PREVIOUS RESEARCH

Introduction

Bullying in the school context has been studied extensively for a number of years (e.g. Besag, 1989; Olweus, 1978; 1991; 1993; Roland & Munthe, 1989; Smith & Thompson, 1991), and the literature in this area is multinational (see, for example, Batch & Knoff, 1994; Ronald & Munthe, 1989). More recently, systematic research into adult bullying – specifically bullying in the workplace – has started. Perhaps the most advanced work is to be found in Scandinavia (e.g. Björkqvist et al, 1994a; Einarsen & Raknes, 1997a, 1997b; Einarsen & Skogstad, 1996; Einarsen et al, 1994a, 1994b; Leymann, 1992a, 1992b, 1992c; Leymann & Tallgren, 1989; Matthiesen, 1990; Matthiesen, Raknes & Röckrum, 1989; Mikkelsen & Einarsen, 2001; Salin, 2001; Vartia, 1996). However, research has also been conducted in countries such as the UK (Cowie et al, 2000; Hoel & Cooper, 2000; Hoel, Cooper & Faragher, 2001; Lewis, 1999; Quine, 1999, 2001, 2003; Rayner, 1997), Ireland (e.g. O'Moore et al, 1998) Austria (Kirchler & Lang, 1998; Niedl, 1995; 1996), Germany (e.g. Zapf & Gross, 2001; Zapf et al, 1996), the Netherlands (e.g. Hubert & van Veldhoven, 2001), Hungary (e.g. Kaucsek & Simon, 1995), and Portugal (e.g. Cowie et al, 2000). Outside Europe, bullying research has

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been carried out in the US (e.g. Baron, Neuman & Geddes, 1999; Keashly, Hunter & Harvey, 1997; Keashly et al, 1994) and in Australia (e.g. Sheehan, Barker & Rayner, 1999).

Bullying in the work context has now become identified as a serious issue. In many countries, trade unions, professional organisations, and human resources departments have become more aware that the behaviours involved in bullying have the potential to undermine the integrity and confidence of employees and reduce efficiency.

Cowie and colleagues have noted that bullying may go beyond “colleague-on-colleague abuse” and become an accepted, or even encouraged, aspect of the culture in some organisations: “A number of organisations now recognise the need to change the culture of the workplace and have developed clear company policies to offer protection from bullying to their employees” (Cowie, Naylor, Rivers, Smith & Pereira, 2002, p. 34). In another recent paper, Archer (1999) uses the fire service as an example of a work sector where bullying is considered as integral part of the organisational culture.

The aim of this chapter is to review the existing literature on the prevalence of bullying at work. In this review, the focus will be on research findings from the UK (England and Wales) and the Scandinavian countries. The reason for this approach is that these countries come closest to the countries where the author’s own studies

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take place (i.e. Scotland and Iceland). Before discussing the prevalence of bullying, some issues regarding the measurement of workplace bullying will be addressed.

Measuring workplace bullying: The questionnaire method

Questionnaire surveys have been the predominant research method in the field, and a number of measuring tools of varying complexity have been devised. Perhaps the simplest survey method involves asking respondents whether they have experienced an event of workplace bullying, with a “yes”/“no” response. Sometimes, frequency scales are used to assess the prevalence of bullying. For example, Einarsen and Skogstad (1996) used a written definition of bullying, and asked respondents whether they had been exposed to bullying at their workplace over the past six months, using a four point response scale (“no”, “yes, once or twice”, “yes, now and then”, and “yes, weekly”).

However, more elaborate questionnaires have been developed. Perhaps, the most extensively used have been forms of the LIPT (*Leymann Inventory of Psychological Terrorization*). Leymann (1989) developed this scale in Swedish, but a revised version (LIPT-II) has been widely used in a German translation (e.g. Niedl, 1996; Zapf et al, 1996). The original questionnaire consists of 45 items representing various bullying acts. Each item is rated on frequency of occurrence. In

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some studies (e.g. Niedl, 1996), a rating scale is also used for duration of each item. Since the LIPT measures defined acts, it is usually not considered necessary to give a definition of bullying. However, Vartia (1996) used a written definition of bullying as well as LIPT in her survey of Finnish municipal employees.

Einarsen and colleagues developed the *Negative Acts Questionnaire* (NAQ) in their studies of Norwegian workers (see, for example, Einarsen & Raknes, 1997a). The questionnaire consists of 22 items, each written in behavioural terms with no reference to terms such as bullying or harassment. The rating scale used (a five-point scale) measures how often respondents have been exposed to a range of negative acts and potentially harassing behaviours during the past six months. The Norwegian Bergen group has also used a scale called the *Bergen Bullying Index* (e.g. Einarsen et al, 1994), which is a five-item scale measuring the extent to which respondents see bullying as an issue affecting them and others in the workplace.

Björkqvist and colleagues developed the third questionnaire, called the *Work Harassment Scale* (WHS), to study aggression among university employees (Björkqvist, Österman & Hjelt-Bäck, 1992). This questionnaire consists of 24 items. Respondents assess on a five-point scale how often they were exposed to 24 types of degrading and oppressing activities on the part of their colleagues in the past six months.

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Apart from the scales derived from Scandinavian research, only few others have been developed. One scale that was recently developed in the UK is that of Quine (1999). In a study of English health care professionals, Quine used a scale of 20 items to assess employee experiences of bullying behaviours. The items were expected to reflect the five groups of behaviours described by Rayner and Hoel in their 1997 paper (see Chapter 1, p. 12).

Advantages of the questionnaire method

The advantage of the questionnaire method is that the researcher can collect large amounts of data in a relatively short space of time. Also, in most studies, anonymity of respondents is assured (which seems to be quite important in this area of study). Moreover, the method facilitates performance of statistical analysis of a range of demographic factors, such as gender, status and age of bullying victims and/or perpetrators of bullying.

Disadvantages of the questionnaire method

There are however some disadvantages to this study method. If no definition is given and the questionnaire relies exclusively on the occurrence of negative or aggressive acts (like was, for example, the case in Leymann's (1992a, 1992c) study), it may not be clear whether "the imbalance of power" criterion is satisfied. On the other hand, if

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operational definitions and self-reports of bullying are used, these self-reports can in some ways be biased (an issue discussed later in this chapter). Apart from these potential problems, the questionnaire format makes it difficult to gain detailed information regarding the processes and dynamics of bullying situations.

Objective vs. subjective measures of bullying

Some authors (e.g. Frese & Zapf, 1988) have also argued for more use of “objective” measurement in organisational research. An objective stressor is then defined as not being influenced by individuals’ cognitive and emotional processing. In contrast, a subjective stressor is highly influenced by individual cognitions and affect. Regarding this issue, Björkqvist and colleagues (1994a) have questioned the possibility of obtaining more objective measures of bullying (some possibilities that have been proposed are statements from co-workers or employers). The authors doubt that such independent measures can be obtained if full anonymity cannot be guaranteed. Also, Einarsen (1996) in conjunction with Baumeister, Stillwell and Wotman (1990), argues that workplace conflicts seldom allow for neutral or independent positions. Moreover, Einarsen and colleagues (1994b) point to the influence of organisational culture on the interpretation of behaviour as bullying and its acceptance. The argument here is that since culture may act as a screen through which behaviours are interpreted, the dichotomy between “subjective” and “objective” bullying is of limited help.

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In addition to this, Einarsen (2000) notes that in order to have a psychological effect on the individual, a potentially harassing behaviour has to be perceived and evaluated. In order to produce a stress reaction, with potential short-term or long-term consequences, a certain situation must be *appraised* as threatening or aversive (regarding this issue, see also Lazarus & Folkman, 1986).

Niedl (1995; cf. Einarsen, 2000) has even claimed that individual perceptions of negative acts are central to the definition of bullying. According to Niedl, targets of repeated negative acts must *perceive* the acts as hostile, humiliating and/or intimidating and also construe these acts as directed to them. Given this argument of Niedl, it may be the case that the self-report method is the only “objective” research method in the field (Einarsen, 2000).

The role of negative affectivity in self-reports of bullying

While the self-report method can be seen as a useful method of studying bullying, researchers must acknowledge the possibility that people’s self-reports are in some ways biased. Quine (1999) has drawn attention to one possible source of bias – that of negative affectivity. Negative affectivity (NA) is defined as a mood-dispositional dimension that reflects stable and pervasive individual differences in negative emotionality and self-concept (Watson & Clark, 1984). In an extensive review article, Watson and Clark (1984) demonstrate that a number of scales,

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purporting to measure constructs such as trait anxiety, neuroticism and hostility, are in fact measures of a more global construct – namely negative affectivity. Based on their literature review, the authors argue that individuals high in NA are more likely (than those low in NA) to experience negative emotions such as distress, discomfort, and dissatisfaction across time and situations. They also claim that high-NA individuals tend to dwell on their failures and shortcomings and to focus more on the negative aspects of other people and the world in general. As a result, these individuals have less favourable view of themselves and other people, and are generally less satisfied with their life circumstances (Watson & Clark, 1984). In line with these propositions, some other authors have claimed that NA may operate as a nuisance factor in self-reports of various kinds. For example, Levin and Stokes (1989) contend that the affective tendency and cognitive style associated with NA may affect the way people experience and evaluate their jobs. These authors have gone on to demonstrate this particular effect of NA (see Levin & Stokes, 1989). In addition, it has been argued (Spector, Zapf, Chen & Frese, 2000) that social job stressors (e.g. interpersonal conflict at work) may be more strongly associated with NA than are task-related stressors (e.g. work overload, lack of control). So far, only one study has focused on the role of NA in reports of bullying at work (Quine, 2003). In this survey study of junior doctors in the UK, Quine found that respondents high in NA were somewhat more likely to report bullying than respondents low in NA; the factor of NA accounted for six per cent

of the variance in reports of bullying. However, more studies are needed to determine the effects of NA on self-reports of bullying.

Prevalence of workplace bullying

Having summarised the main issues regarding the measurement of bullying, it seems appropriate now to review the existing findings on the prevalence of workplace bullying. As previously noted, the focus will be on studies conducted in the UK and Scandinavia. The review will make it evident that bullying is a serious workplace problem, affecting a great number of people. The scale of the problem becomes especially apparent in studies where the focus is not only on victims of bullying, but also on observers (or bystanders) of bullying events. It must be noted, however, that available data can be difficult to compare as it often derives from different ways of measuring bullying.

Prevalence of bullying in UK workplaces

Trade unions in the UK have recognised workplace bullying as a serious problem for several years, and a number of reports have described the misery, psychological distress, physical illness and career damage suffered by bullying victims (IPD, 1996; MSF, 1995; NASUWT, 1995; 1996; TUC, 1998; UNISON, 1995, 1997). The British media have also

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played a critical role in raising public awareness of the problem (Rayner et al, 2002; Lee, 2002). However, bullying at work has only recently become a topic of academic study (see, for example, Hoel & Cooper, 2000; Hoel et al, 2001; Lewis, 1999; Quine, 1999, 2001, 2003; Rayner, 1997).

In the year 1994, Charlotte Rayner conducted the first academic study of workplace bullying in the UK. In this study, Rayner examined the prevalence of bullying among 1,137 part-time university students. The survey was in two main parts (see Rayner, 1997). The first part asked about respondents' worst working situation, went on to attitude questions, and then asked whether they thought they had been bullied or not. The results of this study revealed that 53% of respondents claimed that they had been bullied at some point in their working lives. In addition, 77% reported having witnessed bullying at work. As regards these findings, it must be noted that the study has some serious methodological weaknesses. Perhaps the most serious weakness is the nature of the study sample. The sample was a convenience sample of university students and the study's target population (a population to which the results may be generalised) is unformulated. In other words, the study sample reflected no particular working population. Therefore, the findings should be treated with caution. In addition, respondents were not provided with a clear definition of bullying. Neither did the study rely on fixed criteria of duration or frequency of bullying. Thus, because

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of measurement issues the observed prevalence rates can also be questioned.

In a more recent study, Rayner and associates examined the prevalence of bullying among members of a public employee union (UNISON, 1997). In this survey study, Rayner assessed employee experiences of bullying within a certain time period – namely, within the past six months. The results of the study showed that 14% of respondents had experienced bullying at work. In this study, the response rate obtained was extremely low. The questionnaire was sent out to a randomly generated sample of 5,000 union members, but only 761 (15%) returned the questionnaire. Hence, it is possible that the sample was selective, and the results not applicable to the target population – namely, people working in the UK public services (health care, higher education, public transport etc.).

In a third study conducted in the UK, Quine assessed the prevalence of workplace bullying in an NHS community trust (Quine, 1999). The study sample comprised 1,100 trust employees (response rate 69.6%), and the prevalence was assessed in terms of employee experiences of various types of bullying behaviours (20 types in total). The employees were asked to indicate (using yes/no responses) whether they had been persistently exposed to any of the bullying behaviours in the past 12 months. The results of the study showed that 38% of respondents had experienced one or more types of bullying (e.g. persistent criticism,

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social isolation, undue pressure to produce work, verbal and non-verbal threats), and 42% had witnessed the bullying of others.

In a more recent study of 594 junior doctors (response rate 62%), Quine (2003) concluded that bullying and mistreatment was highly prevalent in this professional group too. Specifically, the study showed that 37% of doctors reported having been bullied in the past 12 months. More than two thirds of respondents (69%) had also witnessed the bullying of others. Moreover, the study showed that 84% of doctors had experienced one or more types of mistreatment in the past 12 months. As previously noted, Quine examined whether self-reports of bullying were influenced by negative affectivity (a factor usually regarded as a source of bias in survey studies). The results of the study indicated that NA did not play an influential role in these reports.

A final study worth mentioning is a survey study conducted by Hoel and Cooper at UMIST¹ (Hoel & Cooper, 2000). The aim of the UMIST study was to determine the prevalence of workplace bullying in various sectors and occupations across Great Britain. Hence, the respondents (randomly selected; N=5,288) came from over 70 organisations in the public, private and the voluntary sectors. The response rate achieved in the study was 43%.

¹ UMIST stands for University of Manchester Institute of Science and Technology, UK

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In the study questionnaire, employees were provided with a definition of bullying and asked to indicate if they had been bullied at work (a) in the past six months and (b) in the past five years. The results showed that 553 respondents (10.6%) reported they had been bullied in the previous six months. Of these, 1.4% reported persistent bullying and 9.2% occasional episodes of bullying. No statistical differences were found between men and women's experiences of bullying. However, younger employees were more likely to experience bullying than older ones. In addition, full-time employees were found to be more likely to experience bullying than part-time employees.²

When Hoel and Cooper expanded the time period to the past five years, almost a quarter of respondents, or 24.7%, reported bullying experiences. In addition, they found that that 46.5% reported having witnessed bullying in the past five years. In a review of the UMIST study, Rayner et al (2002) note that Hoel and Cooper's prevalence data provide a good background against which one can conclude that bullying is a pervasive problem in the UK, affecting a great proportion of the workforce (Rayner et al, 2002, p. 25). However, in this study, a better response rate would have been desirable (the response rate achieved was 43%). If a better response rate had been attained, one would be able to generalise with more confidence the above prevalence rates.

² A similar pattern of findings (i.e. regarding sex, age and hours of work) was obtained in Quine's (1999) study of community trust employees.

The issue of response rate

At this point, it seems appropriate to explain the issue of low response rate in more detail. In survey studies, a response rate is determined out of the number of eligible respondents successfully included in the study. There seems to be no agreed standard for an acceptable minimum response rate. In spite of this, any response rate below 70% is often seen as problematic. As already noted, the response rate in the UNISON study was only 15%, and in the UMIST study it was 43%. The degree of non-response (e.g. 85% in the UNISON study) would be seen as potential source of sample bias. In basic methodology texts (e.g. Bowling, 1997), emphasis is placed on this issue.

According to Bowling (1997), there is always a possibility that non-respondents differ in some important ways from respondents. For instance, in terms of gender, health status and life experiences. Accordingly, when response rate is low, there is a possibility that the survey results are in some ways biased. It is important to note that the potential for sample bias is irrelevant to the sampling method used, e.g. whether randomised or non-randomised method is used. Because of this potential for bias, we must interpret the UNISON and the UMIST findings with caution. The prevalence rates observed may not necessarily reflect the actual rate of bullying in the respective target populations.

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However, the results of the UNISON and UMIST studies are in many ways similar to results from other countries (e.g. Germany and Norway). For instance, in terms of the most frequent categories of bullying at work – namely, work-related bullying and social isolation (see Einarsen et al, 1994b; Rayner et al, 2002; Zapf et al, 1996). Also in line with other studies (e.g. Einarsen & Skogstad, 1996; Leymann, 1996), the UK studies showed that prevalence of bullying was roughly the same among male and female workers. Hence, despite the low response rates, the UK data seem to be quite consistent with other data.

Who are the perpetrators of bullying?

In most UK studies, attempts have been made to describe the perpetrators of bullying, usually in terms of their position, age and sex. It seems to be the case that in UK workplaces, the perpetrators are frequently in positions of supervisors or managers. Rayner (1997), for instance, found that respondents usually identified their line manager or senior manager as the bully. These two categories together accounted for 71% of the bullying. In the UNISON (1997) study, 83% of reported bullies were managers. Similarly, Hoel & Cooper found that 80% of reported bullies were managers. Finally, Quine (1999) found that managers were most frequently reported as bullies. However, in this final study it was also commonplace that the bully was of same level of seniority as the victim (Quine, 1999).

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As regards age, bullies are reported as usually being older than their victim (e.g. Quine, 1999; UNISON, 1997). Managers are likely to be older than employers in lower positions and so, this may be a function of position. However, Rayner et al (2002) have noted that age may be significant as it may be a source of power for the bully: “as we get older our confidence usually increases and perhaps we are more direct in what we say” (p. 70). It is also possible that, in the target’s eyes, age confers power, and so targets are less likely to challenge older people directly, possibly allowing a vicious cycle to develop (Rayner et al, 2002).

When it comes to gender, men are reported as bullies more often than women in UK workplaces (e.g. Hoel & Cooper, 2000; UNISON, 1997). However, when one takes into account that there are fewer women in management positions (there are twice as many men in management positions in the UK, according to Rayner et al, 2002) the issue of gender may be trivial. It has even been argued that bullying in the UK has more to do with abuse of power than with gender as such (see Rayner et al, 2002).

Are targets of bullying singled out or bullied in groups?

According to UK findings, there are some variations in the ways people in UK workplaces are bullied. That is, if targets of bullying are singled out (bullied on their own) or if they are bullied in groups. In the study of part-time university students (Rayner, 1997), people were more likely to be

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bullied in groups (81%) than on their own (19%). A similar result was obtained in the UNISON (1997) study. Around 60% of those bullied reported that they shared their experiences with “several other work-colleagues”, and 31% reported that their whole workgroup was bullied. Only 11% reported they were bullied on their own (UNISON, 1997).

The Hoel and Cooper (2000) study revealed a further pattern of people’s bullying experiences. In this study, more people reported being singled out than had been shown before (31% of those bullied). It was also common that people reported that they shared bullying experiences with several other work colleagues. It was however rare that people reported that their whole workgroup was bullied.

These variations in findings (e.g. between the UNISON findings and the UMIST findings) may possibly be due to selective samples examined. The sample used in the Hoel and Cooper study comprised quite high number of managers, who may not see themselves as part of a “workgroup” in the same way that UNISON members may do (Rayner et al, 2002).

What types of behaviours are reported?

In three of the studies previously reviewed (Hoel & Cooper, 2000; Quine, 1999, UNISON, 1997), respondents’ experiences of negative acts at work were specifically examined. A general finding in all three studies

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was that experiences of work-related bullying and social isolation were most prevalent. For example, in the UNISON study, the behaviours most frequently reported were “withholding information”, “set unrealistic targets”, “meaningless tasks”, “excessive work monitoring”, and “ignored by others”.

In Quine’s (1999) study, the most frequently reported behaviours were “shifting goalposts”, “withholding necessary information”, “undue pressure to produce work”, and “freezing out, ignoring, or excluding”. Finally, the behaviours most frequently reported in the UMIST study (Hoel & Cooper, 2000) were “withholding necessary information”, “having your opinions and views ignored”, “being exposed to an unmanageable workload”, and “given tasks with unreasonable or impossible deadlines”.

Overall, it seems that indirect acts (e.g. information manipulation) are much more common in British workplaces than direct acts (e.g. verbal abuse, physical violence). This pattern of study findings fits well with Björkqvist et al’s (1994) cost/benefit model of aggressive behaviour and also research findings in the related area of workplace aggression (e.g. Baron & Neuman, 1996; see Chapter 1, p. 11).

The UMIST research group recently published a study where relationships between organisational status and experiences of bullying acts were examined (Hoel et al, 2001). The study showed that workers

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and supervisors were more frequently exposed to negative acts than managers. What was more, these two groups (workers and supervisors) were more likely to be exposed to behaviours of a personally derogatory and exclusionary nature. Managers, on the other hand, were most likely to report extreme work pressures and workload. These findings are also in line with the Björkqvist et al's (1994b) cost/benefit model. Based on the reasoning of this model, one would expect exposure to bullying behaviours to be less frequent and more indirect at higher levels of the organisational hierarchy than at the lower levels.

What is the duration of bullying episodes?

The duration of bullying episodes was examined in two of the UK studies (Hoel & Cooper, 2000; Rayner, 1997). In these studies, different patterns of findings were obtained. In the study of Rayner (1997), employees were most likely to report duration of six months or less (42%) or between six and twelve months (25%). However, in 18% of cases the duration of bullying was more than two years.

In the UMIST study, on the other hand, a number of people reported that they had been exposed to bullying acts for one year or more. In 28% of cases, the duration of bullying was between one and two years and in 39% of cases the duration was more than two years. Duration of six months or less was reported in only 17% of cases. Hence, the UMIST

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findings suggest that for many people, bullying at work is a long lasting experience.

Regarding these findings, it may be noted that clinical accounts suggest that bullying episodes may last for a very long time. For example, in an interview study of 30 bullying victims, O'Moore et al (1998) found that 11 (or 37%) of interviewees had been victimised for periods of three to ten years.

Prevalence of bullying in Scandinavian workplaces

Before its emergence in the UK, workplace bullying (or mobbing) was recognised and studied in countries such as Sweden, Norway and Finland. It may even be argued that the most developed research in the field comes from Scandinavia, where there is a strong public awareness, government-funded research, and established anti-bullying legislation (Quine, 1999).

Prevalence of bullying in Sweden

The first systematic research into bullying at work was carried out in Sweden (Leymann, 1992a, 1992c; Leymann & Tallgren, 1989). In Leymann's (1992a, 1992c) study a sample of 2,400 employees representing the Swedish working population were interviewed. In the

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English report of the study (Leymann, 1996), a description of these interviews is not provided. However, in this report, Leymann states that 3.5% of respondents fitted his operational definition of bullying (or mobbing). That is, 3.5% reported frequent experiences of bullying (operational definition: at least once a week) over a long period of time (operational definition: at least six months). The prevalence appeared to be similar among male and female workers. As regards bullying and age, the case was the same. That is, the prevalence of bullying in various age groups was almost the same.

Regarding the research question: "who is bullying whom?" Leymann found that men were most likely to be bullied by other men, whilst women were most likely to be bullied by other women or by women *and* men. This pattern of findings is consistent with the pattern observed in some of the UK studies (e.g. Hoel & Cooper, 2000; UNISON, 1997). Leymann also found that employees were in many cases bullied by more than one individual (rarely though by a whole work team).

Prevalence of bullying in Norway

Research into bullying started somewhat later in the other Scandinavian countries, but in a paper from the mid-1990s, Einarsen and Skogstad describe study of 7,986 Norwegian employees (Einarsen & Skogstad, 1996). This study encompassed a broad array of organisations and professions (14 sub-samples, average response rate: 60%). As

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previously noted (p. 24), the researchers used a written definition of bullying and asked respondents if they had been exposed to bullying in their workplace over the past six months. In addition to estimating the prevalence of bullying, Einarsen and Skogstad examined the duration of bullying episodes and who were reported as offenders of bullying at work.

The results of the study showed that 8.6% of respondents reported being bullied in the past 6 months. Of those, 4% reported they were bullied once or twice, 3.4% said they were bullied now and then, and 1.2% reported being bullied on a weekly basis. Thus, only a small proportion of respondents reported persistent bullying at work. As in the UK studies, the prevalence of bullying was roughly the same among male and female employees. However, older employees reported more bullying than younger ones (notice the reverse pattern in UK studies, e.g. Hoel & Cooper, 2000; Quine, 1999; UNISON, 1997).

Among those who reported the duration of bullying, 41.8% reported a period of six months or less. Around 17% reported a period six to twelve months, while 23.9% had been bullied for more than two years. The researchers note that the mean duration of bullying was 18 months – a finding that supports the view that bullying is in many cases a long lasting experience.

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Regarding the position of the bully, Einarsen and Skogstad found that work-colleagues were reported as perpetrators in approximately 50% of cases. In other cases, immediate supervisors or managers were reported. Interestingly, some of the UK studies (Hoel & Cooper, 2000; UNISON, 1997) showed quite the opposite pattern. That is, in these studies, managers and immediate supervisors were most frequently reported as bullies. One plausible explanation for this cross-cultural difference is a low “power distance” between managers and subordinates in Scandinavian countries (Hofstede, 1980; Brown, 1998).

Power distance is a concept used when comparing work cultures, and refers to people’s attitudes within a hierarchy. In countries with high power distance, the boss is seen as authoritative, unquestioned and obeyed. In low power distance cultures, the boss is seen more as a facilitator of the team (Hofstede, 1980). In Scandinavian countries, where the power distance is low, few psychological distinctions are made in the organisational hierarchy. It is possible that in countries with higher power distance (e.g. the UK), bullying is seen more “normal” and even an acceptable part of management behaviour (Rayner et al, 2002).

Just as Leymann (1996), Einarsen and Skogstad found that victims often reported more than one person as a bully (in most cases colleagues *or* superiors, but in some cases colleagues *and* superiors). Also in line with Leymann’s findings and the UK findings, the results showed that men were most frequently reported as bullies. Finally, Einarsen and Skogstad

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found that among male victims, the most common bullies were other men. Among female victims, the most common bullies were other women or men *and* women.

Apart from this large-scale study of bullying in Norwegian workplaces, few other studies have been conducted in Norway where the prevalence of bullying is examined (e.g. Einarsen & Raknes, 1997a; Matthiesen, 1990; Matthiesen et al, 1989). In line with Einarsen and Skogstad (1996), these studies suggest that the prevalence of bullying in Norwegian workplaces is relatively low, or between 3 and 7%. The lower figure (3%) was obtained in a study of 745 Norwegian assistant nurses (Matthiesen, 1990). The higher figure (7%) was found in a study of 464 male employees in a Norwegian marine engineering industry (Einaren & Raknes, 1997a).

Prevalence of bullying in Finland

Amongst the researchers who have examined the prevalence of bullying in Finnish workplaces are Björkqvist and his colleagues. In a study published in the mid-1990s, these researchers examined the prevalence of bullying (or harassment) in university employees (Björkqvist et al, 1994a). A total of 338 employees took part in the study, giving a response rate of 47% (original sample consisted of 726 employees). The researchers used a 24-item scale (the Work Harassment Scale (WHS); Björkqvist et al, 1992b) to assess employee experiences of harassing

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behaviours at work. They also asked the employees if they had observed any events of harassment in their workplace. Finally, they asked some questions about “the tormentor” (e.g. the position of the tormentor).

The prevalence of harassment was analysed separately for men and women. Unlike other researchers (e.g. Einarsen & Skogstad, 1996), Björkqvist et al found that women were more likely than men to experience workplace harassment. Using statistical criteria (scores above 0.75 on WHS), the researchers regarded 24.4% of the women and 16.9% of the men as victims of harassment. The study also revealed that 32% of respondents claimed to have observed others being harassed, and 17.8% had seen more than one case. Of the observed cases (137 cases), the tormentor was most likely to be the victim’s superior (in 56% of cases). However, it was also common that the tormentor was in a position similar to the victim, or in 32% of cases. In 12% of cases, the tormentor was in a lower position than the victim.

Even though the prevalence of bullying was quite high in this study (24.4% among women and 16.9% among men), the prevalence is markedly lower than in some of the UK studies where a similar methodology is used. That is, the studies where employee experiences of negative acts are examined (e.g. Hoel & Cooper, 2000; Quine, 1999)³.

³ In the UMIST study (Hoel and Cooper, 2000) and in Quine’s (1999) study, 38% of respondents claimed to be persistently exposed to negative acts at work.

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Other studies conducted in Finland suggest that the prevalence of bullying at work is between 5 and 10%. In a study of 949 municipal employees (response rate 65.8%), Vartia (1996) used a definition of bullying and asked respondents if they considered themselves as targets of bullying. Respondents were also asked if they had witnessed the bullying of others. The results of the study showed that 10.1% considered themselves as targets of bullying, and 8.7% had witnessed the bullying of others.

Using a similar methodology (i.e. using a definition of bullying and self-reports), Kivimäki, Elovainio and Vahtera (2000) examined the prevalence of bullying among 5655 hospital employees (response rate: 77%). The results of this study showed that 5% of respondents were currently exposed to bullying at work. This group of employees did not differ from other employees regarding sex, age or occupational background.

Regarding research findings from Finland, it must be noted that the study samples used are quite restricted. That is, the prevalence of bullying is examined in only certain occupational sectors (university employees, municipal employees and hospital employees). So far, no study has been conducted in Finland where the prevalence of bullying is examined across occupational sectors.

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Prevalence of bullying in Denmark

In spite of the pioneering role of Scandinavian research in the field of bullying, assessments of the problem in Danish work-life have just recently started. So far, only two studies have been published where the prevalence of bullying in Danish workplaces is examined.

Hogh and Dofradottir (2001) conducted a study where one-year prevalence of bullying (in the form of repeated exposure to slander and/or nasty teasing) was examined in Danish workplaces. The study sample consisted of 1,857 Danish workers but the original sample used was a randomised one, comprising 4,000 Danish adult citizens. The researchers used the self-report method to assess the prevalence of bullying. That is, respondents were asked if they had been exposed to bullying (gossip/slander or nasty teasing) in the past 12 months. As well as giving a yes/no answer to this question, the bullied ones were asked to specify the position of the perpetrator(s). In addition, they were asked to tell how frequently they experienced the bullying.

The result of the study was that 2% of respondents had persistently (or, "between twice a month and daily") been exposed to slander and/or teasing at work in the previous 12 months. The extent of bullying was quite similar between male and female workers. Of those bullied, 48.6% reported superiors as perpetrators, 82% reported colleagues, and 25.7% reported subordinates. What may possibly explain this pattern of findings

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(regarding perpetrators) is the nature of bullying examined in the study. That is, workers may be more likely to experience slander and/or teasing from colleagues and even subordinates than some other types of bullying (e.g. work-related bullying).

In the second Danish study, Mikkelsen and Einarsen (2001) examined the prevalence of bullying in three kinds of work settings: hospitals, manufactory company and department store (Mikkelsen & Einarsen, 2001). As well as estimating the prevalence of bullying, the researchers tested the hypothesis that the problem of bullying at work is less widespread in Scandinavia than in countries such as the UK.

Two methods were used to assess the prevalence of bullying. First, a definition of bullying was used and respondents were asked if they had been exposed to bullying in the past six months. Second, a 22-item version of the NAQ was used to assess respondents' experiences of negative acts in the past six months. In addition, the respondents were asked if they had witnessed the bullying of others in the past six months.

The results of the study showed that only 2-4% of employees reported being bullied in the previous six months, and in most cases only "now and then". When using an operational criterion of bullying (i.e. weekly exposure to one bullying act in the previous six months), the prevalence ranged from 8% to 25%. However, when a more stringent criterion was used (exposure to two acts per week in the past six months), the

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prevalence ranged from 2.7% to 8%. Thus, in agreement with most previous Scandinavian studies, Mikkelsen and Einarsen found a low level of bullying in Danish workplaces. However, a notable finding in the Danish study was that many respondents reported having witnessed the bullying of others (16 to 18% of respondents, depending on the sample). This proportion of observers still seems somewhat lower than the proportion of observers in UK workplaces (e.g. Quine, 1999; Rayner, 1997)

Cross-cultural variations in prevalence data

Having reviewed the research into the prevalence of bullying in the UK and Scandinavia, it may be concluded that the prevalence is somewhat higher in UK workplaces than in Scandinavian workplaces. It must be noted however that this impression is far from being clear-cut. In fact, cross-cultural comparisons in the field of workplace bullying can be quite complex. This is mainly due to subtle but essential differences between countries in the ways bullying is defined and assessed. In spite of these complications, some attempts have been made to explain the apparent cross-cultural variations in prevalence data (e.g. Einarsen, 2000).

Previously in the chapter, the concept of “power-distance” (see Hofstede, 1980) was used to explain contrasts in study findings regarding perpetrators of bullying (why superiors are most commonly

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reported in UK studies, whilst colleagues and superiors are just as likely to be reported in Scandinavian studies). Einarsen (2000) has used this same concept (the concept of power distance) to explain the low levels of bullying in Scandinavian countries (compared to the levels observed in other countries, such as the UK).

The main reason for using power distance in this context is that power inequalities between offender and target are essential for bullying to take place (Niedl, 1995; Olweus, 1993). Einarsen (2000) defines power distance as “the interpersonal power or influence difference between two persons as perceived by the less powerful of the two” (p. 385). Countries such as Norway, Sweden and Finland have been identified as cultures with relatively small differences in power and status between individuals in different formal and informal positions. According to Einarsen (2000), these countries are therefore likely to have a low prevalence of bullying and harassment compared to countries found to have a larger power distance.

In addition to this, research into cross-cultural variations in work-related values, attitudes and beliefs (e.g. Hofstede, 1980) suggests that Scandinavian work cultures are likely to be more feminine-oriented than many other work cultures (cf. Einarsen, 2000). The implication here is that the Scandinavians are more likely to be tolerant, accommodating and flexible in social relationships. They are also more likely to value unisexuality and fluid sex-roles, as well as the equality between the sexes.

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These sorts of values and beliefs may again indicate less tolerance of aggressive behaviour and power abuse, and thus lower levels of work harassment in these countries (Einarsen, 2000).

A Dutch study (Van Oudenhoven, Mechelse & de Dreu, 1998) also explored the hypothesis that cultural dimensions influence the nature of interpersonal behaviours in organisations. Results showed that managers from countries with a low power distance (e.g. Denmark and the Netherlands) were more likely to use constructive conflict management techniques (e.g. open and co-operative communication when in conflict with superiors) than managers from high power distance countries (e.g. Spain and Belgium). Moreover, managers from feminine cultures (e.g. the Danish culture) showed more problem-solving behaviour when in conflict with colleagues than did managers from masculine cultures (e.g. the UK and Belgium). In so far as these constructive conflict behaviours also apply to the management of conflicts with subordinates, a viable hypothesis is that the low prevalence of bullying in Scandinavia is partly because Scandinavian managers are more constructive and less authoritarian in conflict situations than managers from high power distance cultures (Einarsen, 2000; Mikkelsen & Einarsen, 2001). This hypothesis is in line with research (e.g. Einarsen et al, 1994a; Vartia, 1996) showing bullying to be associated with employee ratings of management style as less conflict solving and more authoritarian.

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Having reviewed some main findings regarding the prevalence of bullying at work, the thesis will now shift in focus and address the question “what are the effects of bullying on peoples’ health and well-being?” In the following chapter (Chapter 3), this question will be addressed from various angles. In the chapter, bullying will be explained in the context of stress theory, and the existing literature on bullying and health outcomes will be presented.

CHAPTER 3

OUTCOMES OF BULLYING: A REVIEW OF PREVIOUS RESEARCH

Introduction

For some time, there has been a tradition – especially in the Continental European countries – to discuss bullying at work in the context of stress theory. That is, bullying is often seen as an extreme form of social stressor at work (e.g. Niedl, 1995, 1996; Zapf & Gross, 2001; Zapf et al, 1996; Wilson, 1991). The basic feature of social stressors at work, according to Zapf et al (1996), is that they are related to the social relations of employees within the organisation. Whereas social stressors usually occur as daily hassles (e.g. Kanner, Coyne, Schaefer & Lazarus, 1981), bullying may on occasion be experienced as a critical life event. This may, for example, be the case when bullying takes the form of physical or sexual abuse. Whilst social stressors in general may vary somewhat in frequency, bullying denotes a social stressor occurring on a regular basis (see definition of bullying in Chapter 1, and measurement of bullying in Chapter 2). Also, social stressors in general may occur under equal or unequal power structures, and the power structures do not need to change because of the stressors. However, bullying as a form of social stressor always takes place under unequal power structures (see again definition in Chapter 1). Regarding this aspect of

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bullying, Zapf et al (1996) note that bullying (or mobbing) can start with an equal power structure. However, for various reasons an unequal power structure will result after some time: “the victims are pushed into an inferior position which limits their resources to defend themselves” (Zapf et al, 1996, p. 217).

Whilst Zapf and colleagues, as well as Niedl (1995, 1996) view bullying as a form of social stressors, Scandinavian researchers (e.g. Leymann, 1992a, 1996) see bullying (or mobbing) as an extreme social phenomenon, *triggered* by extreme social stressors (communication problems, poor social climate etc.), causing a range of stress reactions (biological and psychological) which, in turn, become social stressors for others. For example, Leymann (1996) describes the instigation of bullying in the following way.

Very poor psychological conditions at workplaces may result in biological stress reactions. This in turn can stimulate feelings of frustration. Through psychological processes (especially if employees lack knowledge of how to analyse social stressors at work), frustrated persons can, instead, blame each other, thus becoming each other's social stressors, and triggering a mobbing situation for a single person.

(Leymann, 1996, p. 169)

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Others have described bullying at work as a scapegoating process (e.g. Thylefors, 1987). According to Thylefors, bullying is a complicated interactive process, in which the organisation, the work group, and the victim all have a specific role (cf. Vartia, 1996). Whether bullying is seen as a form of social stressor or a more complex social phenomenon, there is general agreement that victims of bullying may suffer from various health problems, whether these are of physical or psychological nature. In the more general stress literature, there is also a recognised link between stressful life events and adverse health outcomes (Schwarzer & Schulz, 2003; Tennant, 2002; see also Taylor, 1995). The aim of this chapter is to review the existing literature on the health effects of bullying at work. The chapter will also address the issue of how bullying may affect bystanders or observers of bullying. Finally, the potential effects of bullying on the organisation will be discussed.

Before reviewing the literature on bullying and health outcomes, it must be noted that the relationship between bullying and health is so far not clear-cut. Most of the current knowledge about potential effects of bullying is drawn from cross-sectional survey studies. In such studies, it is not possible to interpret the real cause and effect relationship between two variables, in this case bullying experiences and some health measure. The only conclusion we can draw from these studies is that there is an *association* between the two variables. This issue will be discussed in more detail later in this chapter.

Bullying and health outcomes

As previously noted (Chapter 1), existing anecdotal and clinical accounts of bullying and harassment at work often give an outline of the detrimental effects of persistent harassment on victims' health and well-being. In a paper since 1990, Leymann describes his clinical experience with bullying victims and claims that the health effects of bullying can be of psychological as well as psychosomatic nature (e.g. feelings of desperation and helplessness, anxiety and despair, psychosomatic complaints). In the same paper, Leymann also talks about the effects of bullying on social and psychosocial states (Leymann, 1990). The examples he gives about social effects are: social isolation, stigmatising, and social maladjustment. Regarding psychosocial effects, he talks about losses of coping resources: "many coping resources are linked to social situations, and as these change in a negative direction, the coping system breaks down" (Leymann, 1990, p. 122). In addition to these effects, Leymann has noted that prolonged episodes of bullying may lead to severe psychological damage (e.g. depressions, hyperactivity, compulsions), and even to suicide (Leymann, 1990, 1996).

Clinical accounts from the US also give an outline of the potential effects of bullying and harassment at work. In a groundbreaking work in the field, "*The Harassed Worker*", Brodsky (1976) describes three sets of effects on victims. These sets are based on Brodsky's clinical observations and interviews with American victims of harassment.

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Some of the victims observed expressed their reaction by developing vague physical symptoms, such as weakness, loss of strength, chronic fatigue, pains and various aches. Others reacted with depression or symptoms related to depression (e.g. lack of self-esteem, impotence, sleeping problems). A third group reacted with psychological symptoms, such as hostility, hypersensitivity, memory loss, nervousness, and avoidance of social contact.

A number of empirical studies also suggest that a relationship exists between bullying experiences and declining health. The health outcomes most frequently reported are: psychosomatic stress symptoms (Einarsen, Raknes, Matthiesen & Hellesøj, 1996; Leymann, 1992b; Mikkelsen & Einarsen, 2001; Price Spratlen, 1995; Zapf et al, 1996), musculo-skeletal symptoms (Einarsen & Raknes, 1991; Einarsen et al, 1996), anxiety (Einarsen & Raknes, 1991; Einarsen, Matthiesen & Skogstad, 1998; Keashly et al, 1994; Mikkelsen & Einarsen, 2001; Niedl, 1996; Quine, 1999, 2001; Tepper, 2000) and depression (Björkqvist et al, 1994a; Einarsen et al, 1998; Mikkelsen & Einarsen, 2001; Quine, 1999, 2001; Tepper, 2000).

Other symptoms reported in the literature are: lowered self-esteem (Ashforth, 1997; Cortina, Magley, Williams, & Langhout, 2000; Einarsen et al, 1998; Price Spratlen, 1995; Zapf et al, 1996), feelings of low self-confidence (Vartia, 2001); irritability (Einarsen et al, 1998; Niedl, 1996; Zapf et al, 1996), aggressiveness (Björkqvist et al, 1994a), general

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stress (Vartia, 2001), lack of concentration (Björkqvist et al, 1994a; Leymann, 1992b), mental strain (Schat & Kelloway, 2000; Vartia, 2001), emotional fatigue (Einarsen et al, 1998; Tepper, 2000), and sleeping problems (Björkqvist et al, 1994a; Einarsen et al, 1998).

In the national study of bullying in Sweden (see Ch. 2, p. 41), Leymann assessed the relationship between bullying and several health measures (Leymann, 1992a, 1992b, 1992c). On the basis of statistical analyses, he concluded that bullying was mainly linked with cognitive outcomes (e.g. concentration problems and irritability) and psychosomatic complaints (e.g. headaches, nausea, muscular aches). The German researchers Zapf et al (1996), as well as the Austrian researcher Niedl (1996), also suggest that bullying is especially related to psychosomatic health complaints. However, some other researchers (e.g. Einarsen & Raknes, 1991; Mikkelsen & Einarsen, 2001) have concluded that bullying is mainly related to outcomes such as depression and psychological strain (e.g. anxiety and nervous debility).

Even though bullying in general is related to various health outcomes (according to the studies cited above), some types of bullying seem to have especially strong relationships with these outcomes. In a study of German bullying victims, Zapf et al (1996) examined the relationship between bullying and four outcomes: psychosomatic complaints, irritability, depression and self-esteem. The researchers found strong relationships between bullying and all four outcomes. However, of the

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seven types of bullying examined, personal attacks (or “attacking the private person”) had the strongest relationship with the health outcomes. Of the other types of bullying studied, work-related bullying (or “organisational measures”), social isolation, verbal aggression and rumours were also strongly related to the outcome measures.

In the study of Norwegian male employees, Einarsen & Raknes (1997a) observed associations between exposure to workplace harassment and various psychological problems (anxiety, depression, sleeping problems, tension, restlessness, and headaches). In this study, the relationships between four types of bullying (personal derogation, work-related harassment, social exclusion, physical abuse) and health outcomes were also assessed. In line with the German findings (Zapf et al, 1996), Einarsen and Raknes found especially strong correlations between experiences of personal derogation and psychological health.

Until recently, research into health outcomes of bullying in the UK has been relatively sparse. The UNISON (1997) study found some links that were worth pursuing, but 75 per cent of those who were currently bullied reported some psychological health problems (e.g. stress, depression, and lowered self-confidence). However, the severity or level of “harm” was not considered in the study. In Quine’s recent study of community trust employees, it was found that those who reported persistent bullying behaviours in the past 12 months were more likely than other employees to suffer from stress, anxiety and depression (Quine, 1999).

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Hoel and Cooper, in their national study (Hoel & Cooper, 2000), used two health measures – one of which related to physical health, and the other to mental health. The researchers found that employees who were currently bullied were more likely than other employees to show signs of both physical and mental ill health (Hoel & Cooper, 2000; see also Rayner et al, 2002). Regarding the association of bullying with mental health, Rayner et al note that in the context of the study, mental ill health refers to ill health among “the normal population at large”, not to pathological mental disturbance (Rayner et al, 2002, p. 45). In addition to these findings, Hoel and Cooper found that a group of previously bullied employees (i.e. employees who had been bullied within the past five years, but were not currently bullied) were also likely to show symptoms of physical and mental ill health.

Is bullying a cause or an effect of poor psychological health?

Previously in this chapter, it was noted that most current knowledge about potential effects of bullying on psychological health is drawn from cross-sectional studies. The implication of this is that the relationships observed can be explained in more than one way. Indeed, Quine (1999) has argued that the associations between bullying and outcomes may be explained in three ways. It may be the case that bullying does have adverse effects on victim’s psychological health (e.g. cause them to suffer stress, anxiety and depression). However, it is also possible that psychological distress (e.g. being depressed or anxious) may cause a

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person to be victimised by “unscrupulous workers who choose weaker people as their victims” (Quine, 1999, p. 231). What is more, anxiety and depression may weaken a person’s ability to cope with stressful situations such as bullying or make him/her more likely to view other peoples’ behaviour as hostile or critical. Simply speaking, the above explanations are dealing with the issue of cause and effect. In order to determine the causal relation between bullying and psychological health, studies employing longitudinal research design must be conducted.

The third explanation offered by Quine (1999) is that some employees may be more likely than others to report bullying. These may, for example, be the ones who are more pessimistic in outlook. The same people may also be likely to report high levels of psychological distress. In Chapter 2, it was noted that the affective tendency and cognitive style associated with NA is a potential source of bias in reports of bullying. As regards reports of psychological distress, there is some evidence showing that NA often correlates with self-report measures of psychological distress (e.g. Watson, 1988; Watson, Pennebaker & Folger, 1987). Because of factors such as NA, it is therefore possible that the observed relations between bullying and psychological health are somewhat inflated. In an extensive review of research data, Watson and Pennebaker (1989) found that NA often correlated with self-report measures of physical health. Therefore, they concluded that NA acts as a general nuisance factor in health research. Because of the effects of NA on self-report data, there seems to be a good reason to use some

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measure of NA in bullying research, and then test for the effects of NA on observed bullying-outcome relations (see Quine, 2003).

The role of NA in bullying-outcome relations

In a recent paper by Mikkelsen and Einarsen (2002), the role of NA in bullying-outcome relations is thoroughly discussed, though not empirically tested. The authors contend that at least three mechanisms, originally proposed by Spector and colleagues (2000) on the topic of occupational stress, may help explain the role of NA. These are: the perception mechanism, the hyper-responsivity mechanism, and stressor creation mechanism.

Consistent with the *perception mechanism*, NA may affect employees' perceptions of their social work environment and therefore the way they perceive interpersonal behaviours. As noted in Chapter 2, high-NA individuals tend to focus on the negative sides of themselves, other people and the world in general. They are also more inclined to pay attention to and magnify potential threats from their surroundings and to perceive ambiguous stimuli in negative way (Watson & Clark, 1984). Accordingly, they may be more likely to perceive the behaviour of others as signs of bullying. This kind of perceived exposure to bullying may in turn be related to increased levels of reported strain.

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Secondly, in agreement with the *hyper-responsivity hypothesis* (Spector et al, 2000), individuals high in NA may have increased emotional reactivity when facing stressors such as negative interpersonal behaviours (Larsen & Ketelaar, 1991). Therefore, when exposed to bullying acts they may experience more strain than others given the same environmental conditions.

Finally, according to the *stressor-strain creation mechanism* (Spector et al, 2000), high-NA individuals may be more likely to create a social environment in which they are exposed to aggressive behaviours. For example, the behaviour of high-NA individuals may possibly annoy and irritate others, who may in turn react negatively towards them (Burke, Brief & George, 1993; Zapf, 1999b). The particular constellation of high-NA individuals, namely their proneness to experience feelings of distress, anxiety and anger at any time and across variety of situations (Watson & Clark, 1984), may also place them at higher risk of victimisation.

Moreover, the tendency to use coping strategies comprising confrontation, e.g. angrily venting emotions when facing stress (O'Brien & DeLongis, 1996), may also result in high-NA individuals being more frequently involved in interpersonal conflicts, which again may escalate into bullying (Mikkelsen & Einarsen, 2002; see also Einarsen, 2000). As regards this final argument, it must be noted though that whilst distressed individuals may be likely to alter their own work environment

in negative direction, their perceptions of this altered environment may still be valid (Mikkelsen & Einarsen, 2002).

Support at work as a buffer against bullying

In spite of problems with cross-sectional data, researchers tend to conclude that bullying may have various consequences for victims' health. Given this line of reasoning, it must be noted that the effects of bullying on victims' health may vary somewhat. That is to say, some victims may be more affected by their experiences than others. It is for example quite possible that victims who get limited support from superiors or work colleagues are more likely to suffer stress and health related problems than those who get good support. In the literature on occupational stress (e.g. Johnson & Hall, 1988; Payne, 1979) it has been noted that a supportive work environment may act as a buffer, ameliorating the adverse effects of stressful situations on workers' health and well-being.

According to House (1981) and others (e.g. Cohen & McKay, 1984) these buffering effects of support may be explained in two ways (see Cohen & Wills, 1985). Before delineating these explanations, it must be noted that in the present context, stress is seen as a psychological state, comprising aspects of cognitive appraisal and emotion (e.g. Cox, 1978; Lazarus, 1966; Lazarus & Folkman, 1984). To be more exact, stress is

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seen to arise when a person experiences discrepancy (whether real or not) between potentially stressful situations (e.g. bullying situations) and the resources available to the person to cope with these situations.

Given this definition of stress, Cohen and Wills (1985) argue that support at work may intervene between a stressful situation and a stress reaction by attenuating or preventing a stress appraisal response. That is, the perception that others can and will provide necessary resources may change the way a person appraises the situation (i.e. the person may see the situation as less stressful) and/or bolster the person's ability to cope with the situation (cf. Cohen & McKay, 1984; Gore, 1981; House, 1981). In addition to this, Cohen and Wills (1985) note that adequate support may intervene between stress experiences and the onset of adverse health outcomes. That is, support may reduce or eliminate the stress reaction and in that way reduce the risk of pathological outcomes. According to House (1981), support may alleviate the impact of stress appraisal through routes such as providing a solution to the problem, reducing the perceived importance of the problem, and facilitating health-promoting behaviours.

So far, only two studies have examined the moderating (or buffering) role of support in bullying-outcome relations. In a study of Norwegian workers, Einarsen et al (1996) assessed the moderating effects of support on the relationship between bullying and three health measures (psychological, psychosomatic, and musculo-skeletal complaints). The

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researchers assessed support from a structural aspect (e.g. who offers the support, how many offer support) as well as functional aspect (e.g. the value and adequacy of the support received). The results of the study showed clear moderating effects of support on all the relationships assessed.

In the study of community trust employees, Quine (1999) tested the moderating role of support on the relationship between bullying and three health outcomes: anxiety, depression and job induced stress. The support measure used comprised various resources in the work environment, such as feedback and support from peers and superiors, level of workplace morale and positive working practices. The results of the study offered some support to the buffering hypothesis. That is, a supportive work environment was found to ameliorate the adverse effects of bullying on depression. However, a similar effect was not found for the other two outcomes.

The role of personality in bullying-outcome relations

In a review paper on bullying and health outcomes, Einaren and Mikkelsen (2003) suggest that personality traits may play various roles in the bullying process. First, they claim that personality traits may increase the likelihood of a person displaying behaviours that are socially provocative, which in turn may increase the likelihood of interpersonal

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conflicts and escalation of such conflicts (Felson, 1992; Einarsen et al, 1994b; Olweus, 1993). Secondly, they argue that personality traits may possibly influence the extent to which a person is selected as a target (Coyne, Seigne & Randall, 2000; Einarsen, 1999; Zapf, 1999b)¹. Finally, they propose that personality traits may act as mediating or moderating factors in the relationship between bullying and stress reactions (see, for example, Einarsen, 2000).

As to the third issue, empirical findings do indeed suggest that variables pertaining to personality may affect the degree of reported stress symptoms in bullying victims. Einarsen et al (1996), for example, found that self-esteem and social anxiety partially moderated the relationships between bullying and self-report measures of psychological, psychosomatic, and musculo-skeletal health complaints. That is, victims high in social anxiety and/or low in self-esteem reported more health complaints than did victims low in social anxiety and/or high in self-esteem. Another factor that may possibly act as a moderator in bullying-outcome relations is that of generalised self-efficacy.

The construct of generalised self-efficacy (GSE) is commonly seen as reflecting optimistic self-belief (see Schwarzer, 1992), and in the context of stress theory it is construed as a stable and global belief in the ability to deal efficiently with a wide range of stressors (Jerusalem & Schwarzer, 1992; Schwarzer, Bässler, Kwiatek, Schröder & Zhang,

¹ This second issue is however a controversial one, as noted by Einarsen and Mikkelsen (2003).

1997). GSE is therefore considered as a personal resource factor, helping the person to cope with stressful situations (Jerusalem & Schwarzer, 1992). Given this type of definition, GSE can quite possibly be seen as playing a crucial role in bullying situations. That is to say, GSE may affect the way people appraise the situations, as well as affect their ability to cope with the bullying. Whether GSE affects people's cognitive appraisals or their coping responses, these effects may eventually attenuate stress-responses, and even prevent the onset of adverse health outcomes. In other words, GSE may possibly be seen as a buffer, protecting people from the detrimental effects of bullying at work. In a recent study conducted by Mikkelsen and Einarsen (2002) this moderating role of GSE was indeed confirmed. That is, the researchers found that generalised self-efficacy acted as a weak moderator of the relationship between bullying experiences and psychological health complaints. However, there is a need for more research where the effects of GSE on bullying-outcome relations are examined.

Bullying and drinking outcomes

In a recent paper from the US, Richman and colleagues note that whilst people may consume alcohol for varied purposes, one motive for drinking involves the use of alcohol to self-medicate distressful feelings resulting from problematic social conditions (Richman, Rospenda, Flaherty & Freels, 2001). The authors cite to a considerable body of

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research addressing social influences on the use and abuse of alcohol. This line of research has mostly focused on task-related aspects of work, such as nature of work tasks and control over work activities (Greenberg & Grunberg, 1995; Martin & Roman, 1996; Parker & Farmer, 1990). However, researchers have also paid some attention to interpersonal conflicts at work, which have been shown to constitute risk factors for deleterious drinking outcomes (e.g. Appelberg, 1993; Romanov, Appelberg, Honkasalo & Koskenvuo, 1996).

Relationships have also been found between workplace harassment and problematic drinking outcomes (Richman, Flaherty, Rospenda & Christensen, 1992; Richman, Flaherty & Rospenda, 1996; Richman et al, 1999). In one of their studies, Richman and colleagues examined the effects of harassment and abuse in medical settings on drinking outcomes (Richman et al, 1996). Their data showed that physician's experiences of harassment and abuse at work were strongly correlated with outcomes such as "problem drinking", escapist drinking motives, and quantity/frequency of drinking for men and women, controlling for drinking behaviours in the previous year. In a following study of university employees, Richman et al (1999) found that employee experiences of sexual harassment (SH) and generalised workplace abuse (GWA) were cross-sectionally related to drinking outcomes, again for men and women, when other demographic factors (race, age and occupation) were controlled for.

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Apart from these findings from the US, the effects of bullying and harassment on drinking outcomes have rarely been examined. The same applies to the effects of bullying on other health-damaging behaviours, such as smoking and drug use. However, in one Finnish study (Vartia, 2001) associations were found between bullying experiences and frequency of drug use. That is, Vartia found that targets of bullying used sleep-inducing drugs and sedatives more frequently than did their non-bullied counterparts.

Bullying and occupational outcomes

There is a general belief that bullying does not only affect victim's health, but may also have various effects on the organisation. One effect commonly mentioned in the literature is increased absenteeism. There may be several reasons for this sort of effect on the organisation. One reason can be that targets of bullying stay away from work as a result of health problems. A second reason may be that targets use absenteeism as a way of severing contact with the workplace and the "bullies" (Rayner et al, 2002).

Absenteeism

The notion that bullying may lead to increased sickness absence has indeed received some empirical support. However, the link between

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bullying and absenteeism has mostly been tested cross-sectionally (e.g. Barker, Sheehan & Rayner, 1999; Hoel & Cooper, 2000; Matthiesen et al, 1989; Vartia, 2001; Voss, Floderus & Diderichsen, 2001). Regarding these associations, Kivimäki et al (2000) made the claim that poor health may not only be a result of bullying, but may also increase the risk of becoming a victim of bullying.

To exclude this reverse effect of poor health on bullying, Kivimäki et al (2000) tested the link between bullying and absenteeism prospectively. That is, they assessed the associations between bullying and sickness absence, adjusting for baseline absence, health risks, and health status. The result of their analysis was that bullying was still associated with sickness absence (their cross-sectional data had previously shown correlations between bullying and sickness absence). Apart from this study, however, there is no clear evidence as to the effects of bullying on sickness absence.

Job satisfaction, motivation and propensity to leave

A second possible outcome of bullying at work is decreased job satisfaction among victims. Bullying victims may, for example, be less satisfied with superiors and leadership and/or with co-worker interactions. Their overall evaluation of their job may also be more negative than other workers'. Theoretically, decreased job satisfaction may be a direct consequence of negative treatment at work or a consequence of declined health. A number of cross-sectional studies

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have demonstrated links between bullying experiences and decreased job satisfaction (Cortina et al, 2000; Einarsen & Raknes, 1997a; Einarsen et al, 1998; Hoel & Cooper, 2000; Keashly et al, 1994; Price Spratlen, 1995; Matthiesen et al, 1989; Quine, 1999, 2001, 2003; Tepper, 2000). In a study among health care workers, exposure to aggressive behaviour was also associated with reduced job satisfaction (Dougherty, Bolger, Preston, Jones & Payne, 1992).

In the study of Norwegian male workers, Einarsen and Raknes (1997b) examined the associations between job satisfaction and the various forms of bullying (e.g. personal derogation, work-related bullying, social exclusion, physical abuse). The outcome of this analysis was that work-related bullying had particularly strong connection with overall job satisfaction, as well as with satisfaction with supervisors and leaders. Satisfaction with co-worker interaction was, on the other hand, particularly related to personal derogation and social exclusion.

Experiences of bullying have not only been linked with decreased job satisfaction, but also with lowered work motivation, (e.g. Hoel & Cooper, 2000), work withdrawal behaviours (e.g. Schat & Kelloway, 2000), reduced efficiency (e.g. Ashforth, 1997; Bassman, 1992; Einarsen & Raknes, 1991; Einarsen et al, 1994b; Hoel and Cooper, 2000; Pearson, Andersson & Porath, 2000; Price Spratlen, 1995) and decreased organisational commitment (Pearson et al, 2000; Tepper, 2000). In addition, considerable evidence shows that people tend to leave their

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jobs because of bullying (e.g. Bassman, 1992; Pearson et al, 2000; Rayner, 1997; Savva & Alexandrou, 1998; Tepper, 2000; UNISON, 1997). In the UNISON survey, for example, about a quarter of respondents claimed to have left their previous jobs because of bullying.

Finally, some studies in the field have confirmed links between bullying and propensity to leave the job. In a study of 99 bullying victims, Vartia (1991) found for example that 46% had considered leaving their job. Matthiesen et al (1989) also found that workers' reports of bullying were strongly related to intentions to leave the job. Similar results were obtained in Quine's (1999) recent study. Given these findings, it has been noted that not all the people who intend to leave actually do (see Rayner et al, 2002). In a recent study of American workers, Keashly and Jagatic (2000) found a much stronger relationship between bullying and "intention to quit" than between bullying and "looking for a new job" (cf. Rayner et al, 2002).

As with health outcomes, there is some evidence that a supportive work environment may play a moderating (or buffering) role in relationships between bullying and occupational outcomes. In the study of community trust employees, Quine (1999) found that employees who were bullied but experienced good support were less likely to be dissatisfied and to contemplate leaving their jobs than those who were bullied but experienced poor support.

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The question of cause and effect

Regarding the overall findings of bullying and occupational outcomes, it must be noted that the existing research data is mostly cross-sectional in nature. Therefore, it is not possible to conclude that outcomes such as lowered job satisfaction, work motivation or efficiency, result from bullying experiences (instead of playing a causal role in bullying experiences). In addition, it is possible that some people (e.g. those who are high in NA) are more likely than others to report bullying experiences as well as dissatisfaction with their jobs. In order to determine the causal relationships between bullying and occupational outcomes, longitudinal designs must be applied. As previously noted, the effects of factors such as NA on bullying-outcome relations also need to be tested.

“Ripple effects” of bullying

As noted in Chapter 1, workplace bullying is sometimes seen as a process comprising several phases (e.g. Björkqvist, 1992; Leymann, 1990, 1996). In this process, it may be expected that all members of the work unit play a certain role, and then often the role of observer or witness. Empirical evidence does in fact suggest that workers frequently observe the bullying of others (e.g. Björkqvist et al, 1994a; Einarsen et al, 1994a; Kivimäki et al, 2000; Lewis, 1999; Quine, 1999; 2001; Rayner, 1997; Vartia, 2001). Since this is the case, it seems reasonable to

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suggest that the effects of bullying extend beyond those directly bullied. In other words, it is possible that the bullying process creates a generally stressful work environment. For example, workers who are aware of the bullying of others may experience stress due to the possibility that they will become victims themselves. Those who witness the bullying of others may also experience stress when observing negative or non-supportive responses from the organisation, or when feeling powerless in curbing the bullying of their work-colleague.

So far, research has almost exclusively focused on the potential effects of bullying on victims' health and well-being. Yet, some recent studies have considered the well-being of victims as well as observers (or bystanders) of bullying. For example, Kivimäki and colleagues (2000) examined the rates of absenteeism in three groups of hospital employees: those who reported being bullied (victims; 5% of the total sample), those who worked in units where bullying took place (bystanders; 59% of the total sample), and other non-victims. Their cross-sectional data showed that bystanders were more likely than other non-victims to take time off work. However, their prospective analysis revealed that the two groups (bystanders and other non-victims) were just as likely to take time off work.

In a study of municipal employees, Vartia (2001) examined the effects of bullying on the psychological well-being of victims and observers of bullying. That is, Vartia compared three groups of employees (bullying

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victims, observers and non-observers) on measures of general stress, mental stress symptoms (e.g. depression, nervousness) and self-confidence. The study findings showed that both the victim group and group of observers reported more general stress and mental stress reactions than did the group of non-observers. However, only the victim group reported lower levels of self-confidence. The implication of these findings is that observers of bullying may (just like victims) suffer from psychological distress, whilst their self-confidence needs not to be affected.

Results obtained in the UNISON (1997) and the UMIST (Hoel & Cooper, 2000) studies also suggest that the effects of bullying may extend beyond those directly bullied. Rayner (1999) refers to these extended effects as “ripple effects of bullying”. Some of the effects reported in the UNISON (1997) study were increased stress levels (amongst observers), observers feeling worried about becoming victims themselves, and observers wanting to “do something”, but not having the courage to. In the UNISON study, it was also quite common that observers had changed their jobs due to the bullying. In addition, the UMIST findings (Hoel & Cooper, 2000) suggest that bullying may affect peoples’ mental and physical health, whether the people regarded are directly bullied or witness the bullying of others.

Finally, some studies in the field of racial and sexual harassment suggest that the effects of harassing behaviours may extend beyond

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those directly targeted. For example, Gutierrez, Saenz and Green (1994) found that minority as well as non-minority employees experienced increased levels of stress as a result of racial discrimination against minorities in their work group. In the field of sexual harassment, Glomb et al (1997) found that individual and group level measures of sexual harassment (SH) were related to negative outcomes such as lowered job satisfaction and psychological distress. That is, women who had experienced SH directly *or* were members of work groups where SH was prevalent, were more likely than other women to be dissatisfied with their job, and to experience psychological health problems. They were also more likely to take time off work, to contemplate leaving their jobs, and to take extended work breaks (Glomb et al, 1997).

Bullying in hospital settings: Prevalence and occupational health outcomes

Having reviewed previous research on prevalence and outcomes of bullying at work, the thesis will now move on to the author's empirical work on bullying in the hospital setting. The project had two basic aims:

- (1) To assess the prevalence of bullying among trust employees.
- (2) To examine the potential effects of bullying on employee health and well-being.

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As noted in Chapter 1, the studies reported took place in two hospital trusts, one located in Scotland (Study 1; see Chapters 4 and 5) and the other in Iceland (Study 2; see Chapters 6 and 7). In the two studies, somewhat similar issues were addressed, and these were all closely related to the topics already discussed in the thesis – that is, in Chapters 1, 2 & 3. Throughout the empirical chapters attempts will be made to explicate these links between current and previous research.

Contribution to existing knowledge

It seems apposite to finish this chapter by briefly explaining what is new or distinctive about the current research project. This includes explaining what the current project adds to the existing knowledge of bullying at work. What mainly distinguishes the current project from other projects in the field is the methodology used to test the relationship between bullying and occupational health outcomes. Specifically, the methodology used in the project enabled the author to study whether bullying at work is mainly the cause of negative health outcomes or whether the relationship between bullying and health outcomes is more complex.

The methodology selected rested on arguments already presented in the thesis (see pp. 61–63). Whilst, most current knowledge suggests that bullying at work leads to negative job affect and adverse health

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outcomes, it is quite possible that other causal mechanisms are also at work. These other mechanisms were systematically tested in the project. The first mechanism tested was that factors such as negative affectivity (NA) influence the relationship observed between bullying and occupational health outcomes. In particular, that people high in NA are more likely to report bullying at work and also emotional distress and dissatisfaction at work. As noted in this chapter, there may be various reasons for this particular mechanism (see pp. 63 – 64).

The second mechanism tested was a reversed causality between bullying and health outcomes. In particular, the possibility that adverse health outcomes (e.g. high levels of anxiety or depression) place people at more risk of being bullied at work. In other research projects, this possibility of reversed causation has not been directly tested. Of course the issue can be more complex than stated above. For instance, it is possible that bullying and mistreatment is both a cause and a consequence of psychological health problems. It is also possible that observed reversed causal relationships are not based on real occurrence of bullying, but more on individual perceptions and attributions. For instance, the way anxious or depressed individuals perceive and interpret other peoples' behaviour. In spite of all this, it is highly important to study in more detail the relationship between bullying and adverse health outcomes.

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What also adds to the current knowledge is more extended view of the prevalence of bullying and mistreatment in hospital settings. Studies from the UK and other countries (e.g. Denmark and Finland) suggest that bullying in these settings is quite prevalent. Yet, more studies are needed to confirm this view. It seems especially important to assess prevalence rates in more countries. The results reported in this thesis will certainly help to make a better inference about the scale and nature of the problem in public hospitals. The results will also shed light on potential divergence in prevalence rates between countries (see more about this issue in Ch. 2).

CHAPTER 4

WORKPLACE BULLYING IN SCOTTISH HOSPITAL STAFF: PREVALENCE AND NATURE OF BULLYING ACTS

– STUDY 1: PART 1 –

Introduction

So far, researchers in the UK have mostly studied the nature and prevalence of bullying in English workplaces. The aim of this chapter is to report a survey study that was recently carried out in a Scottish workplace – namely, a large NHS hospital trust. The study was descriptive in nature, but its primary aim was to assess the levels of bullying in the trust. The study was cross-sectional in design, and structured questionnaires were used to collect the prevalence data.

Considering previous prevalence data (see review in Ch. 2), it is quite clear that researchers have used disparate ways of measuring bullying at work. However, the two methods most commonly used (but with some variations) are the so-called self-report method (employees asked to state (sometimes on the basis of definition) whether or not they have been bullied at work) and the operational method (employees asked whether they have been exposed to various types negative acts during a certain time period, e.g. in the past 6 or 12 months). These two methods were used in the present study to assess prevalence levels. A third method employed was to ask respondents whether they had witnessed

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the bullying of others (a method assessing indirect exposure to bullying at work). The study aimed to answer a number of questions regarding prevalence rates. These were:

- (Q1) How many employees have experienced persistent negative acts at work in the past 12 months?
- (Q2) How many regard themselves to have been bullied in the past 12 months?
- (Q3) How many have witnessed the bullying of others in the past 12 months?

Other questions addressed in the study were:

- (Q4) Of some 21 types of bullying acts, which ones can be seen as common in the trust? Which ones can be seen as rare?
- (Q5) Is there a relationship between bullying experiences and demographic variables, such as gender and age?

As regards overall prevalence rates, it was assumed (on the basis of previous findings, e.g. the UMIST findings¹) that the number of employees reporting exposure to bullying acts would be somewhat higher than the number classifying themselves to have been bullied. However, using a combination of self-report and operational methods was considered to be more constructive than using just one of the two methods (see arguments listed below). Using the two methods

¹ The UMIST study had shown that 38% of employees reported weekly or daily exposure to bullying acts at work, whereas only 10.6% labelled themselves as being bullied (Hoel & Cooper, 2000).

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simultaneously also allowed for meaningful comparison between employees' perceptions of bullying and reported exposure to negative acts at work.

In some recent work on prevalence estimates (e.g. Mikkelsen & Einarsen, 2001) it is argued that the use of operational methods – in contrast to self-report methods – will yield more “objective” and hence better estimates of prevalence rates. That is, asking respondents about distinct bullying acts seems to yield better estimates of bullying than asking respondents whether they feel bullied at work. The apparent reason for this is that operational measures are less likely to prompt respondents' cognitive and emotional processing, and since such processing may affect response tendencies (see Frese & Zapf, 1988), these measures are seen as more reliable.

However, the operational method is not free from flaws. It has been argued, for instance, that the method is not sensitive to imbalance in power, or the person's possibilities to defend him or herself, which is quite central to definitions of bullying (Salin, 2001). In addition, the operational method does not distinguish between situations that respondents can tolerate and those they cannot. What is more, not all possible bullying acts or strategies may be covered in study questionnaires. As for single acts of bullying, it may also be argued that they are not necessarily of equal severity (Salin, 2001). Whereas some

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acts may occur persistently without being perceived as bullying, others may have severe effects, even though occurring just rarely.

It is quite possible that the limitations of the operational method can be overcome by using respondents' self-reports – given that this method is more subjective in nature. Yet, the self-report method has its own limitations. Einarsen (2000) has argued, for example, that self-report measures are likely to yield certain degree of underreporting. One possible reason for this is that employees, who are regularly exposed to persistent negative acts, are not necessarily aware of the fact that they are being bullied. It may also be the case that some employees decline the victim role, given that this role connotes attributes such as weakness, failure and passivity (Mikkelsen & Einarsen, 2001; Salin, 2001). As a result, it is quite likely that self-report methods produce more conservative estimates of prevalence levels, as compared to operational methods.

Whilst the study's central aim was to examine the prevalence of bullying, the study had three additional aims:

- (1) To assess the usual duration of bullying experiences
- (2) To explore the link between duration of bullying and number of negative acts reported
- (3) To examine some aspects of bullying experiences, using peoples' accounts of recent incidents of bullying

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The second additional aim was selected to test the assumption that bullying at work is an escalating conflict situation. This assumption derives from Björkqvist's (1992) and Leymann's (1990, 1996) dynamic models of bullying at work (see description of models in Ch. 1). So far, only a few studies (Einarsen & Skogstad, 1996; Zapf & Gross, 2001) have confirmed the idea that employee experiences of bullying tend to escalate, or get more severe, over the course of time. In the studies just cited, the process of bullying was examined in terms of frequencies of negative acts. That is, whether victims of long-lasting bullying are attacked more frequently than victims with a short history of bullying. In the present study, a somewhat different approach was used. Instead of looking at frequencies of bullying acts, the issue examined was whether the *number of acts* experienced escalates (increases) over the course of time. As regards the third additional aim, the following two questions were addressed:

- (Q1) Who are the alleged perpetrators of bullying?
- (Q2) Do victims of bullying tend to be singled out (bullied on their own) or bullied in groups?

The former question focused on various attributes of alleged perpetrators, like their age, gender and status within the trust. Answers to the two questions were evaluated and compared to findings already reported in the literature (see literature review in Ch. 2.).

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Before moving on to the actual study, one additional issue needs to be addressed here. This issue was previously discussed in Chapter 2, and regards the role of negative affectivity (NA) in reports of bullying at work. As noted in the chapter, the dimension of NA (defined as mood-dispositional dimension, reflecting negative emotionality and self-concept) has been seen as possible source of bias in prevalence studies, whether subjective or operational criteria are being used. Indeed, Quine (2001, 2003) has recently emphasised the need for studies where the effects of NA on reports of bullying are systematically assessed and, if necessary, controlled for (see also Mikkelsen & Einarsen, 2002). Hence, in the present study, a measure of NA was incorporated, and attempts made to assess the above effects of NA.

THE STUDY

The study was commissioned by a Scottish hospital trust, under the supervision of Professor Lyn Quine. It was the first major independent project to examine workplace bullying in an NHS hospitals trust. The author of this thesis was responsible for various aspects of the study, such as design of study material, methodology used in the study, and analysis of survey data.

As previously noted, the study was cross-sectional in design. It commenced in Summer 2000, when a questionnaire was sent out to a

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randomly generated sample of 3,000 employees working at the hospital trust. The process of data collection lasted for approximately three months, but the various steps in the process are described in the following section.

Method

The sample

The sample of 3,000 hospital employees was selected from a range of occupations. The sampling method used was random cluster sampling – a method based on two distinct steps. First, the study population was divided into several layers (strata), depending on field of occupation (doctors, nurses, technicians etc). Secondly, a random sampling technique (systematic random sampling) was used to select people from these strata. Care was taken that the sampling fraction was the same for each stratum. Hence, the various groups in the population (strata) were correctly represented in the sample.

The profile of the sample was as follows: (see relative proportions in brackets): qualified nurses/midwives (34.9%), unqualified nurses/outpatient assistants (14.7%), doctors (junior; 4.3%), doctors (career grade; 4.5%), professions allied to medicine (6.8%), technical staff (5.4%), administrative and clerical staff (13.1%), ancillary and

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maintenance staff (15.0%), and managers (1.3%). Of the total sample, 83.3% were women and 16.7% men.

To meet the criterion of good statistical power – that is, the study's potential to produce statistically significant test results – a large N was used for the study. In principle, the measure of power depends on several factors, including sample size (N), types of tests used, effect size (w / f), and levels of significance selected (see Cohen, 1988; Welkowitz, Ewen & Cohen, 1991). When planning the present study, the values for all these factors were determined. The degree of power selected was 0.95. In order to decide on effect size, Cohen's (1988) criterion for small effect was used (e.g. $w = .10$). Finally, the level of significance selected was .05.

In order to determine the optimal sample size, these values were entered into a computer programme (G*Power), which aided with the calculation of N. According to the G*Power, an N of 1,300 was required for the study. However, given the potential risk of low response rate (e.g. 50% response rate), this figure was roughly doubled. Hence, an N of 3,000 was eventually selected for the study.

Study materials

A structured questionnaire was used to collect the research data (see description of questionnaire below). Along with the questionnaire,

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employees received a covering letter, in which the nature and purpose of the research was explained (see Appendix I), and a prepaid envelope addressed to researchers at the UKC. Since bullying at work is often seen as a sensitive topic, the covering letter contained a specific paragraph on the anonymity and confidentiality of the questionnaire data. That is, the employees were assured that their replies would be anonymous and treated with full confidentiality.

Since anonymity was guaranteed in the study, a postcard system was used to enhance response rates. That is, whilst the questionnaire itself was anonymous, respondents were asked to sign a pre-paid postcard and to send it back to the researchers once they had returned their questionnaire. This system enabled researchers to distinguish respondents from non-respondents, and thereafter to send reminders to non-respondents (see process of data collection below).

Process of data collection, data entry and analysis

The process of data collection comprised four consecutive steps. In Summer 2000, the study questionnaire (plus other materials) was sent to all 3,000 employees (Step 1). Some four weeks later, a reminder was sent to those employees who had not yet returned their questionnaire (Step 2). After additional four weeks, a second copy of the questionnaire was sent to those who still had not returned the original copy (Step 3). Finally, a second reminder was sent out (Step 4), but only to those who

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had not responded to Steps 1 to 3. Following this final step, the questionnaires received were entered into computer (SPSS for Windows) and analysed.

Regarding the initial step of data collection, it must be noted that researchers did not manage to reach 150 of the employees selected for the study. Hence, the study sample was reduced to 2,850 employees. The most usual reasons for this reduction in sample were that people had recently left their job or they were on temporary leave (e.g. sick leave, maternity leave). The resulting sample of 2,850 employees was monitored in the following three steps of data collection (see Steps 2 to 4 above).

The questionnaire

The questionnaire comprised five sections (see Appendix II). Section 1 contained questions about the respondents' occupational background – that is, the respondents' professional group (doctor, nurse or midwife, administrative or clerical staff, professions allied to medicine etc.) and hours of work (full-time versus part-time). The section also comprised scales measuring *job satisfaction* (Quinn & Staines, 1979), *propensity to leave* (Cammann, Fichmann, Jenkins & Klesh, 1979) and *support at work* (Bosma et al, 1997) – a detailed description of these scales is

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provided in Ch. 5. The scales have all been reported to have satisfactory reliability and validity.

Section 2 contained two questions in which respondents were asked to assess their *general health status* on a five-point scale and to estimate the number of days taken off for sickness in the past 12 months. This section also contained scales measuring *anxiety and depression* (HADS; Zigmond & Snaith, 1983) and *negative affectivity* (Stokes & Levin, 1990). A detailed description of the HADS scale is also provided in Ch. 5. The two scales have been used widely in the literature and are reported to have adequate reliability and validity.

The *negative affectivity* (NA) scale is a conceptually developed scale, focusing on three aspects of NA: nervousness, dissatisfaction with oneself and general pessimism. The scale consists of 21 items, and some examples of items are: “after an embarrassing experience, I worry about it for days”, “I often feel restless and jittery for no apparent reason” (items reflecting nervousness), “I feel that I have a great deal to be proud of”, “when things go wrong, I blame myself” (items reflecting dissatisfaction with oneself), and “I know that things will continually improve in my life”, “I always expect the worst to happen” (items reflecting pessimism).

Respondents rated the items on a scale ranging from 1 (“disagree strongly”) to 6 (“agree strongly”). It may be noted that the scale contains

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an approximately equal number of positively and negatively worded statements to minimize effects of possible response sets, or bias. The scale is used in such a way that higher scores indicate higher levels of NA.

Section 3 included questions about the respondents' *experiences of bullying at work*. A 26-item scale was used to assess respondents' experiences of persistent negative acts at work. The scale derived from Quine's (1999) study of workplace bullying. In her study, Quine used the various scale items (adopted from the literature, e.g. Adams, 1992a, Bassman, 1992) to assess respondents' experiences of five categories of bullying: threat to professional status, threat to personal standing, isolation, overwork, and destabilisation (see examples of these categories in Ch. 1, p. 12).

However, a new categorisation of bullying was employed in the present study. Whilst the categories used in Quine's study were entirely theory based, and originally defined by Rayner and Hoel in 1997, the categories used in this study were empirically derived. That is, respondents' answers to the 26 scale items were factor analysed and the result of this analysis was used to determine the basic structure or categories of bullying at work.

Responses to the 26 scale items were obtained in the following fashion. The employees were asked to indicate by a "yes"/"no" response whether

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they had been persistently exposed to any of the 26 behaviours or acts in the past 12 months. Examples of scale items are: “persistent unjustified criticism or monitoring of your performance”, “persistent attempts to demoralise you”, “setting of impossible deadlines”, and “freezing you out/ ignoring you/excluding you”. Prior to the actual scale, respondents had been provided with Lyons et al’s (1995) definition of bullying at work (see Appendix II).

Following the bullying scale, respondents were asked to indicate (on the basis of Lyons et al’s definition) whether they regarded themselves to have been bullied at work in the past 12 months. The response categories provided were: “never”, “rarely”, “a few times”, and “frequently”. Finally, the respondents were asked to indicate whether they had witnessed others (e.g. work colleagues) being bullied in the past 12 months. The response categories provided here were: “never”, “occasionally”, and “frequently”.

Those who felt that they had been bullied at work were also asked various questions about their experience. Firstly, they were asked about the period of time the bullying had lasted (response categories: “1-3 months”, “4-6 months”, and “7-12 months”), and whether they were currently exposed to bullying (response categories: “yes”/“no”). Secondly, they were asked to describe a recent incident of bullying, and to answer several questions about that incident (e.g. about the position of the bully and whether they had been singled out or bullied as part of a

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group). Finally, they were asked some questions about their actions in the bullying situation (e.g. whether they took some actions to stop the bullying). However, the responses to these final questions were omitted in the present analysis.

Section 4 included a 10-item scale measuring *generalised self-efficacy* (GSE; Wegner, Schwarzer & Jerusalem, 1993). A more detailed description of this scale is provided in Ch. 5. Section 5 contained questions about the respondents' gender and age. This final section also included questions about drinking and smoking habits. These questions are also described in Ch. 5.

Results

Preliminary analyses of data

A total of 1,905 questionnaires were collected in the study. This number of questionnaires signified a response rate of 67%. Frequency analyses were carried out to determine the profile of the final study sample. That is, some four analyses were carried out to establish the profile of respondents (N=1,905) in terms of occupations, hours of work, gender and age. The results of these analyses are shown in Table 4.1.

Table 4.1. Profile of respondents

	%	(n)
<i>Occupational Group (N=1835)</i>		
Qualified nurses/midwives	41	(745)
Unqualified nurses/outpatient assistants	13	(245)
Doctors (junior)	4	(64)
Doctors (career grade)	4	(81)
Professions allied to medicine	9	(168)
Technical staff	4	(79)
Administrative and clerical staff	13	(245)
Ancillary and maintenance staff	9	(171)
Managers	2	(37)
<i>Hours of work (N=1892)</i>		
Full-time	59	(1,113)
Part-time	41	(779)
<i>Gender (N=1891)</i>		
Men	14	(261)
Women	86	(1,630)
<i>Age (N=1856)</i>		
18-30	25	(472)
31-40	29	(538)
41-50	28	(516)
> 50	18	(330)

As regards the profile of occupational groups and gender, it was found that the final sample (N=1,905) represented quite well the original study sample (see profile of original sample in method section). Two of the nine occupational groups were however somewhat over-represented. These were: professions allied to medicine and managers (respective response rates: 84% and 95%). In addition, one of the groups was quite under-represented. This was the group of ancillary and maintenance staff (response rate: 39%).

The bullying scale factor analysed

In order to determine categories or forms of bullying acts, the 26 items on the bullying scale were factor analysed. In the analysis, principal components extraction was used, along with an orthogonal rotation.² Initially, all scores that loaded onto a factor (or component) below .30 were suppressed. Following this, all items with loadings on a factor of more than or equal to .50 were selected.

A scree plot (or plot of eigenvalues) was obtained, which suggested six factors be retained for rotation. As will be demonstrated, these factors appeared to be relatively distinct and interpretable. Preliminary eigenvalues of the factors were: 7.63, 1.74, 1.47, 1.20, 1.09, and 1.01, and the percentage of the total variance explained by each was: 29.33, 6.69, 5.63, 4.62, 4.17, and 3.87, respectively, for a total of 54.31. These six factors were rotated using the Varimax method. The factor solution obtained is presented in Table 4.2.

As shown in Table 4.2, Factor 1 consisted of items referring to acts such as criticism, attempts to demoralise, attempts to humiliate the person, and ignoring/excluding the person. The label that best seemed to capture the essence of these items was "*personal derogation and/or isolation*". Factor 2, on the other hand, consisted of items referring to work and work responsibilities. Therefore, this factor was labelled "*work-*

² This strategy (i.e. using principal components extractions along with orthogonal rotation) has been used in some previous studies, e.g. Einarsen & Raknes (1997a), Zapf et al (1996) – see Chapter 1.

related bullying". Factor 3 consisted of items such as verbal and non-verbal threats and use of abuse, swearwords and obscenities. Hence, this factor was labelled "*threats and verbal abuse*". Factor 4 consisted of two items: persistent teasing and making inappropriate jokes about the person. This factor was labelled "*teasing and ridicule*". Factor 5 consisted of one item, referring to discrimination on racial/gender/disability grounds, and was labelled "discrimination".³ Factor 6 consisted of items referring to physical violence and violence to property, and was therefore labelled "*violence*". For later analyses, scales of five of the six factors (Factors 1, 2, 3, 4, and 6) were constructed and conceived as describing five categories of bullying at work (see comment in foot-note regarding Factor 5).

To determine the orthogonality or distinctness of the constructs obtained (personal derogation, work-related bullying, threats and verbal abuse, teasing and ridicule, discrimination, and violence) the original, unrotated component matrix was rotated using an oblique method (the Promax method) and the results compared to the orthogonal rotation results. Orthogonality was ascertained to the extent that the Varimax and the oblique (Promax) solutions were similar. Indeed, the two factor solutions turned out to be highly similar. In addition to this, it may be noted that the six factors were only weakly, or at most moderately, correlated (see interfactor correlations in Table 4.3).

³ Regarding this factor, it may be noted that discrimination is usually not seen as an aspect of bullying, but more as a concept separate from bullying.

Table 4.2. Principal components of items making the bullying scale

<i>Items</i>	<i>Factor loadings</i> (Varimax rotation)					
	1	2	3	4	5	6
1. Persistent unjustified criticism or monitoring of your performance	.77					
3. Persistent attempts to belittle and undermine your work	.84					
4. Persistent attempts to demoralise you	.82					
5. Persistent attempts to humiliate you in front of colleagues	.76					
6. Destructive innuendo and sarcasm	.58					
11. Undermining your personal integrity	.64					
18. Constant undervaluing your efforts	.64					
19. Freezing you out/ignoring you/excluding you	.50					
25. Displays of open hostility towards you	.51					
7. Undue pressure to produce work	.70					
9. Shifting goalposts without telling you	.72					
13. Removal of responsibility without consultation	.50					
16. Setting of impossible deadlines	.73					
17. Withholding necessary information from you	.61					
12. Verbal and non-verbal threats			.70			
23. Unfounded threats about your job security			.63			
26. Use of abuse, swearwords, and obscenities			.53			
2. Persistent teasing				.78		
10. Making inappropriate jokes about you				.75		
24. Discrimination on racial, gender, or disability grounds					.63	
14. Violence to property						.72
15. Physical violence						.69

Table 4.3. Interfactor correlations

<i>Factors</i>	2	3	4	5	6
1. Personal derogation	.53	.46	.29	.43	.19
2. Work-related bullying	–	.30	.11	.37	.22
3. Threats and verbal abuse		–	.27	.11	.24
4. Teasing and ridicule			–	.02	.18
5. Discrimination				–	.12
6. Violence					–

Reliability of scales

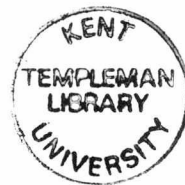
Following the factor analysis, the 21 items extracted were computed into a scale. In addition, five sub-scales were constructed, and these were seen to reflect five categories of bullying at work: personal derogation/isolation, work-related bullying, threats and verbal abuse, teasing and ridicule, and violence. The reliability of the total scale, as well as the reliability of the five sub-scales is shown in Table 4.4. Reliability of the NA scale is also presented in this table. As the table shows, the index used to assess reliability was Cronbach's Alpha. Overall, the alpha values observed were reasonably high. An exception to this though is the value obtained for the *violence* scale, and possibly the value obtained for the *threats and verbal abuse* scale. Since these two sub-scales included only 2 and 3 items respectively, the relatively low alpha-values were somewhat expected.⁴

⁴ Theoretically, the alpha coefficient refers to the extent to which scale items are measuring a "true score" (the construct of interest) rather than random error (Stangor, 1998, p. 84). In practice, a scale of two items is more likely to tap random error than is a scale of five items or more. Hence, if a scale is low in reliability, more items of equal kind usually improve the quality of the scale (Kerlinger, 1992, p. 415).

Table 4.4. Mean, standard deviation, and reliability of scales

<i>Scale</i>	<i>Items</i>	α	<i>M</i>	<i>SD</i>	<i>N</i>
The bullying scale (Total scale)	21	.89	2.3	3.6	1837
Personal derogation/isolation	9	.89	1.2	2.2	1858
Work-related bullying	5	.75	0.9	1.3	1874
Threats and verbal abuse	3	.53	0.2	0.5	1886
Teasing and ridicule	2	.68	0.1	0.4	1892
Violence	2	.29	0.01	0.2	1891
Negative affectivity (NA)	21	.90	62.9	15.0	1726

Distribution of scores on the bullying scale



Before proceeding to the main results section, a comment must be made about the distribution of scores on the bullying scale. As previously mentioned (in the section describing the questionnaire), the response format used for the scale was a dichotomous one (“yes”/“no” responses). In ensuing analyses of the scale, the “yes”/“no” responses were given the numerical codes 0 (“no”) and 1 (“yes”).

As shown in Table 4.4, the mean score obtained on the total scale was 2.27 (SD=3.58). This value, along with the SD value, indicates that most of the respondents’ scores were at the lower end of the scale. In other words, the distribution of scores was considerably (then positively) skewed. To clarify this point, it may be noted that a minimum score on the total scale was 0, whilst the maximum score was 21. Indeed, more than 50 per cent of the respondents had the score 0 on the bullying

scale. This was also the case with the various sub-scales (e.g. personal derogation/isolation, work-related bullying, threats and verbal abuse).

In the main analyses of prevalence levels, respondents were therefore assigned (statistically) to one of the following groups: (1) those who reported one or more types of bullying acts at work (those with scores ≥ 1 on the scale), and (2) those who reported no bullying acts (those with scores = 0 on the scale).

Main results

Initially, the prevalence of bullying was estimated using scores on the bullying scale. As mentioned above, the employees were assigned to two groups, depending on their replies to the scale items. The same kind of procedure was used for the various sub-scales of bullying. On the personal derogation/isolation scale, for example, the employees were assigned to groups depending on their responses to the 9 scale-items (i.e. those with scores ≥ 1 , and those with score =0).

Experiences of bullying acts

Overall, 48% of respondents (n = 877) reported having experienced one or more types of bullying acts in the past 12 months. Table 4.5 shows

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the proportion of employees experiencing the distinct types of acts (21 in total), as well as the five categories of bullying.

Table 4.5. Proportion of employees experiencing bullying acts (types and categories) in the past 12 months

	%	(n)
<i>Personal derogation/isolation (N=1858)</i>	33*	(603)
Persistent unjustified criticism or monitoring of your performance	12	(234)
Persistent attempts to belittle and undermine your work	13	(250)
Persistent attempts to demoralise you	13	(240)
Persistent attempts to humiliate you in front of colleagues	11	(202)
Destructive innuendo and sarcasm	13	(244)
Undermining your personal integrity	12	(228)
Constant undervaluing your efforts	16	(300)
Freezing you out/ignoring you/excluding you	21	(388)
Displays of open hostility towards you	7	(140)
<i>Work-related bullying (N=1874)</i>	39*	(729)
Undue pressure to produce work	23	(429)
Shifting goalposts without telling you	22	(410)
Removal of responsibility without consultation	9	(177)
Setting of impossible deadlines	11	(212)
Withholding necessary information from you	22	(424)
<i>Threats and verbal abuse (N=1886)</i>	13*	(238)
Verbal and non-verbal threats	6	(109)
Unfounded threats about your job security	5	(93)
Use of abuse, swearwords, and obscenities	7	(125)
<i>Teasing and ridicule (N=1892)</i>	7*	(127)
Persistent teasing	5	(86)
Making inappropriate jokes about you	5	(88)
<i>Violence (N=1891)</i>	2*	(32)
Violence to property	1	(12)
Physical violence	1	(23)

Note: (*) Some respondents reported more than one type of act in each category

As Table 4.5 indicates, the categories of bullying acts most frequently experienced were work-related bullying (39%) and personal derogation/

isolation (33%). The types of acts most frequently experienced (and hence, may possibly be seen as common in the trust) were undue pressure to produce work, shifting goalposts, withholding necessary information, and freezing out, ignoring or excluding. If these four acts only had been examined in the study, the observed prevalence rates would have been 41%. The acts least frequently experienced (and may therefore perhaps be seen as rare in the trust) were violence to property and physical violence.

Influence of NA on reports of bullying acts

When the relationship between negative affectivity (NA) and reports of bullying acts was examined, a significant correlation was found ($r = .32$, $p < .001$). Employees high in NA appeared to be somewhat more likely to report exposure to bullying acts than were employees low in NA. However, NA accounted for only 10% of the variance in reports of bullying acts ($R^2 = .10$). In other words, NA only seemed to have minor influence on reports of negative acts at work.

Demographic relationships with bullying experiences

As well as estimating overall prevalence of bullying (so far, in terms of exposure to bullying acts at work), prevalence levels of the five categories of bullying were assessed separately for male and female respondents (see Table 4.6). In addition, the overall prevalence rate in

the four age groups (18-30 yrs, 31-40 yrs, 41-50 yrs and > 50 yrs) was determined.

Table 4.6. Proportion of men and women experiencing the five categories of bullying acts

<i>Category of bullying acts</i>	<i>% (n) of men</i>		<i>% (n) of women</i>		<i>Comparison between the genders (χ^2)</i>
Personal derogation/ isolation	42	(105)	31	(492)	11.2**
Work-related bullying	54	(139)	36	(583)	29.3***
Threats and verbal abuse	22	(57)	11	(178)	25.1***
Teasing and ridicule	10	(26)	6	(101)	5.0*
Violence	3	(8)	1	(23)	3.9*

*p<.05, ** p<.01, ***p<.001

Comparisons between male and female respondents revealed that men were more likely than women to experience all five categories of bullying (see χ^2 values in Table 4.6). Overall, 61% of men reported being exposed to bullying acts at work, as compared to 46% of women ($\chi^2(1)=20.1, p< .001$).

Age, on the other hand, did not seem to be related to experiences of bullying acts. That is, experiences of bullying acts in the four age groups examined – 18-30 yrs, 31-40 yrs, 41-50 yrs, and >50 yrs – were quite similar. The respective proportions of employees experiencing acts were: 46%, 50%, 47%, and 45%.

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Some additional analyses regarding gender showed that the differences observed, (that is, men being more likely to experience bullying acts), applied only to some occupational groups. These were: professions allied to medicine, technical staff, and ancillary and maintenance staff. Indeed, in one occupational group (junior doctors), women were more likely than men to experience bullying acts at work (61% vs. 28%, $\chi^2(1)=6.5, p<.05$).

Self-reports of bullying

Once the prevalence of bullying had been estimated in terms of exposure to bullying acts, the second method – the so-called self-report method – was used to assess prevalence levels. Here, it was examined how many employees considered themselves (or labelled themselves) to have been bullied at work. Using this method, the prevalence level observed was 27%. That is, 27% of respondents (n=501) regarded themselves to have been bullied at work in the past 12 months. Of these, 11% reported they had only rarely been bullied. Other 13% had been bullied occasionally, and 3% had been bullied on regular basis.

As well as asking the employees whether they regarded themselves to have been bullied, they were asked if they had witnessed others (e.g. work colleagues) being bullied in the past 12 months. Here, it was found that 46% (n=831) had witnessed the bullying of others in the past 12 months. Of these, 14% did not report being bullied themselves. Some

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38% claimed to have witnessed bullying occasionally, and 8% had frequently witnessed the bullying of others.

Influence of NA on self-reports of bullying

As with the measure of negative acts at work, the role of NA in self-reports of bullying was examined. It was found that NA was significantly related to self-reports of bullying ($r = .26$, $p < .001$). Given the correlation observed, it was concluded that employees high in NA were somewhat more likely to label themselves to have been bullied than were employees low in NA. However, NA accounted for only 7% of the variance in self-reports of bullying ($R^2 = .07$). Hence, as in the case of reported negative acts, NA seemed to have only minor influence on employees' self-reports of bullying.

Demographic relationships with self-reports of bullying

In line with previous findings (regarding exposure to bullying acts), self-reports of bullying were related to gender. The nature of the relationship was also the same as before. That is, men were more likely to consider themselves to have been bullied than were women (35% vs. 25%, $\chi^2(1) = 11.8$, $p < .01$). However, this finding applied only to the following occupational groups: nurses/midwives, professions allied to medicine, technical staff, and ancillary and maintenance workers.

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In contrast to the previous findings, younger employees (39 yrs old or younger) were more likely to consider themselves to have been bullied than were older employees (older than 39 yrs). About 30% of younger employees considered themselves to have been bullied, but only 23% of the older ones did ($\chi^2(1)=11.0$, $p < .001$).

Duration of bullying episodes

Of the employees who regarded themselves to have been bullied at work, 17% ($n=106$) claimed to be currently exposed to bullying. When this group of employees were asked about the duration of bullying episodes, it was found that in one third (33%) of cases the bullying had lasted for 7 months or more.⁵ In half of the cases (51%), the bullying had continued for 1-3 months, and in 16% cases for 4-6 months.

Bullying as an escalating process

In addition to examining the duration of bullying, the study focused on the link between duration and the number of negative acts reported. The hypothesis tested was that bullying at work is an escalating conflict situation, where the number of acts experienced increases over time. The strategy used to test this hypothesis was to assess and compare (using one-way ANOVA) the number of acts reported by the following

⁵ The response options to this question (regarding duration of bullying) were 1-3 months, 4-6 months, and 7-12 months. However, some respondents made the claim (next to their answer) that the bullying had in fact taken place for more than 12 months.

victim groups: (1) those who reported relatively brief episodes of bullying (one to three months), (2) those who reported somewhat extended episodes (four to six months), and (3) those who reported extended episodes (seven months or more). The mean numbers of acts reported in these groups are shown in Table 4.7.

When the three groups were compared, an overall difference between means was observed ($F(2,343)=43.7, p<.001$). To determine where the difference lay, two separate t-tests were conducted (one test comparing Groups 1 and 2, and the other comparing Groups 2 and 3).

Table 4.7. Duration of bullying episodes and number of bullying acts reported

	<i>Duration of bullying reported</i>	<i>Number of acts reported</i>	
		Mean	SD
Group 1 ($n=178$)	1-3 months	4.9	3.5
Group 2 ($n=56$)	4-6 months	8.3	3.9
Group 3 ($n=112$)	7 months or more	9.1	4.6

Of the two tests, only one revealed a significant result. That is, the only difference detected was between Groups 1 and 2 ($t(1,234) = -6.2, p<.001$). Respondents in Group 2 reported more acts than did respondents in Group 1. In contrast, respondents in Groups 2 and 3 reported a similar number of acts. Thus, the data provided some, yet not complete, support to the notion that bullying is an escalating conflict situation.

The nature of bullying experiences

The final additional aim of the study was to answer two questions regarding victims' experiences of bullying. The questions were: (1) who are the alleged perpetrators of bullying, and (2) do victims of bullying tend to be singled out or bullied in groups? The questions were addressed using victims' accounts of recent bullying incidents. These accounts were provided by 84% (n=423) of self-reported bullying victims.

As regards the first question, it was found that in 52% of cases, the bully was an immediate supervisor or senior manager. In other 31% of cases the bully was of same level of seniority (and in the same work group) as the victim, and in 6% of cases the bully came from another work group. In 11% of cases the position of the bully was not specified. In 55% of cases the bully was older than the victim. In other 24% of cases, the bully was of similar age as the victim, whilst in 20% of cases the bully was younger than the victim. In 3% of cases, the age of bully was not specified.

In 70% of cases the bully was female and in 30% of cases male. When the data were analysed separately for male and female victims, it was found that women were most likely to be bullied by other women (in 76% of cases). Men on the other hand were just as likely to be bullied by women and men (in 45% and 55% of cases respectively).

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As to the second question addressed (see above) it was found that more than two thirds of the victims (70%) reported being singled out, whilst only 28% reported being bullied in groups. Some 2% did not specify whether they had been singled out or bullied in groups. Yet, the overall pattern of findings indicates that victims of bullying are significantly more likely to be to be singled out (bullied on their own) than bullied in groups.

Discussion

The aim of the present study was to assess levels of bullying in a Scottish hospital trust. The results showed that almost one in two trust employees (48%) reported experiencing one or more types of bullying acts in the past year. This compares with one in three (38%) in Quine's (1999) previous study – a study conducted in an NHS community trust, where levels of bullying were assessed in similar way.

Findings from other countries also indicate that bullying among hospital employees is pervasive. For instance, a study conducted in Austrian public hospital (Niedl, 1995) showed that the prevalence of bullying over a six-month period was 26.6%. The results can also be compared with more general findings from the UK, such as those obtained in the UMIST study (Hoel & Cooper, 2000). In this study, which focused on various work sectors and occupations (including NHS trusts), some 38% of

respondents reported persistent experiences of bullying acts in the past six months.

Experiences of bullying acts at work: Categories of bullying

The current prevalence findings were based on respondents' scores on a 21-item bullying scale, derived from preliminary factor analysis. This scale appeared to reflect five categories of bullying at work. That is, the factor analysis (principal component analysis) revealed five separate dimensions or factors of bullying acts at work. The factors were labelled personal derogation/isolation, work-related bullying, threats and verbal abuse, teasing and ridicule, and violence. The reliability of most factors was adequate. However, some of the factors only comprised two or three items, and may not have fully reflected the respective categories (e.g. verbal abuse and violence).

The categories identified were quite similar to those previously reported (see Chapter 1). Zapf et al (1996), for example, identified factors such as attacking the person's attitudes and social relationships, attacking the person with organisational measures, attacking the person's private life, verbal aggression, and physical violence. Einarsen and Raknes (1997a) also reported factors such as attacking the private person, social isolation, work-related measures, and physical violence. However, more research on a wider range of work settings may be needed to validate the categories identified in this study.

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The categories of bullying most frequently reported in the study were work-related bullying (39%) and personal derogation/isolation (33%). The types of acts most frequently reported were: “undue pressure to produce work”, “shifting goalposts”, “withholding necessary information”, and “freezing out, ignoring or excluding”. If these four acts had only been examined, the observed prevalence rates would have been 41%. Findings regarding frequency of individual acts were the same as obtained in Quine’s (1999) previous study. The categories most frequently reported in Quine’s study were isolation and destabilisation.

In the UMIST study (Hoel & Cooper, 2000) and in the UNISON (1997) study, experiences of work-related bullying and social isolation were also most frequently reported. Moreover, findings from other countries (e.g. Germany and Norway) show that the strategies most frequently reported are social isolation, personal attacks/attacks on the person’s private life, and work-related bullying (e.g. Zapf et al, 1996; Einarsen et al, 1994a).

On the whole, the present findings show that subtle or discreet acts were more frequently reported than were direct acts. Indeed, the findings support the notion that covert (or verbal, indirect and passive) forms of aggression are more frequent in workplaces than are overt (or physical, active and direct) forms of aggression (Baron & Neuman, 1996; Björkqvist et al, 1992, Björkqvist et al, 1994b). A possible reason for this is that people tend to maximise what is known as the effect/danger ratio when aggressing against others (Björkqvist et al, 1994b). That is, people

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normally seek to enact behaviours that are effective in harming others while at the same time offer low dangers to themselves (see Ch. 1).

The role of NA in reports of bullying acts

The results showed that NA was moderately correlated with scores on the bullying scale. That is, individuals high in NA were somewhat more likely to report negative acts at work than were individuals low in NA. As noted in Chapter 3, there may be several explanations for this. Firstly, NA may affect people's perceptions of their social work environment and therefore the way they perceive interpersonal behaviours. Accordingly, they may be more likely to perceive the behaviour of others as acts of bullying (Spector et al, 2000). Secondly, high-NA individuals may be more likely to create a social environment in which they are exposed to aggressive behaviours (Spector et al, 2000). Finally, high-NA individuals may possibly be more likely to enter interpersonal conflicts, which again may escalate into bullying (see Einarsen, 2000). Whereas these various explanations may hold, it must be noted that NA explained no more than 10% of the variance in scores on the bullying scale. In other words, NA did not play a critical role in reports of bullying acts.

Demographic relationships with bullying experiences

A somewhat surprising finding was that male employees were generally more likely than female employees to experience bullying acts at work.

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In previous UK studies, the proportion of male and female workers reporting bullying has been quite equal (e.g. Hoel & Cooper, 2000; Quine, 1999). Kivimäki et al's (2000) study of Finnish hospital employees also showed similar prevalence rates between male and female respondents.

The relationship between bullying and gender was most apparent in cases of work-related bullying and threats and verbal abuse. It must be noted though that the overall relationship between bullying and gender only applied to some occupational groups. In one of the groups, the group of junior doctors, it was even the case that women were more likely than men to report bullying acts. This final finding is consistent with Quine's (2003) recent study of junior doctors (see Ch. 2).

Contrary to Quine's (1999) study, where younger employees were more likely than older ones to report bullying at work (see also Hoel & Cooper, 2000; Rayner, 1997), the present study showed similar rates of bullying in various age groups. That is, older employees were just as likely as younger employees to report bullying acts at work.

Self-reports of bullying

The second way of assessing prevalence rates consisted of self-reports of bullying, or respondents' self-labelling. Here, the study examined the number of employees who regarded themselves to have been bullied at

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work in the past 12 months. Using this method, the prevalence level observed was 27%. Of these who labelled themselves to have been bullied, 13% had been bullied occasionally and other 3% frequently. These findings are quite consistent with previous UK studies, where self-labelling has been used (Hoel & Cooper, 2002; Unison, 1997). Again, the factor of NA was somewhat related to reports of bullying. That is, individuals high in NA were more likely to label themselves to have been bullied than those low in NA. However, NA was not conceived to play a vital role in respondents' self-reports. The amount of variance explained by NA was just 7%.

Variations in prevalence rates

From the above discussion, it is clear that the two methods used to assess bullying revealed quite divergent prevalence rates (48% vs. 27%). This divergence may partly be due to the subjective nature of bullying experiences. Two people experiencing the same conditions may arrive at divergent conclusions about whether bullying has occurred – one may perceive the experience as bullying whilst the other may not. Whereas the self-report method takes into account variations in personal perceptions, the operational method is not sensitive to these variations (Mikkelsen & Einarsen, 2001; Quine, 1999; Rayner et al, 2002). It may also be the case that some people who experience bullying acts, but do not use self-labelling, have a lack of awareness (Adams, 1992; Einarsen,

2000; Field, 1996). That is, some people may not acknowledge bullying at work as a critical problem.

In addition, whereas imbalance in power is considered a crucial part of the definition of bullying, the operational method does not directly take this feature into account. Hence, when the prevalence of 48% is considered, there may be some instances where people have been able to defend themselves or retaliate (Salin, 2001). This again indicates that there may be some instances where a term such as interpersonal conflict is more relevant than the bullying term.

A final explanation derives from Archer's (1999) paper on bullying and organisational culture. In this paper, the author claims that in some occupations and organisations, certain types of mistreatment are considered as part of the culture, and therefore not identified with bullying. In the present study, acts such as pressuring someone to produce work or shifting goalposts without consultation may for example be perceived by some employees as part of the work culture, and hence not indicators of bullying.

Whatever may explain the divergence in prevalence rates, it seems to be the case that people who experience persistent negative acts at work are likely to be damaged or somehow affected, whether they label themselves to have been bullied or not (see, for example, Rayner et al's (2002) report of the UMIST findings). It has also been reported that

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people who label themselves as being bullied experience a wider range of bullying behaviours than those who do not label themselves as being bullied (e.g. Rayner, 1999). Hence, despite potential limitations of the operational method (see arguments above), this method may after all be considered crucial in bullying research.

In addition, the possibility cannot be excluded that the self-report method produced a certain degree of underreporting. As noted by Mikkelsen and Einarsen (2001), it may quite possibly be the case that some targets of bullying decline the victim role, given that this role connotes attributes such as weakness and passivity – attributes that most people would feel do not fit their usual self-image. This same type of argument has also been made by Salin (2001): “some employees may be hesitant to label themselves bullied, since the word “bullied” may have connotations of failure and self-blame” (p. 437).

It may therefore be concluded that the self-report method produced a more conservative assessment of bullying, compared with the operational method. When interpreting the above prevalence findings, the response rate achieved in the study (67%) must also be taken into account. Although a response rate of this degree is far higher than in most published studies, it may still have yielded unknown biases (see issue of sample bias in Ch. 2, p. 35).

Self-reports of bullying and demographic variables

In the study, a relationship was found between self-reports of bullying and respondents' gender. Men appeared to be more likely than women to label themselves to have been bullied at work. Again, however, the relationship between gender and bullying only applied to some occupational groups. As regards respondents' age, the results showed that younger employees (< 39 yrs) were overall more likely to consider themselves to have been bullied than older employees (>39 yrs). This finding regarding bullying and age accords with previous UK findings (Hoel & Cooper, 2000; Quine, 1999; Rayner, 1997), and can possibly be explained through factors such as work experience, knowledge of the organisation, and personal networks. According to Rayner et al (2002) these are the kinds of factors that may work against bullying and victimisation, making older employees less likely to report bullying.

Observers (bystanders) of bullying

The third method used to assess prevalence rates was to ask respondents if they had witnessed the bullying of others in the past 12 months. Almost one in two respondents (46%), including many who did not experience bullying themselves, answered this question positively. Of these, 38% claimed to have witnessed bullying occasionally, and 8% frequently. This additional finding must be considered quite vital, since it indicates that bullying is not purely dependent on personal perceptions, but a real interpersonal problem. This finding does also imply that large

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numbers of staff may be affected (directly or indirectly) by this workplace problem.

Duration of bullying

When the duration of self-reported bullying episodes was assessed, the results showed that in 33% of reported cases these episodes lasted for long periods of time (7 months or more). However, in half of reported cases, the bullying lasted for a maximum of three months. Hence, compared to previous UK findings (e.g. Hoel & Cooper, 2000), bullying did not necessarily appear as a long lasting experience. The result applying to a third of respondents (those who reported ≥ 7 months) is worth noting though. It must also be acknowledged that, unlike in previous studies, the present study did not specify or distinguish periods beyond that of seven to twelve months. In other studies, it is quite common that researchers specify additional periods of duration, e.g. duration of 1-2 years and more than two years (see Rayner et al, 2002).

Bullying as an escalating process

In addition to looking at the duration of bullying, the present study examined the link between duration and number of negative acts reported. The hypothesis tested was that bullying, or experience of persistent negative acts, is an escalating conflict situation (e.g. Bjorkqvist, 1992; Leymann, 1990). The study provided some support to

this hypothesis. That is, the data showed that respondents who reported somewhat extended episodes of bullying (4-6 months) experienced a wider range of bullying acts than those who reported brief episodes (1-3 months). Respondents who reported duration of ≥ 7 months did however experience similar number of acts as the middle (4-6 months) group. No other study has focused on duration of bullying and number of acts experienced. However, in future work this approach to the bullying phenomenon may prove fruitful. There may also be a reason to re-examine the links between duration and frequencies of bullying acts. So far, these links have been demonstrated in two empirical studies (Einarsen & Skogstad, 1996; Zapf & Gross, 2001).

The nature of bullying experiences

Finally, the study examined the nature of targets' experiences of bullying, using the following questions: (1) who are the alleged perpetrators of bullying, and (2) do bullying victims tend to be singled out or bullied in groups? As regards the first question, the results showed that the bully was most likely to be an immediate supervisor or senior manager. However, it was also quite common that the bully was of same seniority level as the victim. Women were most likely to be bullied by other women, whereas men were just as likely to be bullied by women and men. In most cases the bully was older than the victim, though in a quarter of cases the bully was of similar age as the victim.

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This overall pattern of findings is quite consistent with previous UK findings. In the UNISON (1997) and UMIST (Hoel & Cooper, 2000) studies, for example, reported bullies were most likely to be in managerial positions. Quine (1999) also found that alleged bullies were most likely to be senior managers or line managers. In all these studies, the reported bullies were also most likely to be older than the victim. However, the finding pertaining to gender was unusual in the present study. Overall, the bully was more likely to be female than male. In previous studies, reported bullies are more likely to be male (e.g. Hoel & Cooper, 2000; Unison, 1997). Given the type of workplace examined (an NHS trust, where the majority of staff is female), the present findings are perhaps unsurprising.

As regards question two, the results showed that more than two thirds of victims (70%) reported being singled out (bullied on their own), whereas less than a third reported being bullied in groups. This type of finding is quite remarkable, given that in previous UK studies the opposite pattern is prominent. For instance, in Rayner's (1997) study of part-time university students, most people (or 81%) reported being bullied in groups (only 19% bullied on their own). A similar result was obtained in the UNISON (1997) and UMIST (Hoel & Cooper, 2000) studies.

Given that women were overall more likely than men to be seen as bullies (see above), the finding that people were more likely to be singled out than bullied in groups may possibly tell us something about bullying

tactics and gender. That is, previous studies have not only shown that people are more likely to be bullied in groups, but also that men are more likely to be reported as bullies than women are. Accordingly, it may be the case that male bullies tend to attack several people at a time, whereas female bullies prefer to select individual targets. However, it may also be the case that the present findings are merely associated with factors (e.g. socio-cultural factors) that are specific to the hospital setting.

Conclusion

This study focused on the prevalence of bullying in a Scottish hospital trust. Results showed that almost one in two trust employees reported experiencing one or more types of bullying behaviours in the past year. In other words, bullying appeared to be a critical problem in the trust. The results do also confirm previous findings (e.g. Quine, 1999; Niedl, 1995) that bullying is widespread among health care professionals. Whilst a higher response rate would have been desirable, the study achieved a 67% response rate, which is far better than in most published studies.

In the study, the categories of bullying most commonly experienced were work-related bullying and personal derogation/isolation. It was particularly common that employees reported acts such as undue

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pressure to produce work, shifting goalposts, withholding necessary information, and freezing out, ignoring or excluding. If these acts only had been examined, the observed prevalence rate would have been 41%.

The results indicated that the method used to measure bullying influences the observed prevalence levels. Operational criteria revealed considerably higher prevalence levels than did self-report criteria (48% vs. 27%). There may be several reasons for this divergence in prevalence rates. For instance, the operational method may be less sensitive to issues such as imbalance in power, variations in personal perceptions, and cultural norms and traditions. In any case, the self-report method seems to yield more conservative assessment of bullying, compared with the operational method.

The factor of negative affectivity (NA) appeared to have slight influence on the two measures employed in the study. That is, on respondents' reports of negative acts at work and their self-reports of bullying. These effects of NA may possibly be explained through mechanisms proposed by Spector et al (2000), such as the perception mechanism and the stressor-strain creation mechanism. Whilst the effects of NA were not strong, the results indicate the need of incorporating this factor in prevalence studies.

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A number of findings were reported regarding victims' experiences of bullying. These focused on aspects such as duration of bullying episodes, characteristics of the bully, and whether victims tend to be singled out or bullied in groups. In addition, findings pertaining to bullying and demographic variables were reported. Some of these findings accorded with previous UK findings, whereas others were particular to this study.

CHAPTER 5

WORKPLACE BULLYING IN SCOTTISH HOSPITAL STAFF: OCCUPATIONAL HEALTH OUTCOMES

– STUDY 1: PART 2 –

Introduction

This chapter focuses on the second part of the study conducted in the Scottish NHS hospital trust. In the first part of the study, the primary aim was to determine the levels of bullying in the trust (see Ch. 4). In this second part, the association between bullying and occupational health outcomes was examined. The literature concerned with bullying and health outcomes was reviewed in Chapter 3. It may be noted again though, that a number of studies have demonstrated links between bullying and various adverse outcomes, such as anxiety, depression and psychosomatic stress symptoms (e.g. Björkqvist et al, 1994a; Einarsen et al, 1996; Leymann, 1992b; Mikkelsen & Einarsen, 2001; Quine, 1999).

In the present study, two of these outcomes (levels of anxiety and depression) were examined. Whilst the relationship between bullying and these outcomes has already been recognised, previous studies in the field are faced with methodological limitations. Firstly, given the cross-sectional design of most studies, the direction of causality in observed relationships remains unknown. Secondly, it is far from clear whether the observed links between bullying and adverse outcomes are

influenced by certain response sets, or bias. In a previous chapter (see Ch. 3), it was noted that one likely source of response bias, influencing observed bullying-outcome relations, is that of negative affectivity.

The construct of negative affectivity (NA) is defined as a mood-dispositional dimension that reflects stable and pervasive individual differences in negative emotionality and self-concept (Watson & Clark, 1984). In some recent literature (e.g. Quine, 2001, 2003; Mikkelsen & Einarsen, 2002), it is argued that NA is likely to partially inflate observed relationships between bullying and health outcomes. The aim of the present study was to address this methodological issue. That is, a measure of NA was incorporated in the study and the potential effects of NA determined.

In the first part of the study, it was found that NA had some moderate influence on employees' reports of bullying at work (see Ch. 4, results section). In this second part, the effects of NA on self-report measures of anxiety and depression were also examined, and the following hypotheses tested:

H1: Employees who report bullying acts at work will show higher levels (more symptoms) of anxiety than those who do not report bullying – even when NA is covaried out.

H2: Employees who report bullying acts at work will show higher levels (more symptoms) of depression than those who do not report bullying – even when NA is partialled out.

Since the present study was cross-sectional in design, it was not possible to determine the causal relationship between bullying and poor psychological health. However, the issue of causality was addressed later on in the project (see study reported in Ch. 7).

In addition to the measures of anxiety and depression, the study included measures assessing general health status and absenteeism. Whilst several studies have demonstrated links between bullying and sickness absence (e.g. Barker et al, 1999; Hoel & Cooper, 2000; Vartia, 2001; see Ch. 3), the association between bullying and general health status is not fully known. However, recent findings from the UK have demonstrated links between bullying and declined physical health (see Rayner et al, 2002). Hence, the next two hypotheses tested in the study were as follows:

H3: Employees who report bullying acts at work will state poorer general health than those who do not report bullying.

H4: Employees who report bullying acts at work will state more days off work in the past year than those who do not report bullying.

Besides examining the above health outcomes, the study focused on two behavioural outcomes – namely, changes in employees' drinking and smoking behaviours. As noted in Chapter 3, there is some evidence from the US suggesting that bullying may be associated with various adverse drinking outcomes, such as increased alcohol consumption (Richman et al, 1996, 1999; see Ch. 3). However, there is no clear evidence as to the links between bullying and changes in smoking behaviour. Quine's (1999) study of health professionals does suggest though that experiences of bullying may be related to changes (notably increases) in smoking *and* drinking behaviours. Accordingly, the following hypotheses were tested:

- H5: Employees who report bullying acts at work will show greater increase in drinking over a period of 1 year than those who do not report bullying.
- H6: Employees who report bullying acts at work will show greater increase smoking over a period of 1 year than those who do not report bullying.

Finally, two occupational outcomes were assessed in the study. These were respondents' general job satisfaction and their propensity to leave the job. The relationship between bullying and these outcomes has actually been demonstrated in number of studies (e.g. Einarsen &

Raknes, 1997a; Hoel & Cooper, 2000; Keashly et al, 1994; Matthiesen et al, 1989; Quine, 1999; Vartia, 1991). However, the methodological limitations mentioned above apply to these studies. For instance, some of the studies have not acknowledged the effects of extraneous factors, such as the effects of NA, on the above relationships. In the present study, the potential effects of NA were determined, and the following hypotheses tested:

- H7: Employees who report bullying acts at work will be less satisfied with their job than those who do not report bullying – even when NA is covaried out.
- H8: Employees who report bullying acts at work will be more likely to contemplate leaving than those who do not report bullying – even when NA is partialled out.

In Chapter 3, it was noted that in spite of problems with cross-sectional data, researchers tend to conclude that bullying at work has a causal impact on people's health. In view of this line of reasoning, it was argued that bullying does not necessarily affect all employees to the same extent. One of the factors considered to counteract or moderate the effects of bullying is having a supportive work environment (see, for example, Quine, 1999). As yet, only two studies have confirmed this buffering effect of support at work (Einarsen et al, 1996; Quine, 1999;

2001). In the present study, an attempt was made to replicate these findings.

In addition, the moderating (or buffering) role of a second factor – that of generalised self-efficacy (GSE) – was examined in the study. As noted in Chapter 3, GSE is a personal resource factor, reflecting optimistic self-beliefs. In a recent study (Mikkelsen & Einarsen, 2002), this factor was found to moderate relationships between exposure to bullying acts and health complaints. In the present study, the four hypotheses testing moderating (or buffering) effects of support at work and GSE were:

- H9: Employees who report bullying acts, but have good support (or high sense of self-efficacy) will show lower levels of anxiety than those who report bullying, but have poor support (or low sense of self-efficacy).

- H10: Employees who report bullying acts, but have good support (or high sense of self-efficacy) will show lower levels of depression than those who report bullying, but have poor support (or low sense of self-efficacy).

- H11: Employees who report bullying acts, but have good support (or high sense of self-efficacy) will be more satisfied with their jobs than those who report bullying, but have poor support (or low sense of self-efficacy).

H12: Employees who report bullying acts, but have good support (or high sense of self-efficacy) will be less inclined to leave than those who report bullying, but have poor support (or low sense of self-efficacy).

The final issue addressed in the study was that of ripple effects of bullying (see Chapter 3). As may have been expected, considering previous research in the field, the present study revealed that a number of trust employees, or some 46%, had witnessed the bullying of others in the past 12 months (see Ch. 4, results section). In Chapter 3 some evidence was presented, showing that bullying at work may not only affect those directly exposed to bullying, but also those who observe the bullying of others (e.g. Hoel & Cooper, 2000; Vartia, 2001). In the present study, this kind of ripple effect was tested with regard to four outcome measures. These were: levels of anxiety and depression, general job satisfaction and propensity to leave. The hypotheses tested were as follows:

H13: Observers (bystanders) of bullying will show higher levels (more symptoms) of anxiety than non-observers.

H14: Observers (bystanders) of bullying will show higher levels (more symptoms) of depression than non-observers

H15: Observers (bystanders) of bullying will be less satisfied with their job than non-observers.

H16: Observers (bystanders) of bullying will be more likely to contemplate leaving than non-observers.

As may be gathered from previous hypotheses (hypotheses 1 to 12), the measure used to assess employees' direct experiences of bullying was the 21-item bullying scale (a scale measuring exposure to persistent negative acts at work). The scale was one of two measures used to assess prevalence rates in the trust. The second measure employed was a self-report measure of bullying (see Ch. 4).

In this second part of the study, the bullying scale was employed since previous studies (e.g. Hoel & Cooper, 2000) have shown that people who experience aggressive or somehow unpleasant acts at work are quite likely to be damaged or somehow affected, whether they actually label themselves as being bullied or not. Theoretically, it may also be argued that the mere exposure to persistent negative acts at work is a serious stress factor that may have detrimental effects on people's health.

Description of occupational health measures

In the previous chapter, the various aspects of study method were thoroughly described (see Ch. 4). As noted in this chapter, a structured questionnaire was sent out to a randomly generated sample of 3,000 hospital employees. The questionnaire comprised five sections, and the measures used in this second part of the study were as follows (see also Appendix II).

Job satisfaction and propensity to leave the job: A five-item scale (Quinn & Staines, 1979) was used to assess job satisfaction. The scale is described as reflecting employees' general affective reaction to their job. Examples of scale items are: "all in all, how satisfied would you say you are with your job?" and "in general, how well would you say that the job measures up to the sort of job that you wanted when you took it?" As shown in Appendix II, the response format used varied between items. However, the scale was used in such a way that higher scores (the five item scores added) reflected higher levels of job satisfaction.

Propensity to leave the job: A three-item scale was used to assess respondents' inclinations to leave their job (Cammann et al, 1979). Examples of scale items are: "how likely is it that you will actively look for a new job in the next year?" and "how often do you think about leaving your job?" As with the job satisfaction scale, the response formats used varied between items. Yet, higher scores on the scale (the three item

scores added) were seen as reflecting stronger inclination to leave the job.

Support at work: A nine-item scale was used to assess respondents' perceptions of support at work. In six of the items (derived from Bosma et.al, 1997), employees were asked to assess three aspects of work-related support: support from colleagues (example: "my colleagues are willing to listen to my work-related problems"), support from supervisors/line managers (example: "I get help and support from my supervisor/line manager/team leader"), and clarity/consistency of information received from line management (example: "I get sufficient information from my line management"). In the additional three items, respondents were asked if they felt adequately supported by their colleagues and/or line management and whether they felt that they work in a generally supportive work environment. All nine items were rated on a scale ranging from 1 ("never") to 4 ("often"). Hence, higher scores on the scale (the nine item scores added) were seen to reflect higher degree of support at work.

General health status and sickness absence: Two questions were used to assess respondents' perceptions of their general health and their estimates of sickness absence in the past twelve months. These were: "how would you describe your health?" (response options: "very poor", "poor", "in between", "good", and "very good") and "how many days have you had off work for illness in the past 12 months?" (respondents asked

to approximate the number of days). The self-report measure of general health status is a recognised method of measuring health, and many studies have demonstrated its power to predict objective measures of physical health (see, for example, Idler, 1992).

Anxiety and depression – the Hospital Anxiety and Depression Scale:

A 14-item measure (*HADS*; Zigmond & Snaith, 1983) was used to assess respondents' levels of anxiety and depression. Seven of the scale items reflect symptoms anxiety and seven reflect symptoms of depression. The items were all rated on a 4-point scale. Examples of items measuring anxiety are: "worrying thoughts go through my mind" and "I feel restless as if I have to be on the move". Examples of items measuring depression are: "I still enjoy the things I used to enjoy" and "I feel as I am slowed down".

Cut-off points are provided to give the best separation between non-cases (scores between 0 and 7), doubtful cases (scores between 8 and 10), and cases (scores ≥ 11) of clinical anxiety and depression. However, the scale can also be used to assess respondents' levels of anxiety and depression. Appropriate item scores are then added to achieve two total scores, one reflecting levels of anxiety and the other levels of depression. In the production of the scale, care was taken to separate out the concept of emotional and somatic illness, so the scores are not to be affected by the presence of bodily illness.

Negative affectivity: A 21-item scale was used to assess negative affectivity (NA). Examples of scale items are: “after an embarrassing experience, I worry about it for days” and “when things go wrong, I blame myself”. Respondents rated the items on a scale ranging from 1 (“disagree strongly”) to 6 (“agree strongly”). Higher scores on the scale (the 21 item scores added) were seen as reflecting higher levels of NA. A more detailed description of the scale is provided in Ch. 4.

Exposure to bullying at work: The measure used to assess employees’ experiences of bullying was the 21-item scale (a scale derived from preliminary factor analysis; see Ch. 4). The scale was assumed to measure five categories of bullying: personal derogation/isolation (9 items), work-related bullying (5 items), threats and verbal abuse (3 items), teasing and ridicule (2 items), and violence (2 items). Examples of items reflecting the five categories are as follows (names of categories in brackets): “persistent unjustified criticism or monitoring of your work performance”, “persistent attempts to demoralise you”, “freezing you out/ignoring you/excluding you” (personal derogation/ isolation); “setting of impossible deadlines”, “withholding information from you” (work-related bullying); “verbal and non-verbal threats”, “use of abuse, swearwords and obscenities” (threats and verbal abuse); “persistent teasing”, “making inappropriate jokes about you” (teasing and ridicule); and “violence to property”, “physical violence” (violence).

Respondents were asked to indicate by a “yes”/“no” response whether they had been persistently exposed to any of these behaviours in the past 12 months. Prior to the scale, respondents were provided with a comprehensive definition of bullying at work (see Lyons et al’s (1995) definition of bullying in Appendix II).

Generalised self-efficacy: A 10-item scale was used to assess respondents’ general sense of self-efficacy (GSE; Wegner, Schwarzer & Jerusalem, 1993). Examples of scale items are: “I am confident that I could deal efficiently with unexpected events”, “thanks to my resourcefulness, I know how to handle unforeseen situations”, and “I can remain calm when facing difficulties because I can rely on my coping abilities”. The items were rated on a scale ranging from 1 (“not at all true”) to 4 (“exactly true”). Higher scores on the scale (the 10 item scores added) were seen to reflect respondents’ higher sense of GSE.

Drinking and smoking habits: Finally, five questions were used to assess the respondents’ drinking and smoking habits. First, the respondents were asked to describe their typical drinking habits (quantity and frequency of drinking), and to assess whether the quantity of alcohol consumed had increased or decreased in the past 12 months. Second, the respondents were asked to indicate whether they smoked or not. The ones who did smoke were then asked to describe their average daily consumption of cigarettes and to assess whether their smoking had increased or decreased in the past 12 months.

Selection of scales

All the scales were carefully selected for the study. The measure of *job satisfaction* (Quinn & Staines, 1979) was selected for two reasons. First of all, it was a simple and relatively brief measure of overall job satisfaction. Secondly, the scale has been shown to be a reliable and valid measure of workers' job satisfaction (Cook, Hepworth, Wall & Warr, 1981). Apart from the Quinn and Staines' measure, a number of other scales were assessed, for instance, the Minnesota Satisfaction Questionnaire (*MSQ*; Weiss, Dawis, England & Lofquist, 1967) and the Job Descriptive Index (*JDI*; Smith, Kendall & Hulin, 1969). These scales were regarded less suitable, since they focused on distinct aspects of the job (e.g. satisfaction with supervision, working conditions, co-worker interactions, task variety) instead of employees' general affective reaction to the job.

The measure of *propensity to leave* (Camman et al, 1979) is a sub-scale of the Michigan Organisational Assessment Questionnaire: A measure widely used in the literature. The scale was mainly selected because of its good face validity and sound psychometric features (see Cook et al, 1981). Apart from this scale, there are not many standardised measures of turnover intentions. In fact, most studies of occupational stress rely on single-item measures of propensity to leave instead of multi-item scales. Yet, the Camman et al's (1979) measure has been used with good results in bullying research (see, for example, Quine, 1999).

The measure of *support at work* was partly based on Bosma et al's (1997) measure of work-related support. This six-item scale was selected for two reasons. First of all, the scale is shown to be a reliable measure of support at work (Bosma et al, 1997). Secondly, the distinct scale items focus on two important features of support at work – namely, perceived availability and adequacy of support from colleagues and supervisors. The three items added to the scale (see items 7, 8 and 9 in Appendix II) were seen to yield a more elaborate index of support. The scale finally employed was seen to reflect employees' overall perception of support at work. Apart from the Bosma et al (1997) scale of support at work, a number of other scales have been used in the literature. Among these are Karasek et al's (1982) measures of supervisor and co-worker support (Karasek, Triantis & Chaudhry, 1982). In contrast to the Bosma et al support measure, these scales focused on only one aspect of support at work (availability of support from supervisors and/or co-workers), and were therefore regarded less suitable for the study.

The measure of *anxiety and depression* (the Hospital Anxiety and Depression Scale; *HADS*) was selected from a number of scales focusing on these two mental states (separately or in combination). Examples of other scales are: The Hopkins Symptom Checklist (*HSCL-25*; Derogatis, Rickels, Uhlenhuth & Covi, 1974), the Center for Epidemiological Studies' Depression Scale (*CES-D*; Radloff, 1977) and the State-Trait Anxiety Inventory (*STAI-S*; Spielberger, Gorsuch &

Lushene, 1970). These various scales have been shown to have good psychometric properties. Yet, for several reasons, the HADS was seen most appropriate for the study. In particular, the scale entails the virtues of being short, measuring both anxiety and depression, and yielding cut-off points for probable clinical levels (see description of scale above). Moreover, the HADS has repeatedly been shown to be a reliable and valid measure of state anxiety and depression (Moorey et al, 1991; Zigmond & Snaith, 1983). What is more, the scale is seen to separate nicely mental and physical health problems (Zigmond & Snaith, 1983).

The 21-item measure of *negative affectivity* (NA; Stokes & Levin, 1990) was selected for two reasons. In order to explain the first reason, it must be noted that NA is defined as a multi-faceted construct (see Watson & Clark, 1984). That is, NA is seen to reflect three aspects of emotional and cognitive dispositions. Firstly, it reflects ongoing feelings of nervousness and tension. Secondly, it involves negative attitudes about oneself and low self-esteem. Thirdly, it entails negative attitudes about other people and life in general (Watson & Clark, 1984, p. 466).

A number of scales are seen to tap one of these aspects, for instance the Eysenck Personality Inventory of Neuroticism Scale (*EPI-N*; Eysenck & Eysenck, 1968), the Taylor Manifest Anxiety Scale (*TMAS*; Taylor, 1953), the Rosenberg Self-Esteem Scale (*RSE*; Rosenberg, 1965) and the Beck Depression Inventory (*BDI*; Beck, Ward, Mendelson & Erbaugh, 1961). However, the Stokes and Levin (1990) measure is the

only measure that simultaneously taps all the three aspects of NA (nervousness/calmness, satisfaction/dissatisfaction with oneself and pessimism/optimism). Therefore, this scale was selected for the study. Apart from this reason, the 21-item NA scale has been shown to have good psychometric properties, e.g. good internal consistency and construct validity (see Stokes & Levin, 1990, pp. 178–181).

The measure of *generalised self-efficacy* (GSE) was selected on similar grounds as the NA scale – that is, because of its good conceptual and psychometric properties. According to Schwarzer (1992), the construct of GSE reflects optimistic self-belief. That is, the person's belief that he or she can cope efficiently with a range of stressful situations. The 10-item GSE measure (Wegner et al, 1993) was designed to tap this construct. In contrast to other measures of dispositional optimism, such as the Life Orientation Test (*LOT*; Scheier & Carver, 1985) and the revised Life Orientation Test (*LOT-R*; Scheier, Carver & Bridges, 1984), the 10-item GSE measure explicitly refers to personal agency, i.e. the belief that one's actions are responsible for successful outcomes.

The GSE scale has been used in numerous research projects, where it has yielded excellent internal consistency (Schwarzer & Scholz, 2000). Evidence for the validity of the scale (e.g. construct validity) has also been reported. For instance, the GSE has been shown to correlate highly with measures of proactive coping, self-regulation, and procrastination (Schwarzer & Jerusalem, 1999).

Results

The response rate obtained in the study was 67%. Since a description of the final sample is provided in Ch. 4, only a brief description is given here. The sample consisted of 1,905 trust employees, representing nine occupational groups. Of the total sample, 59% were full-time workers and 41% part-time workers. Most of the respondents were female (86% vs. 14% male) but the proportion of respondents in the various age groups (18-30 yrs, 31-40 yrs, 41-50 yrs, >50 yrs) was quite equal.

Preliminary analyses of data

Prior to the main analyses, the means and standard deviations of all continuous variables were calculated. The reliability of scales was also determined, using coefficient alpha.

Table 5.1. Means, standard deviations and reliability of scales

<i>Scale</i>	<i>Items</i>	<i>α</i>	<i>M</i>	<i>SD</i>	<i>N</i>
The bullying scale	21	.89	2.3	3.6	1837
Job satisfaction	5	.84	12.2	2.8	1830
Propensity to leave	3	.66	8.0	2.7	1887
Support at work	9	.93	28.5	5.7	1784
Anxiety (<i>HADS</i>)	7	.86	7.1	7.2	1904
Depression (<i>HADS</i>)	7	.81	4.3	7.2	1905
Sickness absence	1	–	7.3	23.2	1845
General health status	1	–	4.3	0.7	1869
Negative affectivity	21	.90	62.9	15.0	1726
Generalised self-efficacy	10	.88	18.5	4.3	772

The results of these analyses are presented in Table 5.1. As the table shows, satisfactory alphas were found for all the scales. Indeed, most of the scales had excellent internal consistency.

Correlations between scales

Pearson's product-moment correlations between scales were also calculated. The correlations found are presented in Table 5.2. The alpha-value selected for assessing these correlations was .05. Using this value, all the correlations observed were found to be statistically significant. However, some of the correlations were rather weak, such as the correlation between bullying and generalised self-efficacy ($r = -.09$).

Table 5.2. Correlations between scales

Scale	2	3	4	5	6	7	8
1. The bullying scale	-.42	.35	-.55	.42	.46	.32	-.09 ^a
2. Job satisfaction	–	-.64	.56	-.34	-.45	-.37	.18
3. Propensity to leave		–	-.44	.26	.35	.23	-.07 ^a
4. Support at work			–	-.34	-.42	-.33	.18
5. Anxiety (<i>HADS</i>)				–	.67	.68	-.36
6. Depression (<i>HADS</i>)					–	.64	-.34
7. Negative affectivity						–	-.49
8. Generalised self-efficacy							–

Note: All the above correlations were significant at the $p < .001$ level, apart from: a $p < .05$

Of most relevance to the present study were correlations between NA and the other scales, given that NA was expected to play a role in bullying-outcome relationships (that is, to partially inflate these relationships). In Chapter 4, it was reported that NA was moderately

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correlated with scores on the bullying scale. Indeed, this finding is confirmed in Table 5.2 ($r = .32$, $p < .001$). In addition, the table shows that NA correlated with scores on the scales measuring job satisfaction, propensity to leave, anxiety and depression (four of the outcome variables assessed). The correlations with the scales reflecting levels of anxiety and depression were remarkably strong ($r = .68$, $p < .001$ and $r = .64$, $p < .001$), and the correlations with job satisfaction and propensity to leave were moderately strong ($r = -.37$, $p < .001$ and $r = .23$, $p < .001$). Hence, there seemed to be a good reason for incorporating the measure of NA in later analyses.

As regards correlations between bullying and occupational health outcomes, Table 5.2 shows that scores on the bullying scale were moderately correlated with anxiety ($r = .42$, $p < .001$) and depression ($r = .46$, $p < .001$), and also with job satisfaction ($r = -.42$, $p < .001$) and propensity to leave ($r = .35$, $p < .001$). It may be noted that observed relationships between bullying and outcomes were not influenced by background variables, such as age, gender and occupation.

As for relationships between the four outcome variables, Table 5.2 shows that the two health variables (anxiety and depression) were quite strongly correlated ($r = .67$, $p < .001$). A similar degree of correlation was detected for the two occupational variables (job satisfaction and propensity to leave; $r = -.64$, $p < .001$). However, given the conceptual relationship between anxiety and depression, and also between job

attitudes and propensity to leave, the correlations observed may not be surprising.

Main Results

Various hypotheses regarding bullying and outcomes were tested in the study. These hypotheses were mostly tested through analyses of covariance (ANCOVA), but also through chi-square (χ^2) tests. The groups of employees compared in the tests were created using two kinds of scores on the bullying scale (scores ≥ 1 and scores = 0). That is, the employees were divided into groups of those who (1) reported one or more types of bullying acts at work in the past year (n=877), and (2) those who reported no bullying acts in the past year (n=960).¹

Means and standard deviations of continuous outcome measures were calculated for the two groups separately, and the results obtained are shown in Table 5.3. The table also shows the number of respondents in the two groups created. For convenience, the groups were labelled the “bullied” and the “non-bullied” group.

¹ Due to the distribution of scores on the bullying scale (see Ch. 4, preliminary results), the scale was treated as a dichotomous, rather than a continuous one. Accordingly, analyses of variance and chi-square tests were used to test the study hypotheses.

Table 5.3. Means and standard deviations for continuous outcome measures: Results presented separately for “bullied” and “non-bullied” respondents

<i>Outcome measure</i>	<i>Bullied</i>			<i>Non-bullied</i>		
	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>
Job satisfaction	11.1	2.7	787	13.3	2.4	834
Propensity to leave	8.9	2.7	805	7.1	2.4	858
General health status	4.2	0.7	808	4.4	0.7	855
Sickness absence	8.9	26.2	797	5.5	19.8	843
Anxiety	7.6	4.0	849	5.1	3.2	923
Depression	4.6	3.3	849	2.4	2.3	923

Note: The terms “bullied” and “non-bullied” refer to the groups of respondents who (a) reported ≥ 1 bullying acts at work in the past year and (b) reported no bullying acts at work in the past year

Bullying and psychological health outcomes

Firstly, the study assessed the relationship between bullying and psychological health outcomes (i.e. levels of anxiety and depression). Given that NA was strongly correlated with these outcomes (see Table 5.2), the relationship was tested through analysis of covariance (ANCOVA), where NA was treated as a covariate. The result of this analysis showed that employees who reported bullying showed significantly higher levels of anxiety (adjusted means 7.0 versus 5.7; $F(1,1660) = 83.1, p < .001$) and depression (adjusted means 4.2 versus 2.8; $F(1,1646) = 131.8, p < .001$) than those who did not report bullying

Thus, the first two study hypotheses were supported. The strength of association between bullying and the two outcomes was assessed using coefficient eta squared (η^2). The η^2 values observed were .05 and .07,

indicating that 5% of the variance in adjusted anxiety scores and 7% of the variance in adjusted depression scores associated with bullying experiences.

Additional analyses revealed that employees who reported bullying were significantly more likely to suffer clinical levels of anxiety ($\chi^2(2)=161.9$, $p < .001$) and depression ($\chi^2(2)=120.8$, $p < .001$) than other employees. This was found when cut-off points were applied to the HADS anxiety and depression measures; a strategy used to distinguish cases (scores: ≥ 11), doubtful cases (scores: 8-10), and non-cases (scores: 0-7) of clinical anxiety and depression. Of the group of employees who reported bullying acts, 23% suffered clinical levels of anxiety and 6% suffered clinical levels of depression. In contrast, only 7% of those who did not report bullying suffered clinical levels of anxiety and 1% suffered clinical levels of depression (see significant chi-square results above).

Bullying and general health status / sickness absence

The next step in the analysis was to test whether employees who had experienced bullying acts at work reported poorer general health and more days off work (in the past year) than did other employees. Before testing this, the correlation between NA and the two outcomes was examined. It was found that NA was only weakly correlated with reports of sickness absence ($r = .06$, $p < .05$), but moderately correlated with reports of general health status ($r = .28$, $p < .001$).

Despite these weak or moderate correlations with NA, ANCOVA tests were again conducted, where NA was treated as a covariate. Test results showed that employees who had experienced bullying acts reported significantly more days off work (8.6 days vs. 5.7 days on average, $F(1,1637) = 5.8, p < .05$) than did other employees. Additionally, they reported poorer general health than did other employees (adjusted means: 4.2 versus 4.4; $F(1,1660) = 13.1, p < .001$). Hence, study hypotheses 3 and 4 were supported. Observed η^2 values ($\eta^2 = .002$ and $\eta^2 = .008$) indicated though that only 0.4% of the variance in adjusted sickness absence scores and 0.8% of the variance in adjusted health status scores was associated with bullying experiences.

Bullying and reported changes in drinking and smoking

This part of the analysis focused on sub-samples of employees who described themselves to be drinkers ($n=873$) or smokers ($n=226$). As in other analyses, the two sub-samples were divided into groups of those who (1) reported one or more types of bullying acts at work, and (2) reported no bullying acts. Within these groups, the employees were again divided into four sub-groups, depending on whether their drinking or smoking had increased or decreased in the past 12 months. Thus, a total of eight groups were identified in the study (see Table 5.4), and these were used to test study hypotheses 5 and 6.

Table 5.4. Reports of bullying acts (in the past year) and changes in drinking/ smoking habits

Changes in habits	<i>Bullying acts reported</i>		<i>No bullying acts reported</i>	
	Decreased / remained the same % (n)	Increased % (n)	Decreased / remained the same % (n)	Increased % (n)
Drinking	83 (659)	17 (134)	92 (805)	8 (68)
Smoking	64 (146)	36 (83)	85 (193)	15 (33)

The hypotheses were tested using two chi-square tests, one dealing with changes in drinking (see top row in Table 5.4), and the other with changes in smoking (see bottom row in Table 5.4). The results showed that employees who had experienced bullying were significantly more likely to report an increase in drinking than were other employees ($\chi^2(1)=33.4$, $p < .001$). They were also more likely than other employees to report an increase in smoking ($\chi^2(1)=28.1$, $p < .001$). Hence, study hypotheses 5 and 6 were supported.

Bullying and job satisfaction / propensity to leave the job

In the analysis of bullying and occupational outcomes, the factor of NA was again taken into account. The analysis examined whether employees who reported bullying were less satisfied with their jobs and more likely to contemplate leaving than those who reported no bullying. Preliminary analyses had shown that NA correlated with reports of job satisfaction, and also with reports of propensity to leave (see Table 5.2).

Therefore, hypotheses 7 and 8 were tested through ANCOVA, where NA was treated as a covariate.

The results showed that employees who reported bullying acts were significantly less satisfied with their job than other employees (adjusted means: 11.3 versus 13.0, $F(1, 1618) = 197.1, p < .001$). The results also showed that employees who reported bullying acts were significantly more inclined to leave their jobs than were other employees (adjusted means: 8.8 versus 7.3; $F(1, 1660) = 136.9, p < .001$). Thus, study hypotheses 7 and 8 were supported. Observed η^2 values ($\eta^2 = .11$ and $\eta^2 = .08$) indicated that 11% of the variance in adjusted job satisfaction scores and 8% of the variance in adjusted propensity to leave scores associated with bullying experiences.

Support at work and generalised self-efficacy as buffers against bullying

The role of support at work and generalised self-efficacy in bullying-outcome relationships was examined, using the following four outcome variables: anxiety, depression, job satisfaction and propensity to leave. It was expected that the two factors would act as buffers (or moderators), protecting people from the potentially adverse effects of bullying. These moderating effects were tested through two-way ANCOVAs, where NA was treated as a covariate. The factors employed in the analyses were created through specific scores on the scales measuring bullying experiences, support at work and generalised self-efficacy (see below).

The bullying factor: Like in previous analyses, two types of scores on the bullying scale (scores ≥ 1 and scores =0) were employed to create the following groups of employees: (1) those who reported one or more types of bullying acts at work in the past year (n=877), and (2) those who reported no bullying acts in the past year (n=960).

The support at work factor: Scores on the support at work scale were split at the median (Med=29,0), creating the following groups of employees: (1) those who reported good support at work (n=960), and (2) those who reported relatively poor support at work (n=835).

The GSE factor: Scores on the generalised self-efficacy (GSE) scale were also split at the median (Med=30,0), creating the following groups of employees: (1) those who had high levels of self-efficacy (n=421), and (2) those who had low levels of self-efficacy (n=351).

Buffering effects of support at work

First, the buffering role of support at work was assessed. The observed ANCOVA findings supported hypotheses 9, 10 and 12, but not hypothesis 11. Employees who reported one or more types of bullying acts, but experienced good support at work had significantly lower scores on the scales measuring anxiety, depression and propensity to leave than those who reported bullying, but experienced poor support. However, similar buffering effects were not detected for job satisfaction.

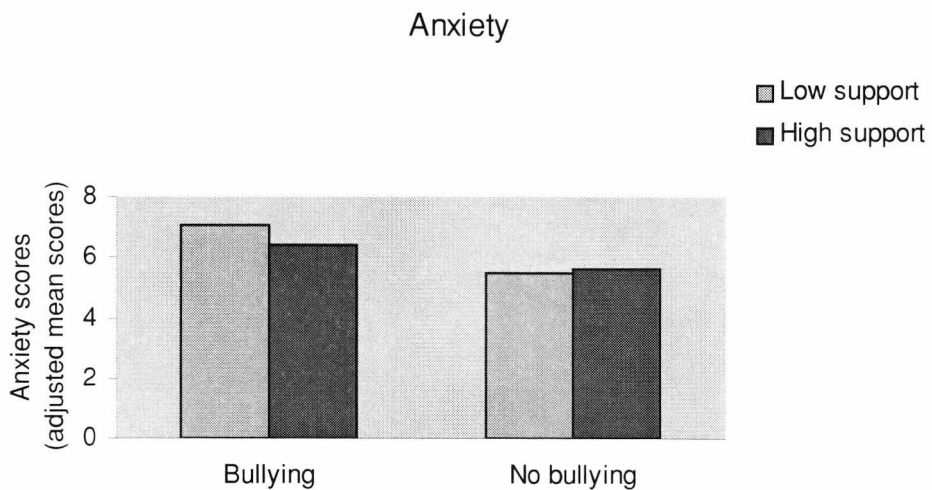
Table 5.5 and Figure 5.1 show the main effects of bullying and support on the various outcome variables, and the interaction effects of bullying and support, after NA has been covaried out.

Table 5.5 Main effects and interaction (moderating) effects of bullying and support at work on occupational health outcomes: ANCOVA results

<i>Outcome</i>	<i>Main effects of bullying</i>	<i>Main effects of support</i>	<i>Interaction (moderating) effects</i>
Anxiety	F(1,1572)=53.3	F(1,1572)=4.2 ^b	F(1,1572)=7.7 ^a
Depression	F(1,1557)=63.7	F(1,1557)=32.8	F(1,1557)=8.7 ^a
Job satisfaction	F(1,1539)=61.1	F(1,1539)=199.1	F(1,1539)=3.2 ^c
Propensity to leave	F(1,1576)=42.5	F(1,1576)=109.0	F(1,1576)=8.0 ^a

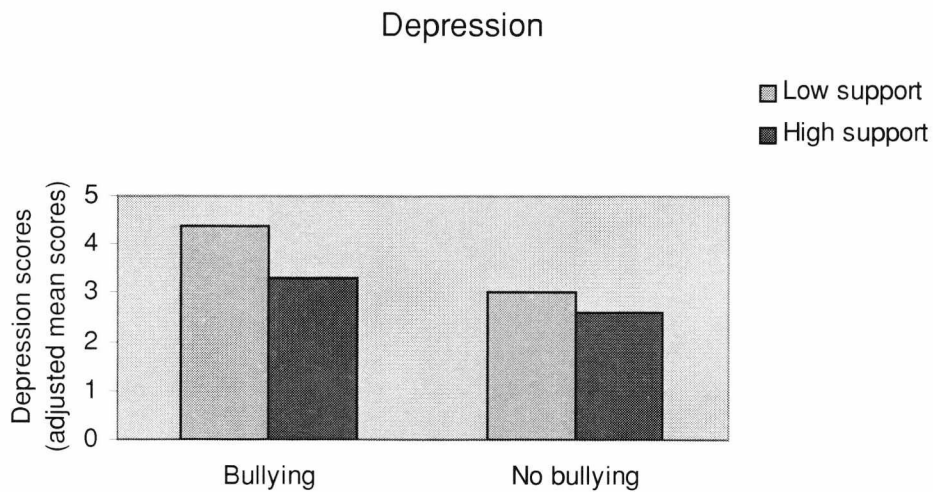
Note: All the above F-values were significant at the $p < .001$ level, apart from: a $p < .01$, b $p < .05$ and c $p > .05$ (ns)

Figure 5.1. Buffering effects of support at work on occupational health outcomes: ANCOVA results

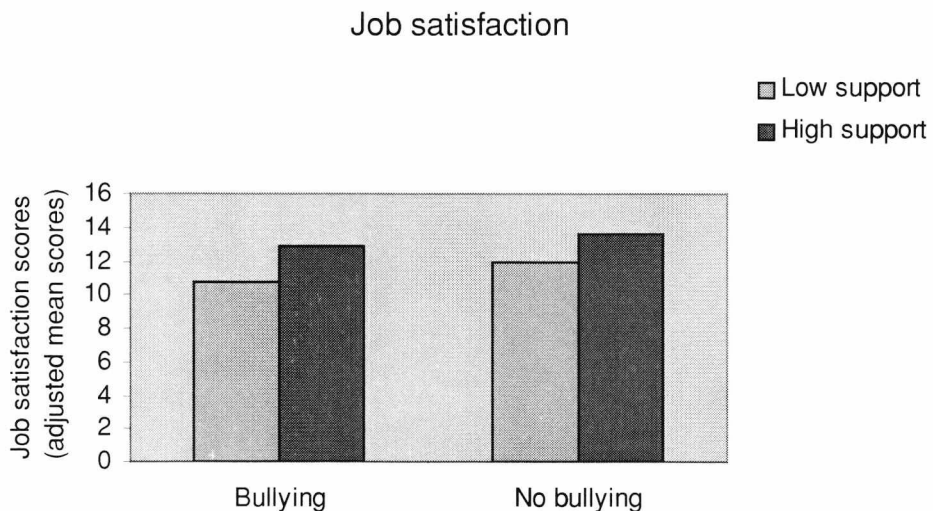


Buffering effects detected at the $p < .01$ level, main effects of support also detected at the $p < .05$ level. Observed simple main effects of support (high vs. low support) in: (a) “bullying” conditions: $F(1, 1572) = 10.4, p < .01$ (b) “no bullying” conditions: $F(1, 1572) = 0.27, p > .05$.

Figure 5.1 (continued): Buffering effects of support at work on occupational health outcomes: ANCOVA results

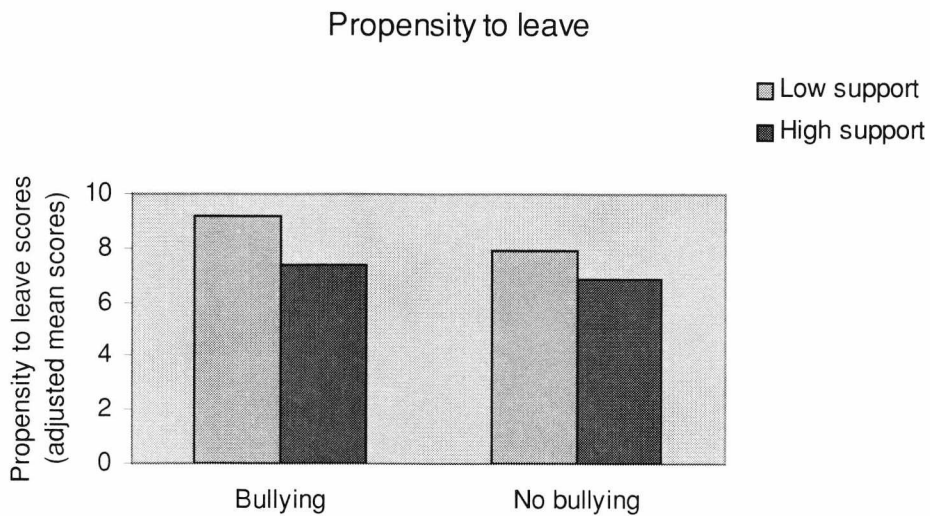


Buffering effects detected at the $p < .01$ level, main effects of support also detected at the $p < .001$ level. Observed simple main effects of support (high vs. low support) in: (a) “bullying” conditions: $F(1, 1557) = 33.74, p < .001$ (b) “no bullying” conditions: $F(1, 1557) = 4.5, p < .05$.



No buffering effects detected, however, main effects of support at work detected at the $p < .001$ level.

Figure 5.1 (continued): Buffering effects of support at work on occupational health outcomes: ANCOVA results



Buffering effects detected at the $p < .01$ level, main effects of support also detected at the $p < .001$ level. Observed simple main effects of support (high vs. low support) in: (a) "bullying" conditions: $F(1, 1576) = 79.0, p < .001$ (b) "no bullying" conditions: $F(1, 1576) = 33.8, p < .001$.

As Figure 5.1 indicates, the buffering effects of support were especially marked for depression and propensity to leave (see simple main effects of low vs. high support within "bullying" and "no bullying" conditions – notably the stronger effects of support in the "bullying" conditions).

Buffering effects of GSE

Whilst buffering effects of support at work were detected in the study, similar effects of generalised self-efficacy (GSE) were not found. That is, GSE as a personal resource did not seem to play a protective role in any of the bullying-outcome relationships (see non-significant interaction effects in Table 5.6). In addition, GSE in itself did not seem to influence

the outcome variables studied. That is, no main effects of GSE were detected in the four analyses conducted (see non-significant main effects in Table 5.6).

Table 5.6. Main effects and interaction effects of bullying and GSE on occupational health outcomes: ANCOVA results

<i>Outcome</i>	<i>Main effects of bullying</i>	<i>Main effects of GSE</i>	<i>Interaction (moderating) effects</i>
Anxiety	F(1,669)=43.2 ^a	F(1,669)=0.19	F(1,669)=0.016
Depression	F(1,662)=44.6 ^a	F(1,662)=0.00	F(1,662)=1.12
Job satisfaction	F(1,650)=71.9 ^a	F(1,650)=0.40	F(1,650)=0.03
Propensity to leave	F(1,669)=59.2 ^a	F(1,669)=2.1	F(1,669)=0.40

Note: The only significant F-values were the ones for main effects of bullying (a), these were all significant at the $p < .001$ level

Ripple effects of bullying

The final step of the present analysis was to test the potential effects of bullying on observers. In the analysis, the term observer referred to those who had not experienced bullying themselves, but had (currently or in the past 12 months) witnessed the bullying of others. One-way ANOVAs and independent samples t-tests were used to assess the potential effects of bullying on this group of employees. The outcome measures studied were: anxiety, depression, job satisfaction, and propensity to leave.

The three groups compared in the ANOVA tests (as well as in the t-tests) were: (a) employees who had direct experiences of bullying (bullied respondents), (b) employees who had not experienced bullying themselves, but had witnessed the bullying of others (non-bullied/observers), and (c) employees who had no experiences of bullying at work (non-bullied/non-observers).

To explain further, group (a) consisted of those employees who had scores ≥ 1 on the bullying scale ($n=290$). Group (b) consisted of employees who had scores = 0 on the bullying scale, but had witnessed the bullying of others (occasionally or frequently; $n=258$). Finally, group (c) consisted of employees who had scores = 0 on the bullying scale, and had not witnessed the bullying of others ($n=690$).

Descriptive statistics (means and standard deviations) for the three groups on the occupational health measures are presented in Tables 5.7 and 5.8. The ANOVA results obtained for the four outcome variables are also shown in the tables. As the tables indicate, overall differences between the three groups were found for all the outcomes examined. In order to determine where these overall differences lay, a series of t-tests was carried out (see Tables 5.7 and 5.8). In the various tests, the focus was especially on the groups of observers and non-observers, since these were the groups central to the study hypotheses (see introduction).

Table 5.7. Mean scores on anxiety and depression: Data presented separately for bullied respondents, observers, and non-observers

<i>Group</i>	<i>Anxiety</i>			<i>Depression</i>		
	<i>Mean</i>	<i>SD</i>	<i>n</i>	<i>Mean</i>	<i>SD</i>	<i>n</i>
Bullied (B)	7.1	3.8	284	4.2	3.3	281
Observers (O)	5.4	3.4	253	2.7	2.4	252
Non-observers (N)	4.9	3.1	675	2.2	2.2	669
ANOVA	F(2,1209)=40.6			F(2,1199)=60.2		
t-tests	B/O t (535)= -5.1			B/O t (531)= -6.0		
	B/N t (957)= -9.0			B/N t (948)= -10.8		
	O/N t (926)= -2.2 ^b			O/N t (919)= -2.7 ^a		

Note: All the above F and t-values were significant at the $p < .001$ level, apart from: a $p < .01$, and b $p < .05$

The results from the t-tests fully supported the final study hypotheses. That is, the results showed that observers of bullying had higher levels of anxiety ($t(926) = -2.2, p < .05$) and depression ($t(919) = -2.7, p < .01$) than did non-observers. In addition, the results showed that observers were less satisfied with their jobs ($t(907) = 4.3, p < .001$) and more inclined to leave the job ($t(939) = -4.3, p < .001$) than were non-observers.

Whilst the study hypotheses focused on observers and non-observers of bullying, it may be noted that of the three groups examined, the group showing the highest scores on anxiety and depression was the group of bullied employees (see means presented in Table 5.7 and t-test results). This group also showed the highest scores for propensity to leave, and the lowest scores for job satisfaction (see means presented in Table 5.8 and t-test results).

Table 5.8. Mean scores on job satisfaction and propensity to leave: Data presented separately for bullied respondents, observers, and non-observers

<i>Group</i>	<i>Job satisfaction</i>			<i>Propensity to leave</i>		
	<i>Mean</i>	<i>SD</i>	<i>n</i>	<i>Mean</i>	<i>SD</i>	<i>n</i>
Bullied (B)	11.6	2.6	281	8.3	2.5	288
Observers (O)	12.7	2.3	245	7.7	2.3	255
Non-observers (N)	13.5	2.4	664	7.0	2.4	686
ANOVA	F(2,1187)=58.7			F(2,1226)=32.1		
t-tests	B/O t (523)=5.1			B/O t (541)= -2.7 ^a		
	B/N t (943)=10.7			B/N t (972)= -7.6		
	O/N t (907)=4.3			O/N t (939)= -4.3		

Note: All the above F and t-values were significant at the $p < .001$ level, apart from: a $p < .01$

Hence, when contrasting direct and indirect experiences of bullying, the former type of experiences appeared to have more adverse effects. However, a conclusion of this sort must be speculative, since the above findings are based on cross-sectional data, making inferences of causal effects impossible.

Discussion

The aim of the present study was to determine the association between bullying and occupational health outcomes. Previous studies have repeatedly confirmed the relationship between bullying experiences and reduced emotional and psychosomatic health, and also between bullying and work-related outcomes (e.g. reduced job satisfaction and propensity to leave). These relationships observed are usually based on self-report

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survey data, where the effects of potential third variables are not taken into account. However, concerns have been raised that reports of bullying and occupational health outcomes may be affected by dispositional variables, such as negative affectivity (NA), making the observed relationships somewhat spurious (see Quine, 1999; Mikkelsen & Einarsen, 2001). In other words, the issue has been raised that people who are high in negative affectivity are more likely to report bullying experiences and also to report adverse outcomes, such as low levels of job satisfaction and high levels of anxiety and depression.

Due to this methodological concern, a measure of negative affectivity (Stokes & Levin, 1990) was incorporated in the present study. It may be noted though that NA was expected to partially inflate the observed relationships between bullying and the various outcome measures, rather than to fully explain them. The hypotheses tested in the study focused on the following variables: anxiety and depression, general health status, sickness absence, increase in drinking and smoking, job satisfaction and propensity to leave the job. Given the potential role of NA in self-reports of bullying and these outcomes, the various hypotheses were mostly tested through analyses of covariance (the factor of NA treated as a covariate).

The relationship between bullying and occupational health outcomes

The results of the analyses showed that employees who had experienced bullying acts at work had higher levels of anxiety and depression than other employees. They also reported taking more days off work for sickness and had poorer general health than other employees. In addition, they were less satisfied with their jobs and more likely to contemplate leaving. This pattern of findings was consistent with six of the study hypotheses (see hypotheses 1 to 4 and 7 to 8), and replicated previous findings in the field (e.g. Barker et al, 1999; Einarsen & Raknes, 1991, 1997a; Hoel & Cooper, 2000; Keashly et al, 1994; Matthiesen et al, 1989; Mikkelsen & Einarsen, 2001; Price Spratlen, 1995; Quine, 1999, 2003; Vartia, 2001).

In addition, the findings suggest that NA does not play a critical role in observed relationships between bullying and occupational health outcomes. Yet, the degree of association between bullying and occupational health outcomes varied somewhat. Whereas 11% of adjusted job satisfaction scores and 8% of adjusted propensity to leave scores associated with bullying experiences, less than 1% of the adjusted sickness absence scores and general health scores associated with reports of bullying. However, the finding that bullying is only weakly associated with sickness absence is in line with previous study findings (e.g. Hoel & Cooper, 2000; Price Spratlen, 1995; Einarsen & Raknes, 1991). One possible reason for this seemingly weak relationship is that

people often tend to under-report their own absenteeism (Johns, 1994). People who are bullied may find it particularly important to minimise their absenteeism – for instance, in order to avoid stigma of malingering. Yet, it is also possible that targets of bullying, in spite of growing health problems, decide to remain working for the fear of retribution if they took time off work (Rayner et al, 2002).

The finding that bullying explained more of the variance in job attitudes than in psychological health variables was quite surprising. However, the results showed that reports of bullying associated with 5% of the variance in adjusted anxiety scores and 7% of the variance in adjusted depression scores. In addition, the results showed that employees who reported bullying were more likely to suffer clinical levels of anxiety and depression than other employees. This latter finding accords with previous findings from the UK (Quine, 1999).

Study hypotheses 5 and 6 focused on bullying experiences and increase in drinking and smoking behaviour. These hypotheses were also supported by the data. That is, the results showed that employees who had experienced bullying at work were more likely to report increase in smoking and drinking (in the past 12 months) than were other employees. The relationship between bullying and adverse drinking behaviours was previously reported by Richman and her colleagues (Richman et al, 1992, 1996, 1999), but no other study has systematically assessed the relationship between bullying and increase in smoking

behaviours. Whilst the present study only tested the direct relationships between bullying and increase in drinking and smoking behaviours, it is quite possible that adverse emotional states (e.g. feelings of frustration, self-blame and hopelessness) and other factors (e.g. lowered self-esteem, decreased job satisfaction) play a mediating role in these relationships (Richman et al, 1997; Richman, Shinsako, Rospenda, Flaherty & Freels, 2002). More research is needed to determine the mechanisms through which bullying is linked to poor health habits, such as drinking and smoking.

Moderating effects of support at work and generalised self-efficacy

Hypotheses 9 to 12 focused on the idea that support at work and generalised self-efficacy (GSE) may act as buffers, ameliorating the effects of bullying on job attitudes and psychological health. These hypotheses were partly confirmed by the data. That is, the results showed that employees who reported one or more types of bullying, but experienced good support had lower scores on the scales measuring anxiety, depression and propensity to leave than those who reported bullying, but experienced poor support. In a previous study, Quine (1999) had found that support at work moderated the relationship between bullying and three outcome variables (depression, job satisfaction, and propensity to leave). Einarsen et al (1996) also found that support at work moderated the relationship between bullying and

three health outcomes (psychological, psychosomatic, and musculo-skeletal health complaints).

The measure of support used in the present study mostly reflected two aspects of support at work: perceived availability and adequacy of support from work colleagues or supervisors. However, in order to interpret the above buffering effects, the functional aspect of support is also crucial. According to Cohen and his colleagues, esteem support and appraisal support are the types of support functions most relevant to the buffering hypothesis (Cohen and Hoberman, 1983; Cohen & Syme, 1985; see also Wills, 1985). Having someone to talk to about problems and receiving help with dealing with these problems (appraisal support) seems to be a broadly effective means of coping with stressful events. Moreover, threats to self-esteem may be the most serious element of stressful experiences, and hence the type of stress that is most important to counter (Cohen & Hoberman, 1983). Thus, esteem support of various kinds (e.g. offering sympathy and reassurance, helping the person to feel better about himself or herself) is likely to play a critical role in the buffering process.

Whereas buffering effects of support at work were detected in the study, similar effects of generalised self-efficacy (GSE) were not found. That is, the results did not suggest that GSE moderates the relationship between bullying and occupational health outcomes. In contrast, Mikkelsen and Einarsen (2002) found that GSE did act as a weak moderator of the

relationship between bullying and psychological health outcomes. Other studies have shown that people with a strong sense of self-efficacy show less psychological and physical strain in response to work stressors than those with a weak sense of self-efficacy (Jex & Bliese, 1999; Jimmieson, 2000; Schaubroeck & Merritt, 1997). It may therefore be questioned whether the measure of self-efficacy used in the present study (Wegner, Schwarzer & Jerusalem, 1983) adequately captured the aspects of social competence essential to the management of interpersonal conflicts or aggression. In fact, only one item out of ten explicitly referred to social interactions. A more domain-specific scale for self-efficacy – for instance, a scale focusing on stressful social interactions – may possibly have yielded different results.

Study hypotheses 13 to 16 focused on the potential ripple effects of bullying at work. In line with hypotheses 13 and 14, the results showed that observers of bullying had higher levels of anxiety and depression than did non-observers. In addition, the results showed that observers were less satisfied with their jobs and more inclined to leave the job than non-observers. Hence, hypotheses 15 and 16 were also supported by the data. Similar ripple effects of bullying have been found in studies from Norway and Finland. In a study of 2,215 Norwegian employees, Einarsen et al (1994b) found that 21 per cent of respondents reported lowered job satisfaction due to bullying at work, and 14 per cent perceived bullying as a daily strain. Yet in this study, only 8.6 per cent of respondents had direct experiences of bullying. A study of Finnish

municipal workers revealed that witnesses of bullying reported more general stress and mental stress reactions than workers who had not witnessed bullying at work (Vartia, 2001). In the UNISON study, it was also found that 73 per cent of witnesses reported increased stress levels, and 44 per cent worried about becoming targets of bullying themselves (Rayner, 1999). These findings, in conjunction with the present results, suggest that the effects of bullying on observers may be either direct (e.g. when they fear being the next target) or indirect (e.g. when their general well-being is reduced as a result of the hostile and abusive work environment).

Effects of cognitive and affective variables

The present study did not measure the cognitive and affective variables that may link workplace bullying to occupational health outcomes. Theory suggests that negative mood, anger, feelings of fear and helplessness, perceptions of injustice, damaged social identity, and attributions mediate the effects of workplace bullying on employee attitudes and psychological health (Anderson & Pearson, 1999; Barling, 1996; Barling, Rogers & Kelloway, 2001; Lazarus & Folkman, 1984). Barling (1996), for example, has argued that the immediate effects of the psychological experience of bullying are negative mood (e.g. annoyance, irritation), cognitive distraction, and fear of hostile behaviours. To the extent that these immediate effects are not alleviated, they may result in more distant effects, such as deteriorating psychological and physical

health, decreased job satisfaction and turnover intentions, poor job performance and absenteeism (cf. Keashly & Jagatic, 2003).

The omission of potential mediators in the present study may possibly explain the weak or moderate relationships detected between bullying and outcome variables. Yet, it must also be acknowledged that the outcomes assessed in the present study are most definitely influenced by a wide range of factors. Among the factors discussed in the stress literature are critical life events, daily hassles, family stressors, and finally work-related stressors (see Zapf, Dorman & Frese, 1996). What can be inferred from this is that any single factor can only explain a fraction of the variance in health variables and job attitudes.

Methodological limitations

The findings of the present study must be interpreted with some caution. Since the data were cross-sectional, there may be several explanations for the relationships observed between bullying and occupational health outcomes. One possibility is that bullying does indeed lead to lowered job satisfaction, increased levels of psychological distress, and declined general health. However, a second possibility is that poor health status places the person at more risk of being bullied at work (Einarsen & Raknes, 1997a; Quine, 1999). For instance, anxious or depressed individuals may be more likely to be singled out because others perceive them as weak and incapable of retaliating effectively against unfair

treatment. It may also be the case that anxious or depressed individuals create tension in a work group and elicit negative reactions from others (Felson, 1978; Einarsen et al, 1994a; Hoel & Salin, 2003). A possible result of this is that aggressive interaction develops in which the distressed person becomes the primary target (Felson, 1992). A third possibility is that bullying and adverse health outcomes are reciprocally related. For instance, exposure to bullying may lead to increased psychological distress, which in turn may increase the person's vulnerability of being singled out. In brief, the design of the present study does not allow for inferences of causal relationships. In order to resolve the issue of cause and effect longitudinal studies are needed.

A second reason for caution is that all the data were based on self-reports. It is therefore plausible that response bias influenced the relationships between bullying and occupational health outcomes. However, several features of the study reduce the likelihood that the relationships observed were strictly spurious. First of all, the influence of negative affectivity was taken into account in most of the analyses. Second, in order to ensure a common awareness of the bullying concept, respondents were provided with a clear definition of bullying. Finally, operational criteria were used to determine exposure to bullying. That is, respondents were asked to indicate whether or not they had experienced specific bullying behaviours. It may be argued that this method is less likely than other methods (e.g. asking the person whether he or she *feels* exposed to bullying) to prompt respondents' cognitive or

emotional processing (see Mikkelsen & Einarsen, 2001; Salin, 2001), and hence less susceptible to response bias. Despite all this, it is always possible to argue that some uncontrolled variable accounts for the observed relationship between bullying and occupational health outcomes. It is possible for example that social desirability and general job stress act as confounding variables (Shneider, Swan & Fitzgerald, 1997). In order to accurately assess the impact of bullying on job-related and psychological outcomes, the inclusion of other control variables is necessary.

A third reason for caution is the 67% response rate achieved in the study. Although a response rate of this degree is far higher than in most published studies, it may still have yielded unknown bias. The existence, nature and effects of these potential biases are all important issues, especially in the bullying literature, which heavily relies on questionnaire data.

Conclusion

The results of the study confirmed most of the hypotheses outlined in the introduction. First of all, the results showed that employees who had experienced bullying acts at work had higher levels of anxiety and depression than other employees. They also reported taking more days off work for sickness and had poorer general health than other

employees. In addition, they were more likely to report increase in smoking and drinking in the previous year. Moreover, they were less satisfied with their jobs and were more likely to contemplate leaving.

Secondly, the results supported the hypothesis that support at work may act as a buffer, protecting people from some of the adverse effects of bullying. It is plausible that other factors such as job control and personal dispositions (e.g. self-esteem, self-efficacy, locus of control) also play this protective role. However, buffering effects of generalised self-efficacy were not detected in the present study. In most of the analyses conducted, the factor of negative affectivity (NA) was treated as a covariate. The various significant results indicate that NA does not play a critical role in relationships between reports of bullying and occupational health outcomes.

Thirdly, the results supported the hypothesis that bullying at work may not only affect the targets but also their colleagues and other observers. Specifically, the results showed that observers of bullying had higher levels of anxiety and depression than did non-observers. They were also less satisfied with their jobs and more likely to contemplate leaving. Similar ripple effects of bullying have been found in studies from Scandinavia and the UK.

Overall, the present results replicate and extend previous findings on the extent to which bullying is related to occupational health outcomes, and

thereby provide some cross-validation of these results. However, the results of the study must be interpreted with caution. Since the study was based on cross-sectional data, inferences about causal relationships cannot be made. In addition, the data came entirely from self-reports, which leads to the possibility that mono-method bias or unmeasured third variables influenced the relationships observed. In order to accurately assess the impact of bullying on job-related and psychological outcomes, the inclusion of variables others than NA is necessary.

CHAPTER 6

WORKPLACE BULLYING IN ICELANDIC HOSPITAL STAFF: PREVALENCE AND NATURE OF BULLYING ACTS – A CROSS-CULTURAL COMPARISON –

– STUDY 2: PART 1 –

Introduction

The study reported in this chapter was a second large-scale study of workplace bullying in a hospital setting. The study was conducted in an Icelandic public hospital, and the aims of the study were determine the prevalence of bullying, and the relationship between bullying and psychological health outcomes. Just as the study previously reported (see Ch's 4 & 5), this second study was divided into two parts. The first part (reported in this chapter) focused on prevalence levels, whereas the second part (reported in Ch. 7) focused on the relationship between bullying and health outcomes. Along the two parts, special efforts were made to compare and contrast the present findings to the previous findings from Scotland – hence, the term cross-cultural comparison in the above title.

So far, it has been concluded that bullying is widespread among Scottish hospital employees (see prevalence findings in Ch. 4). Using operational criteria (asking people about exposure to persistent negative acts), the prevalence rate observed was 48 per cent. Using self-labelling criteria

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(asking people whether they had been bullied at work), the reported prevalence rate was somewhat lower, yet close to 30 per cent. Other findings from the UK also indicate that bullying is a critical problem in the health care profession. In a study of NHS trust employees, Quine (1999) found prevalence rates of 38%, when using operational criteria (exposure to one or more bullying acts in the past year). In a second study of NHS hospital employees (Hoel & Cooper, 2000), a rate of 10,7% was found (self-reported exposure to bullying in the past 6 months)

However, findings from other countries, such as Denmark and Finland, show somewhat lower prevalence rates. A rate of 16% was found in a sample of Danish hospital employees (reported exposure to one or more acts in the past 6 months; Mikkelsen & Einarsen, 2001), and a rate of 5% was found in a sample of Finnish hospital employees (self-reported exposure to bullying in the past 6 months; Kivimäki et al, 2000). As yet, the prevalence of bullying has not been studied in Icelandic hospital settings. Hence, the present study was a preliminary work in these settings. A question quite central to the study was: Will the observed prevalence rates be similar to those observed in the UK (for example, in Scotland), or will the rates be closer to those detected in Scandinavia (for example, in Denmark and Finland)?

There was some reason to believe that the rates of bullying would be similar to the rates observed in Scandinavia, and hence lower than the

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rates observed in the UK. This assumption rested on the idea that Scandinavian work cultures are in some ways distinct from work cultures in other countries. One cultural feature that is seen as quite distinctive in Scandinavia is low power distance (see Einarsen, 2000; Hofstede, 1980). In this respect, the Icelandic work culture is likely to be similar to other Scandinavian work cultures. That is, the feature of low power distance is also likely to apply to Icelandic workplaces. As previously noted (in Ch. 2), work cultures of this kind tend to show lower rates of bullying and harassment.

Assuming that the Icelandic work culture is also similar to Scandinavian work cultures in other respects, it is possible that the Icelandic work culture is more feminine-oriented than other work cultures (according to Einarsen (2000), people in this type of culture are more tolerant, flexible and accommodating in social relationships). In addition, they may be more likely to value fluid sex roles and equality between the sexes. Value systems of this kind may again signify less tolerance of aggressive behaviours and/or power abuse, and thus lower levels of bullying in these work cultures.

Two methods were again used to assess prevalence rates – namely the operational method (reported exposure to one or more bullying acts in the past year) and the self-report method (self-reported exposure to bullying in the past year). These methods were previously described in Chapter 4. A third method used in the study was to ask employees

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whether they had witnessed the bullying of others (an indirect measure of prevalence levels).

Using these three methods, the following questions were addressed in the study (see equivalent questions in Ch. 4):

- (Q1) How many employees have experienced persistent negative acts at work in the past 12 months?
- (Q2) How many consider themselves to have been bullied in the past 12 months?
- (Q3) How many have witnessed the bullying of others in the past 12 months?

Other questions addressed in the study were:

- (Q4) Of some five categories of bullying, which ones can be seen as frequent? Which ones can be seen as rare?
- (Q5) Is there a relationship between bullying experiences and demographic variables (e.g. gender and age)?

Previous studies have consistently shown that observed prevalence rates do vary considerably depending on the criteria or methods used to assess these rates (e.g. Hoel & Cooper, 2000; Mikkelsen & Einarsen, 2001; Salin, 2001). In the study of hospital employees, Mikkelsen and Einarsen (2001) found, for example, that 3% of respondents considered themselves to have been bullied at work in the past six months, whilst

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16% reported persistent exposure to negative acts at work over the same time period. In the study of Scottish hospital staff (see Ch. 4), a similar contrast in data was detected (prevalence rates observed: 48% versus 27%).

Hence, the present study was also expected to yield divergent prevalence rates. However, the two study methods (the operational and the self-report method) were assumed to be connected in certain way. This assumption rested on previous findings from the UK (UNISON, 1997). The findings reported in Rayner (1999) showed that people who labelled themselves to be bullied reported more types of negative behaviours than those who did not label themselves to be bullied. In the present study, an observation of this kind was expected.

Whilst the study's primary aim was to assess prevalence rates, the study also had some three additional aims. These were:

- (1) To assess the usual duration of bullying experiences
- (2) To examine the link between duration of bullying and number of negative acts reported
- (3) To explore some aspects of bullying experiences, using employees' accounts of recent incidents of bullying.

The purpose of the above analyses was twofold. Firstly, to learn about the nature of bullying in Icelandic work settings, and secondly to

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compare and contrast the nature of experiences in two work cultures – namely, the Icelandic and Scottish work cultures (see equivalent analyses in Ch. 4).

Finally, the role of NA in bullying reports was examined. In the study previously reported, results showed that NA correlated with two of the measures used to assess prevalence rates. That is, NA correlated with reports of exposure to bullying acts and also with self-reports of bullying (see Ch. 4, results section). Whilst the factor did not appear to have strong effects on these measures, only one study has demonstrated equivalent effects of NA on bullying reports (Quine, 2003). Hence, there was a good reason to re-assess the effects reported in Ch. 4.

THE STUDY

Contrary to the previous study, which was a commissioned study by the Scottish hospital trust, the current study was an independent piece of work by the researchers at the UKC. The study was longitudinal in design – that is, there were two distinct waves of measurement. The first wave took place in Autumn 2001 (*Time 1*) and the second wave took place in Winter 2002 (*Time 2*). Part of the survey data (the *T1* data) were used to determine prevalence levels, whilst the whole data set (the *T1* and *T2* data) was used to assess the relationship between bullying and psychological health outcomes (see Ch. 7). In order to carry out the

Chapter 6: Icelandic hospital staff – Prevalence and nature of bullying study, ethical approval from the Icelandic Bioethics Committee was needed. The approval was provided in Spring 2001.

Method

The sample

The study sample comprised 2,460 hospital employees. These employees came from a range of occupational groups. The sampling method used was systematic random sampling – a method based on two successive steps. First, a numbered list of all members of staff was entered into a computer. Care was taken that the list was randomly arranged. Second, a recognised computer programme (Microsoft Excel) was used to randomly select the sample units (N=2,460) from this list.

The profile of the sample was as follows (relative proportions shown in brackets): nurses/ midwives (22.8%), nursing assistants (10.3%), doctors (9.8%), professions allied to medicine (14.2%), technical staff (3.2%), administrative and clerical staff (11.3%), ancillary and maintenance staff (21.3%), and managers (5.7%). Of the total sample, 80.4% were women and 19.6% were men. Given the randomised sampling method, these proportions of occupational groups and proportions of women and men were seen to reflect the profile of the trust.

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As in the Scottish study, a large N was used to meet the criterion of good statistical power. Again, the degree of power selected was 0.95. Using an ad hoc power analysis (in G*Power), the optimal N was calculated from two other values – the value of significance level selected ($\alpha = .05$) and the effect size selected (small effect, e.g. $w = .10$). The N required in this study was 1,230. The final N was still doubled, given the potential risk of low response rate. The final sample size ($N = 2,460$) also allowed for potential sample attrition over time – that is, between the two waves of measurement ($T1$ and $T2$).

Study materials

Two questionnaires (T1 and T2 questionnaires) were used in the study (see description of questionnaires in the following section). Along with the questionnaires, the employees received a covering letter, in which the nature and purpose of the research was explained (see Appendix III) and a prepaid envelope. In the covering letter, employees were assured that all replies would be treated with full confidentiality. However, anonymity could not be guaranteed in the study, since the study was longitudinal in nature, requiring that respondents had to be contacted on more than one occasion.

In order to protect confidentiality of data, all the 2,460 employees were provided with unique (and randomly arranged) numerical codes (respondent numbers). These numbers were printed on the front pages

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of questionnaires 1 and 2, and used by completion of the study, and during data entry, to match the two sets of questionnaires received. A second reason for the code system was to distinguish respondents from non-respondents at T1 – a strategy needed to create a T2 follow-up sample (see below).

Process of data collection, data entry and analysis

In September 2001, the T1 questionnaire was sent out to the 2,460 hospital employees, along with other study materials. The employees were asked to complete the questionnaires promptly, and to return them in the envelopes provided to locked boxes, located in the two central areas of the hospital. The period of data collection lasted for approximately 6 weeks. By the end of this period, all the envelopes received were assembled and posted to the Department of Psychology at the UKC, where the questionnaire data were entered into computer (SPSS for Windows) and analysed.

It was found that not all 2,460 employees had received the T1 questionnaire. The most usual reasons for this were that employees had recently left their job or they were on temporary leave. After adjusting for this, the estimated number of potential respondents was 2,293. In the following process of data collection, the responses from this group were monitored.

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The second wave of the study took place in January 2002, when the T2 questionnaire was sent out to all those who already had responded to the T1 questionnaire. The coding system described above was used to identify this follow-up sample. The process of data collection was the same as before – that is, completed questionnaires were returned to locked boxes placed in the hospital, whose contents were eventually sent to the UKC. This second period of data collection lasted for 4 weeks. On delivery of all questionnaires (T1 *and* T2 questionnaires) to the UK, the coding system was again used – this time to match the two sets of questionnaires collected. Following this matching procedure, the whole data set was entered into computer (SPSS for Windows) and analysed.

The questionnaires

The original versions of the T1 and T2 questionnaires were written in English. In the study's preparation stage, the questionnaires were translated to Icelandic. These translations were done in accordance with the requirements adhering to scientific work. That is, translation and back-translation by bilingual consultants with a university degree in psychology and/or English.

The T1 questionnaire

The questionnaire used at Time 1 contained four sections (see Appendix IV). Section 1 included questions about the respondents' occupational background. That is, the respondents were asked about their professional group and hours of work (full-time vs. part-time). Section 2 comprised scales measuring *psychosomatic complaints* (the *CHIPS*; Cohen & Hoberman, 1983) and *anxiety and depression* (the *HADS*; Zigmond & Snaith, 1983). The content and nature of these scales is described in the following chapter (see Ch. 7). It may be noted here though that all the scales have been widely used in the literature and are reported to have satisfactory reliability and validity. Section 2 also included a scale measuring *negative affectivity* (*NA*; Stokes & Levin, 1990). The NA scale is a 21-item scale measuring three aspects of NA (nervousness, dissatisfaction with oneself, and general pessimism). A detailed description of this scale is provided in Ch. 4.

Section 3 included questions about the respondents' *experiences of bullying at work*. The 21-item bullying scale (see Ch's 4 & 5) was used to assess respondents' experiences of bullying acts at work. The scale is seen to reflect five categories of bullying: personal derogation/isolation (nine items), work-related bullying (five items), threats and verbal abuse (three items), teasing and ridicule (two items), and violence (two items).

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Responses to the 21 scale items were obtained in the following fashion. The employees were asked to indicate by a “yes”/“no” response whether they had been persistently exposed to any of the 21 behaviours or acts in the past 12 months. Examples of scale items are (names of categories in brackets): “persistent attempts to demoralise you”, “freezing you out/ignoring you/excluding you” (personal derogation/ isolation), “setting of impossible deadlines”, “withholding necessary information from you” (work-related bullying), “use of abuse, swearwords, and obscenities” (threats and verbal abuse), “making inappropriate jokes about you” (teasing and ridicule), and “physical violence” (violence). Prior to the actual scale, respondents had been provided with Lyons et al’s (1995) definition of bullying at work (see Appendix IV).

Following the bullying scale, respondents were asked to indicate (on the basis of Lyons et al’s definition) whether they regarded themselves to have been bullied at work in the past 12 months. The response categories provided were: “never”, “rarely”, “a few times”, and “frequently”. Finally, the respondents were asked to indicate whether they had witnessed others (e.g. work colleagues) being bullied at work in the past 12 months. The response categories provided here were: “never”, “occasionally”, and “frequently”.

Those who felt that they had been bullied at work were also asked various questions about their experience. Firstly, they were asked about the period of time the bullying had lasted (response categories: “1-3

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months”, “4-6 months”, “7-12 months”, “more than 12 months”), and whether they were currently exposed to bullying (response categories: “yes”/“no”). Secondly, they were asked to describe a recent incident of bullying, and to answer several questions about that incident (e.g. about the position of the bully and whether they had been singled out or bullied as part of a group). Finally, they were asked some questions about their actions in the bullying situation (e.g. whether they took some actions to stop the bullying). However, the responses to these final questions were left out in the present analysis.

Finally, section 4 contained questions about the respondents’ gender and age. As the description above indicates, the questions and scales used in the present study were highly similar to the ones used in Scotland (see Ch’s 4 & 5). The reason for using equivalent questions was to facilitate the intended comparison between the two countries (see introduction).

The T2 questionnaire

The questionnaire used at Time 2 was simply a brief version of the T1 questionnaire (see Appendix VI). That is, it contained three of the sections previously used. First, the respondents were asked to complete the two scales measuring psychological and psychosomatic health: The *CHIPS* (Cohen & Hoberman, 1983) scale and the *HADS* (Zigmond &

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Snaith, 1983) scale. A description of these scales is provided in the following chapter (see Ch. 7). Secondly, the respondents were asked to complete the negative affectivity (*NA*; Stokes & Levin, 1990) scale (see section 1 in Appendix VI). Finally, they were asked to report their experiences of 21 types of bullying acts (see description of acts in Ch's 5 & 6) in the past 4 months (see section 2).

Having described the study questionnaires, the results pertaining to prevalence of bullying will now be reported. It may be noted again that these results were exclusively based on the T1 survey data. Other results of the study are reported in the following chapter. These additional results were based on the more extensive (T1 *and* T2) data set (see Ch. 7; workplace bullying and psychological health outcomes).

Results

Preliminary analyses of data

A total of 713 questionnaires were collected in the study's primary stage. This number of questionnaires represented a response rate of 31%. Frequency analyses were carried out to determine the profile of respondents (N=713) in terms of occupations, hours of work, gender and age. The results of these analyses are presented in Table 6.1.

Table 6.1. Profile of respondents

	%	(n)
<i>Occupational Group (N=706)</i>		
Nurses/midwives	30	(214)
Nurse assistants	12	(81)
Doctors	10	(74)
Professions allied to medicine	17	(117)
Technical staff	2	(16)
Administrative and clerical staff	14	(101)
Ancillary and maintenance staff	11	(78)
Managers	4	(25)
<i>Hours of work (N=689)</i>		
Full-time	58	(398)
Part-time	42	(291)
<i>Gender (N=708)</i>		
Men	15	(105)
Women	85	(603)
<i>Age (N=688)</i>		
17-30	21	(145)
31-40	23	(156)
41-50	31	(214)
> 50	25	(173)

As for the profile of occupational groups, it was found that the final sample (N=713) matched the original study sample reasonably well (see profile of original sample in method section). One of the groups was however somewhat over-represented. This was the group of nurses and midwives (response rate: 43%). Some other two groups were slightly under-represented. These were the ancillary and maintenance group and managers (respective response rates: 18% and 20%).

As regards gender, it was found that men were somewhat under-represented in the final sample. The response rate observed for men

was 22%, whilst the response rate for women was 31%. In spite of this finding, the actual number of male respondents was considered adequate for subsequent analyses, such as those focusing on prevalence levels in male vs. female employees.

Reliability of scales

The two scales employed in the study were: (1) the 21-item bullying scale and (2) the negative affectivity (NA) scale. The reliability of these scales was assessed, and the results obtained are shown in Table 6.2. The bullying scale was indeed applied in two ways. That is, in addition to using the total scale (all 21 items), some five sub-scales were constructed (personal derogation/isolation, work-related bullying, threats and verbal abuse, teasing and ridicule, and violence)¹. The reliability of these sub-scales is also presented in Table 6.2. As the table shows, the index used to assess reliability was Cronbach’s Alpha.

Table 6.2. Mean, standard deviation, and reliability of (T1) scales

<i>Scale</i>	<i>Items</i>	<i>α</i>	<i>M</i>	<i>SD</i>	<i>N</i>
The bullying scale (Total scale)	21	.91	1.2	2.8	695
Personal derogation/isolation	9	.91	0.5	1.6	701
Work-related bullying	5	.75	0.5	1.0	700
Threats and verbal abuse	3	.66	0.1	0.5	707
Teasing and ridicule	2	.55	0.05	0.3	706
Violence	2	.57	0.01	0.1	705
Negative affectivity (NA)	21	.87	55.9	13.1	631

¹ Equivalent sub-scales were employed in Scotland, and the same labels used (see results section in Ch. 4; the bullying scale factor analysed).

On the whole, the reliability observed was fairly high. An exception to this is perhaps the α -value obtained for the *teasing and ridicule* scale and the *violence* scale. The reliabilities of these two scales were still considered acceptable.

Correlations between bullying sub-scales

As well as examining scale reliability, correlation analysis was carried out to assess the degree to which the bullying sub-scales were correlated. In other words, the inter-correlations between the five sub-scales were examined (see Table 6.3).

Table 6.3. Correlations between bullying sub-scales

	1	2	3	4	5
1. Personal derogation/isolation	–	.55	.67	.42	.21
2. Work-related bullying		–	.46	.30	.09 ^a
3. Threats and verbal abuse			–	.31	.27
4. Teasing and ridicule				–	.29
5. Violence					–

Note: All the above correlations were significant on the $p < .001$ level, apart from: a $p < .05$

As Table 6.3 shows, all the five sub-scales were significantly correlated. The strongest correlation observed was that between personal derogation/isolation and threats and verbal abuse. The personal derogation scale did indeed have strong or moderate correlation with all the other sub-scales. There was also a moderately strong correlation between work-related bullying and threats/verbal abuse. The weakest

correlations found were those between violence and the other four scales.

Distribution of scores on the bullying scale

As indicated in Table 6.2, the mean score obtained on the total bullying scale was close to one ($M=1.2$). This mean value, along with the SD value (see again Table 6.2), indicates that (just as in the Scottish study; see Ch. 4) that most of the respondents' scores were at the lower end of the scale (note that a maximum score on the scale was 21, whilst the minimum score was 0). In fact, more than two thirds of respondents had the score 0 on the total scale, and this was also the case with the various sub-scales (e.g. personal derogation/ isolation, work-related bullying, threats and verbal abuse).

In the main analysis of prevalence rates, respondents were therefore assigned to the following groups, depending on their scores on the total scale: (1) those who reported one or more types of bullying acts (those with scores ≥ 1), and (2) those who reported no bullying acts (those with scores = 0).

Main results

At first, prevalence levels were assessed through scores on the bullying scale. As noted above, respondents were assigned to two groups, depending on their scores on the scale (scores ≥ 1 and scores = 0). The same procedure was used for the various sub-scales of bullying.

Experiences of bullying acts

On the whole, 28% of employees (n=194) reported having experienced one or more types of bullying acts in the past 12 months. Whilst this prevalence rate may be considered quite high, it was significantly lower than the rate previously reported (48%; see Ch. 4): $\chi^2(1)=80.8$, $p < .001$. Table 6.4 shows the proportion of respondents experiencing the distinct types of bullying acts, as well as the five categories of bullying. The table also shows comparable figures from Scotland.

The categories of bullying most commonly reported were work-related bullying (22%) and personal derogation/isolation (15%). The category least frequently reported was violence. A second category reported quite rarely was teasing and ridicule. As Table 6.4 shows, this same pattern of findings was observed in the study of Scottish hospital employees.

Table 6.4. Proportion of employees experiencing bullying acts (types and categories) in the past 12 months

	<i>The present study</i>		<i>Study of Scottish NHS employees</i>	
	%	(n)	%	(n)
<i>Personal derogation/isolation</i>	15*	(102)	33	(603)
Persistent unjustified criticism or monitoring of your performance	6	(41)	12	(234)
Persistent attempts to belittle and undermine your work	5	(32)	13	(250)
Persistent attempts to demoralise you	5	(33)	13	(240)
Persistent attempts to humiliate you in front of colleagues	3	(24)	11	(202)
Destructive innuendo and sarcasm	8	(55)	13	(244)
Undermining your personal integrity	7	(47)	12	(228)
Constant undervaluing your efforts	6	(43)	16	(300)
Freezing you out/ignoring you/excluding you	7	(51)	21	(388)
Displays of open hostility towards you	6	(45)	7	(140)
<i>Work-related bullying</i>	22*	(153)	39	(729)
Undue pressure to produce work	8	(53)	23	(429)
Shifting goalposts without telling you	12	(87)	22	(410)
Removal of responsibility without consultation	8	(58)	9	(177)
Setting of impossible deadlines	9	(61)	11	(212)
Withholding necessary information from you	10	(67)	22	(424)
<i>Threats and verbal abuse</i>	8*	(54)	13	(238)
Verbal and non-verbal threats	4	(30)	6	(109)
Unfounded threats about your job security	5	(36)	5	(93)
Use of abuse, swearwords, and obscenities	2	(16)	7	(125)
<i>Teasing and ridicule</i>	4*	(29)	7	(127)
Persistent teasing	4	(25)	5	(86)
Making inappropriate jokes about you	2	(11)	5	(88)
<i>Violence</i>	1*	(8)	2	(32)
Violence to property	1	(5)	1	(12)
Physical violence	1	(5)	1	(23)

Note: (*) Some respondents reported more than one type of acts in each category

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However, as with overall prevalence rates, the prevalence of four categories of bullying was lower in the present study (see the following chi-square results): personal derogation/isolation ($\chi^2(1)=81.7$, $p < .001$); work-related bullying ($\chi^2(1)=65.7$, $p < .001$); threats and verbal abuse ($\chi^2(1)=12.8$, $p < .001$); teasing and ridicule ($\chi^2(1)=6.2$, $p < .05$); violence ($\chi^2(1)=1.1$, $p > .05$).

Influence of NA on reports of bullying acts

When the relationship between negative affectivity (NA) and reports of bullying acts was assessed, a significant correlation was found ($r = .31$, $p < .001$). Indeed, the correlation observed was almost identical to the one observed in Scotland (see Ch. 4, results section). Employees high in NA appeared to be somewhat more likely than employees low in NA to report persistent bullying acts. However, NA accounted for only 10% of the variance in reports of bullying acts ($R^2 = .10$).

Demographic relationships with bullying experiences

The relationship between bullying and two demographic factors, gender and age, was again examined in this study (see equivalent analysis in Ch. 4). It was found that male and female respondents were just as likely to report exposure to bullying acts in the past 12 months (32% of men and 27% of women; $\chi^2(1)=1.0$, $p > .05$). In other words, experiences of bullying acts were not related to gender.

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Experiences of bullying also appeared to be irrelevant of age. That is, experiences of bullying acts in the four age groups examined were quite similar. An equivalent finding was reported in Ch. 4. In the current study, the respective proportions of employees experiencing acts were: 29% (17-30 yrs), 28% (31-40 yrs), 26% (41-50 yrs), and 28% (>50 yrs).

Self-reports of bullying

Using the self-report method, the prevalence level observed was 13%. That is, some 13% of respondents (n=89) regarded themselves to have been bullied at work in the past 12 months. Of these, 5% claimed they had only rarely been bullied at work. Other 6% had been bullied occasionally, and 2% frequently. As with reports of bullying acts, this prevalence rate was significantly lower than the rate previously observed in Scotland (a rate of 27%; see Ch. 4: $\chi^2(1)=55.9$, $p < .001$).

As for the number of observers or bystanders, it was found that 34% had witnessed the bullying of others. In line with the above chi-square findings, this figure (whilst considerably high) was significantly lower than the figure observed in Scotland (46%; see Ch. 4: $\chi^2(1)=32.6$, $p < .001$). In the current study, some 30% claimed to have witnessed bullying occasionally, and 4% had frequently witnessed the bullying of others. It may be noted that many of these bystanders, or some 18%, had not experienced bullying themselves in the past 12 months.

Influence of NA on self-reports of bullying

As in the case of reports of bullying acts, the correlation observed between NA and self-reports of bullying was almost identical to the one observed in Scotland (see Ch. 4, results section); $r = .25$, $p < .001$. Employees high in NA appeared to be somewhat more likely than employees low in NA to regard themselves to have been bullied at work. However, NA accounted for only 6% of the variance in self-reports of bullying ($R^2 = .06$).

Demographic relationships with self-reports of bullying

In accordance with the results presented above (as to reports of bullying acts), no relationship was found between self-reports of bullying and gender. The proportion of men who considered themselves to have been bullied at work was 16%, whilst the corresponding proportion of women was 12% ($\chi^2(1)=1.3$, $p > .05$).

In addition, no relationship was observed between self-reports of bullying and age. In the four age groups examined, similar proportions of people considered themselves to have been bullied at work, or 12% (17-30 yrs), 11% (31-40 yrs), 12% (41-50 yrs), and 15% (>50 yrs).

Experiences of bullying acts and self-reports of bullying

Given the discrepancies in prevalence rates observed through the operational method (respondents' reports of bullying acts; a rate of 28% observed) and the self-report method (respondents' self-labelling; a rate of 13% observed), additional analysis was carried out, where the focus was on the group of employees who reported one or more types of bullying acts at work in the past 12 months (n=194). The question addressed in the analysis was: What kinds of experiences (if any) distinguish those who also labelled themselves to have been bullied and those who did not use this self-labelling? At this point, it may be noted that of those who reported one or more types of bullying acts, only 40% (n=77) did actually label themselves to have been bullied. The rest of the group (60%, n=114) did not consider themselves as victims of bullying.

At first, frequency analysis was carried out, where these two sub-groups, labelled "the bullied group" (n=77) and "the non-bullied group" (n=114) were compared in terms of their respective experiences of bullying acts at work. The results obtained in these analyses are shown in Table 6.5. As the table indicates, there were notable differences between the two sub-groups of employees (the "bullied" and "non-bullied" group). Of the five comparisons made between the groups (one for each category of bullying), significant differences were found for the following categories: personal derogation/isolation ($\chi^2(1)=68.8$, $p < .001$), threats and verbal

abuse ($\chi^2(1)=30.1$, $p < .001$), teasing and ridicule ($\chi^2(1)=10.3$, $p < .01$), and violence ($\chi^2(1)=6.2$, $p < .05$).

Table 6.5. Proportions of employees (“bullied” vs. “non-bullied”) who reported the five categories of bullying acts at work

<i>Category of bullying acts</i>	<i>“Bullied” respondents</i>		<i>“Non-bullied” respondents</i>	
	<i>%</i>	<i>(n)</i>	<i>%</i>	<i>(n)</i>
Personal derogation/ isolation	88	(68)	27	(31)
Work-related bullying	75	(58)	82	(94)
Threats and verbal abuse	48	(37)	12	(14)
Teasing and ridicule	25	(19)	8	(9)
Violence	8	(6)	1	(1)

However, no difference was found between the two groups regarding experiences of work-related bullying ($\chi^2(1)=1.4$, $p > .05$). In fact, the group of “non-bullied” respondents were most likely to report one or more of the acts reflecting this particular category – then especially the following two acts: undue pressure to produce work (33%) and shifting goalposts without telling the person (40%).

When a multiple regression analysis was conducted, using reports of bullying categories as predictors (all five categories in one step), and respondents’ self-labelling (or lack of self-labelling) as a criterion variable, it was found that the types of experiences that best predicted self-reports of bullying were: personal derogation/isolation (beta= .67, $p < .001$), threats and verbal abuse (beta= .12, $p < .05$), and teasing and

ridicule (beta= .10, $p < .05$). The total regression model explained some 63% of the variance in employees' self-labelling ($R^2 = .63$).

In addition to the above results, it may be noted that the "bullied" group reported on average 7 types of bullying acts (mean score on the bullying scale (M)=7.12, SD= 4.6), whilst the "non-bullied" group reported on average 2 types of acts (mean score on the bullying scale (M)=2.31, SD=1.8). The range of scores on the bullying scale was also broader in the group of "bullied" employees, or 18 (Minimum score=1 and Maximum score=19). In contrast, the range observed in the "non-bullied" group was 12 (Minimum score=1 and Maximum score=13).

Duration of bullying and number of acts reported

Apart from assessing prevalence rates in the hospitals, the study focused on the usual duration of bullying experiences and also the link between duration of bullying and number of negative acts reported (see equivalent analysis in Ch. 4). The group of employees examined comprised those who regarded themselves to have been bullied in the past 12 months (n=89)

Of the total group, 75% (n=67) described the duration of their experience (1-3 months, 4-6 months, 7-12 months, >12 months), and the findings obtained were as follows. In one third of cases (33%), the bullying had

lasted for more than 12 months.² In additional third of cases (31%), the bullying had lasted for 1-3 months. In 19% of cases it endured for 4-6 months, and in 16% of cases for 7-12 months. It may be noted that this particular pattern of findings, namely that people were most likely to report short-term (1-3 months) or long-term (>12 months) bullying episodes, was also detected in the Scottish study.

The procedure used to test the link between duration of bullying and number of bullying acts reported was the same as the one used in Scotland (see Ch. 4, results section). That is, one-way analysis of variance was used to compare the following victim groups: (1) those who reported relatively short bullying episodes (one to three months), those who reported somewhat extended episodes (four to six months (2) or (3) seven to twelve months), and (4) those who reported extended episodes of bullying (twelve months or more). The mean numbers of acts reported in these four groups are presented in Table 6.6.

When the four groups were compared, an overall difference between means was observed ($F(3, 63)=11.7, p< .001$). To determine where this difference lay, three separate t-tests were conducted – one test comparing Groups 1 and 2, a second one comparing Groups 2 and 3, and a final one comparing Groups 3 and 4 (see respective groups in Table 6.6).

² This specific response option (“12 months or more”) was not available in previous study (see Ch.4), but seems (according to the present findings) to be quite crucial.

Table 6.6. Duration of bullying episodes and number of bullying acts reported

	<i>Duration of bullying reported</i>	<i>Number of acts reported</i>	
		Mean	SD
Group 1 (<i>n</i> =21)	1-3 months	3.0	2.7
Group 2 (<i>n</i> =13)	4-6 months	8.6	5.2
Group 3 (<i>n</i> =11)	7 months or more	6.6	5.8
Group 4 (<i>n</i> =22)	12 months or more	10.2	3.5

Of the three tests, only one revealed significant results. That is, the only difference detected was between groups 1 and 2 ($t(1,32) = -4.2, p < .001$). Respondents in Group 2 reported more acts than did employees in Group 1. However, respondents in Groups 2, 3 and 4 reported a similar number of bullying acts. Thus, as in the Scottish study (see Ch.4), the data provided some, yet not complete, support to the notion that bullying is an escalating conflict situation.

The nature of bullying experiences

The final additional aim of the study was to explore two aspects of bullying experiences (a profile of the most common bully and the type of bullying experienced) using victims' accounts of recent incidents of bullying. Some 47% ($n=37$) of self-reported bullying victims provided descriptions of recent bullying incidents. This same group also provided a profile of the most common bully – namely, their gender, age and position. It was found that in 59% of cases, the bully was a person of same level of seniority (and from the same work group) as the victim. In

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other 33% of cases the bully was someone in a senior position, e.g. immediate supervisor and/or senior manager (in Scotland, these were the most common bullies, specified in 52% of cases; see Ch. 4). In 5% of cases, the bully came from another work group, whilst in 3% of cases the bully was not specified. In 55% of cases the bully was older than the victim. In other 28% of cases the bully was of similar age as the victim and in 17% of cases the bully was younger than the victim. In Scotland, a similar pattern of findings was detected (see Ch. 4, results section).

In 72% of cases, the bully was female and in 26% of cases male. In the additional 2% of cases, male and female bullies were reported (occasional cases, in which more than one bully was specified). When the data were analysed separately for male and female victims, the following was found. Women were most likely to be bullied by other women (in 84% of reported cases). Men on the other hand were most likely to be bullied by other men (in 90% of reported cases).

The findings pertaining to gender were in one respect similar to the Scottish findings. That is, in the Scottish study it was also found that women were on the whole more frequently reported as bullies. However, at a more specific level (when the gender of the victim was taken into account), the current findings departed somewhat from the previous findings. In the Scottish study, women were also most likely to be bullied by other women. Yet, men were in that study just as likely to be bullied by women and men (see Ch. 4, results section).

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The second issue addressed in the current analysis regarded the type of bullying employees experienced – that is, whether victims of bullying were more likely to be singled out (bullied on their own) or bullied in groups. The results showed that 59% of bullying victims reported being singled out, whereas 41% reported being bullied in groups. Hence, the study suggests that the former type of bullying (people being singled out) was more frequent in the hospital, although the second type (people being bullied in groups) was commonplace too.

Discussion

The aim of the present study was to determine the levels of bullying in an Icelandic hospital trust. The results of the study showed that almost a third of respondents (28%) reported experiencing one or more types of bullying acts in the past year. This finding suggests that bullying is more widespread in Icelandic hospitals than in Danish hospitals. In a study of 236 Danish hospital employees, Mikkelsen & Einarsen (2001) found that 16% reported exposure to one or more types of bullying acts in the past 6 months. However, a prevalence of 28% is considerably lower than the prevalence observed in the UK. A study of NHS community trust employees showed a prevalence of 38% (Quine, 1999), and the study of Scottish hospital staff showed a prevalence of 48% (see Ch. 4; results section). A prevalence of 46.9% was also observed in a recent study of Northern Irish nurses (McGuckin, Lewis & Shevlin, 2001).

In all of the above studies, the prevalence was assessed in terms of exposure to one or more types of bullying acts in the past six (McGuckin et al, 2001) or twelve months (Quine, 1999). Based on Hofstede's (1980) theory, it has been suggested (e.g. Einarsen, 2000) that the relatively low levels of bullying in Scandinavian work-life may be due to the low power distance and feminine and egalitarian culture of these countries (see Ch. 2). Since the Icelandic work culture is in many ways similar to the Scandinavian work culture, this argument may to some extent be relevant to the present findings.

Whilst the study points to cross-cultural variations in prevalence rates, it must be noted that this finding is restricted to only one occupational sector – namely, the health sector. When this sector is compared with other work sectors (e.g. trade and industry), it is often seen as a high-risk setting in terms of bullying (e.g. Leymann & Gustafsson, 1996; Niedl, 1995; Vartia, 1993, 1996; Zapf, 1999a). For instance, results from Germany (Zapf 1999a) indicate that employees of the health sector have a seven-fold risk of being bullied at work (cf. Zapf, Einarsen, Hoel & Vartia, 2003). Niedl (1995) and Vartia (1993, 1996) also report high levels of bullying in the health and social sector. This suggests that certain aspects of the health sector culture may influence the levels of bullying observed. For instance, health care organisations are often highly hierarchical, with physicians possessing the highest rank and as such the most power within the organisation. Such status and power

differentials increase the risk of power abuse. In some cases, bullying and harassment may even be institutionalised (Brodsky, 1976). If group norms are permissive regarding aggressiveness in social interaction, bullying may be more likely to occur. In terms of the effect/danger ratio (Björkqvist et al, 1994b), the threshold of aggressive behaviour may also be lowered in large and hierarchical organisations (Einarsen, 2000). The possibility of experiencing danger or social condemnation because of aggressive behaviour may be diminished as a result of the many layers of superiors, and the unequal distribution of power in these organisations.

According to Leymann (1996), bullying may also be linked with poorly organised work environment where role and command structures are unclear. As an example of such environment, Leymann (1996) points to a situation of nurses in hospital settings. Nurses are often caught between two distinct sets of authorities, facing high and often conflicting demands from doctors, on the other hand, and from nursing managers on the other, with increased pressure and conflicts as likely outcomes. Yet, another aspect may be inherent in the very nature of the job itself. Some jobs in the health and social sector involve high requirements for co-operation and teamwork. It may be the case that teamwork requirements offer more possibilities of interpersonal conflicts, and in instances where conflicts are not resolved bullying is a possible outcome (Hoel & Salin, 2003; see also Zapf et al, 1996).

Experiences of bullying acts: Categories of bullying

Respondents in the present study were most likely to report experiences of work-related bullying (22%) and personal derogation or isolation (15%). The category least frequently reported was physical violence or violence to property. Activities like teasing and ridicule also seemed to be infrequent. This same pattern of findings was detected in the study of Scottish hospital employees (see Ch. 4), and several other studies have shown that people are most likely to report strategies such as social isolation, personal attacks and work-related bullying (e.g. Hoel & Cooper, 2000; Zapf et al, 1996; Einarsen et al, 1994b). Overall, the findings suggest that subtle or discreet acts (e.g. ignoring the person, shifting goalposts without telling the person, withholding necessary information from the person) are more frequently experienced than direct acts (e.g. verbal threats, use of abuse, swearwords and obscenities). This pattern of findings accords with the view that rational-appearing aggression and other forms of covert aggression (e.g. social manipulation) are more frequently used in the workplace than are overt forms of aggression (Baron & Neuman, 1996; Björkqvist et al 1992a; Björkqvist et al, 1994b).

The role of NA in reports of bullying acts

The results showed that NA was moderately correlated with scores on the bullying scale. In line with the findings previously reported (see Ch.

4), NA explained some 10% of the variance in scores on the bullying scale. The findings from the two studies therefore suggest that NA only plays a minor role in reports of bullying. In line with previous findings from Scandinavia (e.g. Høgh & Dófradóttir, 2001; Kivimäki et al, 2000) and the UK (e.g. Hoel & Cooper, 2000; Quine, 1999), the results indicated that women and men were just as likely to experience bullying at work. This finding applied to all the occupational groups studied. The results also showed similar rates of bullying in various age groups. This latter finding accords with the results from Scotland (see Ch.4).

Self-reports of bullying

When the second criterion of bullying was used – namely, the self-labelling criterion – the prevalence level observed was 13%. That is, 13% of respondents considered themselves to have been bullied at work in the past 12 months. Women and men were just as likely to label themselves as targets of bullying. In most cases, respondents reported occasional exposure to bullying. Only 2% reported frequent exposure to bullying. This radical drop in prevalence rates (from 28%, when operational criteria were used, to 13%, when self-report criteria were used) is consistent with findings from Denmark (Mikkelsen & Einarsen, 2001) and Finland (Salin, 2001). As noted in previous chapters, there may be several reasons for this divergence in prevalence rates (see Ch. 2 & 4). One possible reason is that self-report criteria are more sensitive to variations in personal perceptions (Rayner et al, 2002). These

measures may also be more sensitive to variations in personal vulnerability to mistreatment and abuse. In addition, it may be argued that self-report measures are more sensitive to factors such as imbalance in power (Salin, 2001) and norms about acceptable and unacceptable workplace behaviours (Archer, 1999).

Using the self-report criterion, the present study indicates that bullying is more widespread in Icelandic hospitals than in Danish and Finnish hospitals. When using this criterion, Mikkelsen and Einarsen (2001) found that 3% of Danish hospital employees reported exposure to bullying. Similarly, Kivimäki et al (2000) found that 5% of Finnish hospital employees reported exposure to bullying. Yet, the prevalence observed in this study (13%) was significantly lower than the prevalence observed in Scotland (27%, see Ch. 4). It must also be noted that in the Danish and Finnish studies, the time scale of bullying was not the same as in the present study. In the Danish study (Mikkelsen & Einarsen, 2001) a time scale of 6 months was used, whereas in the Finnish study (Kivimäki et al, 2000), respondents were asked about current exposure to bullying at work.

The role of NA in self-reports of bullying

In the present study, it was found that NA accounted for only 6% of the variance in self-reports of bullying. This finding is in line with the findings previously reported (see Ch. 4) and also with Quine's (2003) study of

junior doctors. As regards the number of observers or bystanders, the study indicated that 34% had witnessed the bullying of others in the past 12 months. It may be noted that many of the observers, or some 18%, had not experienced bullying themselves. This finding, in conjunction with the above findings, indicates that bullying is not simply in the “eye of the beholder”, but a real interpersonal problem.

Experiences of bullying acts and self-reports of bullying

Given the divergence in prevalence rates observed in this study (28% versus 13%, depending on the criteria used, see above), additional analysis was carried out to determine the link between self-reports of bullying and reports of bullying acts at work. In the analysis, the groups of employees assessed were labelled “the bullied group” (employees who reported bullying acts *and* regarded themselves to have been bullied) and “the non-bullied group” (employees who reported bullying acts at work but did not regard themselves to have been bullied). These groups were contrasted in various ways, and the results were quite informative. First of all, the results showed that the group of bullied respondents were significantly more likely to have experienced personal derogation and/or isolation than the group of non-bullied respondents. They were also more likely to report threats and verbal abuse, teasing and ridicule, and violence. However, the two groups were just as likely to report work-related bullying. A possible explanation for this finding is that acts such as withholding information and undue pressure to produce

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work are frequently regarded as “normal” work practices. That is, many people may think of these acts as part of the work culture, and hence not signs of bullying.

Secondly, the results showed that the “bullied” group reported on average 7 types of bullying acts, whilst the “non-bullied” group reported on average 2 types of acts. This finding is in line with results from the UNISON study (Rayner, 1999). Finally, the results showed that the range of scores on the 21-item bullying scale was broader in the group of “bullied” respondents. Hence, the present findings indicate that people’s perceptions of bullying are somewhat dependent on the number of acts experienced. However, it is also possible that other factors determine self-reports of bullying. One possible factor is the perceived effect of exposure to individual acts. If people are deeply affected by particular acts (e.g. if the person experiences the act as extremely humiliating or malicious), they may be more likely to report bullying. In future studies, it may be fruitful to examine not only the range of acts experienced but also the perceived severity of these acts.

Duration of bullying and number of acts reported

As the study of Scottish hospital employees, the present study focused on the duration of bullying experiences and the link between duration of bullying and number of acts reported. Using the self-report measure of bullying, the results showed that in 33% of reported cases, bullying

lasted for more than 12 months. This finding suggests that bullying is often a long lasting experience. However, people seemed to be just as likely to experience brief episodes of bullying. That is, the results showed that 31% of respondents experienced bullying for a maximum period of 3 months. The other periods regarded in the survey, 4-6 months and 7-12 months, were reported by 19% and 16% of respondents respectively. The finding that bullying is most likely to be short-term (1-3 months) or long-term (> 12 months) experience is in line with the results previously reported (see Ch. 4). What seems to distinguish the groups of employees who reported extended and brief episodes of bullying is the number of acts experienced. That is, the results showed that employees who reported extended episodes of bullying (>12 months) experienced a wider range of bullying acts than those who reported brief episodes of bullying (1-3 months). However, the groups of employees who reported duration of 4-6 months or 7-12 months reported similar amount of acts as the group who reported duration of 12 months or more. This pattern of findings is also consistent with the pattern previously observed in Scotland (see Ch. 4). Thus, the two studies provide some, whilst not complete, support to the notion that bullying is an escalating conflict situation – namely, that the number of acts experienced escalates over the course of time.

The nature of bullying experiences

Finally, the study examined the nature of targets' experiences of bullying, using employees' accounts of recent bullying events. One of the questions addressed in the study was: what is the usual profile of the alleged bullies (e.g. their position and gender)? In contrast to the results previously reported (see Ch. 4) and other findings from the UK (showing that bullies are most likely to be managers or immediate supervisors, e.g. Hoel & Cooper, 2000; Quine, 1999), the results showed that the bully was most likely to be a work-colleague. In only a third of cases (33%) the bully was someone in a senior position, such as an immediate supervisor and/or senior manager. Results from Finland and Norway also indicate that the perpetrators of bullying are often of same seniority level as the target (Björkqvist et al 1994a; Einarsen & Skogstad, 1996).

One plausible explanation for this cross-cultural difference is a lower power distance between managers and subordinates in Scandinavian and Icelandic workplaces. As noted in a previous chapter, the concept of power distance is sometimes used to describe people's attitudes within a hierarchy (see Ch. 2). In countries with high power distance, the supervisor is seen as authoritative, unquestioned and obeyed. In contrast, in low power distance cultures, the supervisor is seen more as a facilitator of the work team (Hofstede, 1980, 1993). In line with the above argument, it is possible that in countries with higher power distance (e.g. the UK), bullying is seen more "normal" and even an

acceptable part of management behaviour (Rayner et al, 2002; see also Zapf et al, 2003).

As for age, the current findings showed that the bully was most likely to be older than the victim, though in several cases the bully was of similar age as the victim or younger than the victim. In the study previously reported, a similar pattern of findings was detected (see Ch. 4). Other studies from the UK also indicate that bullies are more likely to be older than their targets (Rayner et al, 2002). As for gender, the results showed that in more than two thirds of cases (72%) the bully was female. Given the great proportion of female employees in Icelandic hospitals, this particular finding is hardly surprising. When the data was analysed separately for male and female victims, it was found that women were most likely to be bullied by other women. In contrast, men were most likely to be bullied by other men. In the previous study of Scottish hospital employees, women were also most likely to be bullied by other women. However, in this study, men were just as likely to be bullied by women and men (see Ch. 4). The present findings are also consistent with findings from Norway and Sweden, showing that men are most likely to be bullied by other men whereas women are most likely to be bullied by other women (Einarsen & Skogstad, 1996; Leymann, 1996).

The final question addressed in the study was: do bullying victims tend to be singled out or bullied in groups? The results indicated that victims were somewhat more likely to be singled out than bullied in groups.

Unfortunately, this particular issue has not been systematically addressed in Scandinavian studies. Therefore, a cross-cultural comparison is limited to findings from the UK. In the UMIST study (Hoel & Cooper, 2000) it was found that victims of bullying were more likely to be bullied in groups. However, the results from Scotland showed that victims were more likely to report being bullied on their own. In line with the present findings, the results from Scotland also showed that women were more likely than men to be seen as bullies. It is therefore plausible that the interpretation previously offered (see Ch. 4) also applies to the present study. That is, it is possible that the present findings tell us something about bullying tactics and gender. In studies showing that people are more likely to be bullied in groups (e.g. Hoel & Cooper, 2002), it is also found that men are more often reported as bullies than women (see Rayner et al, 2002). Accordingly, it may be the case that male bullies tend to attack several people at a time, whereas female bullies prefer to select individual targets. In future research on bullying and gender, this hypothesis deserves attention.

Potential limitations of the study

Given the prevalence levels of 28% and 13% in the present study (depending on the criterion used to assess bullying), it must be noted that these data may not accurately reflect the actual prevalence of bullying in Icelandic hospitals. The reason for this is the relatively low response rate achieved in the study (a response rate of 31%). According

to Hoel et al (1999), there are various reasons why data on bullying may be exaggerated. For instance, it is possible that personality factors (e.g. negative affectivity, locus of control) influence reports of bullying. However, in the present study, the role of negative affectivity was systematically assessed. The results indicated that NA did not have critical influence on employee reports of bullying. In spite of this, it may be the case that people who actually experienced bullying were more likely to respond to the study questionnaire because of its personal relevance. However, the finding that more people reported having witnessed bullying at work (34%) than experienced bullying themselves (13%) indicates that the study sample was not biased in this way, i.e. that victims of bullying were over-represented in the final sample.

On the other hand, it is possible that bullying was under-rated in the study. That is, it is possible that the group of non-respondents were more likely to have experienced bullying than the group of respondents. In addition, it is possible that self-reports of bullying do not reflect the true scale of the problem. For instance, some bullying victims may decline the victim role, given that this role implies attributes such as weakness, failure and passivity (Mikkelsen & Einarsen, 2001; Salin, 2001). In view of all this, the present findings must be interpreted with some caution.

Conclusion

The results of this study suggest that bullying is relatively common in Icelandic hospitals. Almost a third of respondents (28%) reported experiencing one or more types of bullying acts in the past year. The prevalence observed was somewhat higher than in Denmark, yet considerably lower than in the UK. Whilst the study points to cross-cultural variations in prevalence rate, it must be emphasised that this finding is limited to only one work sector – namely, the health sector. When this sector is compared with other work sectors, it is often seen as a high-risk setting in terms of bullying. It is quite possible that cultural factors influence the levels of bullying in this sector. Yet, it may also be the case that factors related to the job (e.g. time pressure, role conflict, requirements for co-operation and teamwork) influence the rate of bullying in this sector.

Respondents in the current study were most likely to report experiences of work-related bullying and personal derogation or isolation. This finding accords with previous findings in the field. According to the present findings, the factor of NA only had a minor influence on reports of bullying acts at work. In line with previous findings from Scandinavia, women and men were just as likely to experience bullying at work. The results also showed similar rates of bullying in various age groups.

Chapter 6: Icelandic hospital staff – Prevalence and nature of bullying

Whilst 28% of respondents reported exposure to bullying acts at work, only 13% labelled themselves to have been bullied at work. In most cases, respondents reported occasional exposure to bullying. According to the present study, self-labelling is to some extent related to the number of bullying acts experienced. However, it is possible that other factors (e.g. personal vulnerability to mistreatment and abuse, perceived imbalance in power, perceived effects of bullying acts) influence self-reports of bullying.

A number of findings were reported regarding victims' experiences of bullying. These focused on issues such as duration of bullying episodes, the usual profile of the bully, and whether the victims tended to be singled out or bullied in groups. Some of these findings were consistent with the findings from Scotland, such as the findings regarding duration and nature of bullying experiences (victims more likely to be singled out than bullied in groups; see Ch. 4). However, discrepancies also were found between the two studies. For instance, the present study showed that bullies were most likely to be work-colleagues (instead of manager or immediate supervisor; see Ch. 4). The concept of power-distance can possibly help to explain this divergence in study findings.

CHAPTER 7

WORKPLACE BULLYING IN ICELANDIC HOSPITAL STAFF: PSYCHOLOGICAL HEALTH OUTCOMES

– STUDY 2: PART 2 –

Introduction

This chapter deals with the second part of the study conducted in an Icelandic public hospital. In this part, prospective panel data (*T1* and *T2* data) were used to assess the relationship between bullying and psychological health outcomes. So far, most studies in the field have used cross-sectional designs to demonstrate relationships between bullying and adverse health outcomes (see literature review in Ch. 3). However, in a recent study of 5,655 Finnish hospital employees, Kivimäki et al (2000) employed cross-sectional and prospective data to test the association between bullying and sickness absence. When using their cross-sectional data, they found that victims of bullying (5% of the sample, identified through self-reports) had 51% greater risk of medically certified sickness absence and a 23% greater risk of self-certified sickness absence than non-victims.

The authors offered two possible explanations for these cross-sectional findings (see Kivimäki et al, 2000, p. 659). First, they suggested that exposure to bullying increases the risk of sickness absence. Secondly,

they proposed that bullying, as a dynamic process, denotes a vicious circle where poor health is a result of bullying and a factor increasing the likelihood of victimisation. In order to test the first possibility, Kivimäki et al used their prospective data, where they adjusted the rate ratios for baseline absence (rates of sick leave a year prior to the study), demographic factors, health risk behaviours, and general health status. In their fully adjusted model, the risk of medically certified and self-certified sickness absence remained significantly higher in bullying victims than in other staff.

As the description of Kivimäki et al's (2000) study indicates, longitudinal study designs tend to be more useful than cross-sectional designs when the issue of cause and effect is to be addressed. Since the prospective design is non-experimental, the question of causal inference is still quite complex. However, when compared with cross-sectional designs, the prospective design offers the opportunity to assess temporal ordering of relationships. In several basic methodology texts (e.g. Asher, 1976; Baltes & Nesselroade, 1979; Cook & Campbell, 1979), it is argued that three criteria must be met so that causal relationships between pairs of variables can be demonstrated.

Firstly, the variables in question must correlate or co-vary, as shown for example by non-zero associations between the two variables (a criterion of covariation). Secondly, the relationship must not be attributable to any other variable or set of variables, i.e. it must persist in conditions where

other variables (sometimes regarded as third variables) are in some way controlled (a criterion of non-spuriousness). Thirdly, the supposed cause must precede or be synchronous with the supposed effect in time, as indicated by the change in the cause occurring no later than the associated change in the effect (a criterion of time order). Evidence for the first two criteria may be obtained from purely cross-sectional data. However, the third criterion can usually be tested adequately only with prospective data – that is, in studies where data are collected at two or more distinct time periods (Menard, 1991).

As demonstrated in the example of Kivimäki et al's (2000) study, the criterion of covariation was clearly taken into account (the relationship between bullying and sickness absence demonstrated). In addition, they tried to ensure that observed relationships between bullying and sickness absence were not due to third variables (e.g. prior sickness absence, health risk behaviours, general health status). Apart from this study, numerous other studies have demonstrated relationships between bullying and adverse health outcomes (e.g. Einarsen et al, 1996; Björkqvist et al, 1994a; Mikkelsen & Einarsen, 2001; Quine, 1999; Zapf et al, 1996; see review of empirical findings in Ch. 3).

However, one shortcoming of many previous studies is that relationships between bullying and outcomes are usually assessed without controlling

for potential third variables.¹ In the literature, various third variables have been suggested to explain these relationships. Examples are social desirability and negative affectivity (e.g. Mikkelsen & Einarsen, 2001; Quine, 1999, 2003; Zapf et al, 1996). In the study of Scottish hospital staff (see Ch. 5), the factor of negative affectivity (NA) was incorporated. When controlling for this factor, associations between bullying and occupational health outcomes (e.g. anxiety, general health status, job satisfaction, and propensity to leave the job) were still found. Yet, more studies are clearly needed where the effects of NA are taken into account.

The aim of the present study was to examine more thoroughly the relationships previously found between bullying and psychological health outcomes. Using a prospective panel design, the relationships between chronic and acute forms of bullying and three particular outcomes (anxiety, depression and psychosomatic complaints) were determined. In the process of analysing these relationships, special efforts were made to rule out the effects of potential third variables on these relationships. The variables selected in the study were prior psychological health, prior psychosomatic complaints, and negative affectivity. Efforts were also made to assess reversed causal relationships between bullying and psychological health outcomes (a strategy recommended by several authors, e.g. Einarsen & Raknes, 1997a; Quine, 1999). That is, analyses were carried out to determine not

¹ Quine's (2003) study of junior doctors is one exception. In this study, the role of NA in bullying-outcome relationships was systematically assessed.

only the effects of bullying on emotional and psychosomatic problems (controlling for prior psychological health, prior psychosomatic complaints, and negative affectivity), but also the potentially reversed effects of these health problems on perceptions and experiences of workplace bullying. Although qualitative studies (e.g. interviews with bullying victims) indicate that exposure to bullying precedes psychological health problems (see, for example, Björkqvist et al, 1994a; O'Moore et al, 1998), the possibility of reversed causation needs to be systematically assessed.

As noted above, the present study distinguished two forms of bullying experiences – namely, chronic or enduring experiences of bullying and acute or time-limited experiences of bullying. This particular approach was based on a study recently conducted in the US (Rospenda, Richman, Wislar & Flaherty, 2000), where the health effects of chronic versus acute experiences of bullying and harassment were assessed. That is, Rospenda et al assessed exposure to bullying and sexual harassment over a two-year period by surveying respondents (2,038 university employees) at two measurement points, one year apart. Among the outcome measures used in the study were alcohol dependence and problem drinking. The results of the study indicated that employees who reported exposure to bullying throughout the study (indicating two-years duration of bullying experiences) were more likely to report one or more indicators of problem drinking (assessed at time 2) than employees who experienced bullying at only one time-point (e.g. at

time 1 only) or not at all. In other words, employees exposed to chronic bullying were more likely to manifest drinking problems than those who had experienced bullying on a time-limited basis. Although the above findings were restricted to adverse drinking outcomes, it has recently been argued (see Keashly & Jagatic, 2003) that the methodology used in the study is important in identifying and assessing a range of effects of enduring versus temporary bullying experiences. Therefore, the factor of duration (i.e. duration of bullying experiences) was taken into account in the present study.

Description of psychological health measures

In the previous chapter, the various aspects of study method were thoroughly described (see Ch. 6). As noted in this chapter, two questionnaires were used in the study (a *T1* and *T2* questionnaire), and these were distributed to samples of hospital employees with an interval of 4 months. The questionnaires were of similar kind and the measures used in this second part of the study were as follows (see also Appendices IV and IV).

Measures derived from the T1 questionnaire

Psychosomatic complaints: The scale used to assess psychosomatic symptoms or complaints was Cohen and Hoberman's (1983) *Inventory*

of Physical Symptoms (CHIPS). The scale contains 33 types of common physical symptoms, e.g. back pain, stomach aches, cold or cough. During production of scale, items were carefully selected so as to exclude symptoms of obviously psychological nature (e.g. nervousness or anguish). The scale does however include many physical symptoms that are traditionally viewed as psychosomatic, e.g. headache or weight loss. The 33 scale items are rated (on a scale ranging from 0=“not at all” to 4=“extremely”) for how much the pertinent symptoms have bothered the person during the past two weeks

Anxiety and depression: The Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983) was used to assess levels of anxiety and depression. The HADS is a 14-item measure, seven items of which measure anxiety and seven of which measure depression. In the production of the scale, care was taken to separate out the concept of emotional and somatic illness, so the scores are not affected by the presence of bodily illness. For more detailed description of the scale, see Ch. 5.

Negative affectivity (NA): Stokes and Levin’s (1990) 21-item scale was employed to assess respondents’ levels of negative affectivity. A detailed description of this scale is provided in Ch’s 4 & 6.

Exposure to bullying at work: The measure used to assess respondents’ experiences of bullying was the 21-item scale (see description of the

scale in Ch's 5 & 6). The respondents were asked to indicate by a "yes"/"no" response whether they had been exposed to one or more types of bullying acts in the past 12 months. The various scale items were seen to reflect five categories of bullying at work: personal derogation/isolation, work-related bullying, threats and verbal abuse, teasing and ridicule, and violence.

Measures derived from the T2 questionnaire

In the study's second wave (T2), the measures of *psychosomatic complaints* (CHIPS; Cohen & Hoberman, 1983), *anxiety and depression* (HADS; Zigmond & Snaith, 1983), and *negative affectivity* (NA; Stokes & Levin, 1990) were again used (see Appendix VI). The 21-item bullying scale was also used for the second time to assess respondents' *experiences of bullying*. However, the time-scale used at T2 varied from the time-scale used at T1. That is, the time-span of bullying experiences varied between the two study periods. At T1 respondents were asked to report their experiences of bullying "in the past 12 months", whereas at T2 they were asked to report their experiences of bullying "in the past 4 months". This strategy was used to distinguish four patterns or categories of bullying experiences: chronic experiences of bullying (bullying reported at T1 and T2), remission of bullying (bullying reported at T1 only), recent onset of bullying experiences (bullying reported at T2 only), and absence of bullying experiences (no bullying reported at T1 or T2).

Patterns of bullying experiences

As noted above, four patterns of bullying experiences were distinguished in the study (chronic bullying, remission or onset of bullying, absence of bullying). These patterns were identified through various transformations of raw questionnaire data. To start with, the T1 scores on the bullying scale were split into values of 0 (no bullying reported) and 1 (bullying reported). Secondly, the T2 scores on the bullying scale were split into values of 0 (no bullying reported) and 2 (bullying reported). Using the above values (0 vs. 1 and 0 vs. 2) a variable was created, reflecting four possible combinations of these values and inherently the four patterns of bullying experiences: 0 (no bullying reported at T1 or T2; absence of bullying), 1 (bullying reported at T1 only; remission of bullying), 2 (bullying reported at T2 only; onset of bullying), and 3 (bullying reported at T1 and T2; chronicity of bullying). This new variable was used in the study to determine the relative effects of chronic and acute patterns of bullying on psychological health outcomes.

Results

A total of 713 employees completed the T1 study questionnaire (31% response rate); 494 of these (69%) were followed up in the second wave of the study (T2). Of the final study sample (N=494), 86% were female and 14% were male. The age range in the sample was 18 to 69 years

($M=43$, $SD=11.8$). Examination of scores on the various T1 measures showed no differences between the 494 employees included in the final analyses and the 215 employees for whom T2 data were missing. For instance, the two groups reported similar levels of bullying at work and showed similar scores on the *CHIPS* and the *HADS*.

Preliminary analyses of data

Prior to the main analyses of data, the means and standard deviations of scales were determined for the final sample ($N=494$). The reliability of scales was also assessed, using coefficient alpha. The results of these analyses are shown in Table 7.1. As the table indicates, satisfactory alphas were found for all five scales. The alpha values observed were also quite stable throughout the study (see alpha-values observed for individual scales at T1 and T2).

Table 7.1. Means, standard deviations and reliability of scales

Scale	Time 1				Time 2			
	<i>M</i>	<i>SD</i>	α	<i>N</i>	<i>M</i>	<i>SD</i>	α	<i>N</i>
The bullying scale	1.0	2.6	.87	493	1.0	2.4	.88	485
Anxiety	4.0	3.1	.81	489	4.0	3.3	.84	491
Depression	2.6	2.6	.75	480	2.4	2.7	.77	488
Psychosomatic complaints	13.7	12.8	.90	427	14.2	13.2	.92	423
Negative affectivity	55.5	13.0	.87	442	54.1	13.4	.87	439

Contemporaneous correlations between scales

Contemporaneous correlations between the measures of bullying at work, negative affectivity (NA), and psychological health outcomes were also determined (see Tables 7.2 and 7.3). Table 7.2 presents the inter-correlations at Time 1, whereas Table 7.3 shows the comparable correlations at Time 2. Whilst these concurrent correlations were not central to the present study, they replicate what is typically found in cross-sectional studies (see also correlations reported in Ch. 5). When interpreting the various values of Pearson's r , the following criteria were used (Hoyle, Harris & Judd, 2002). Values above .50 were seen as strong, values between .30 and .50 were seen as moderate, and values below .30 were seen as weak.

It was found that exposure to bullying correlated moderately or weakly with the three outcome measures (e.g. anxiety, $r = .40$, $p < .001$; depression, $r = .43$, $p < .001$; and psychosomatic health complaints $r = .20$, $p < .001$, at Time 1). The direction of correlations showed that exposure to bullying associated with higher levels of anxiety and depression, and with more psychosomatic complaints. As Tables 7.2 and 7.3 show, the correlations between bullying and the *HADS* measures (anxiety and depression) were roughly the same throughout the study. However, the correlation between bullying and the *CHIPS* measure was somewhat stronger at Time 2 ($r = .34$, $p < .001$) than at Time 1 ($r = .20$, $p < .001$).

Table 7.2. Pearson's product-moment correlations between study measures at Time 1

<i>Measure</i>	2	3	4	5
1. The bullying scale	.40	.43	.20	.30
2. Anxiety (<i>HADS</i>)	–	.57	.59	.63
3. Depression (<i>HADS</i>)		–	.40	.52
4. Psychosomatic complaints (<i>CHIPS</i>)			–	.33
5. Negative affectivity (NA)				–

Note: All the above correlations were significant at the $p < .001$ level

Throughout the study, the measure of NA was strongly and consistently correlated with anxiety ($r = .63$ and $r = .62$, $p < .001$) and depression ($r = .52$ and $r = .61$, $p < .001$), and moderately correlated with psychosomatic complaints ($r = .33$, $p < .001$ and $r = .45$, $p < .001$).

Table 7.3. Pearson's product-moment correlations between study measures at Time 2

<i>Measure</i>	2	3	4	5
1. The bullying scale	.38	.43	.34	.27
2. Anxiety (<i>HADS</i>)	–	.58	.60	.62
3. Depression (<i>HADS</i>)		–	.52	.61
4. Psychosomatic complaints (<i>CHIPS</i>)			–	.45
5. Negative affectivity (NA)				–

Note: All the above correlations were significant at the $p < .001$ level

In addition to the above findings, it may be noted that the three measures of psychological health (anxiety, depression and psychosomatic complaints) were significantly and quite strongly inter-correlated. However, given the conceptual relationship between these outcomes, the correlations observed may not be surprising. The strongest correlation detected was between anxiety and psychosomatic

complaints ($r = .60, p < .001$), and the weakest correlation was between depression and psychosomatic complaints ($r = .40, p < .001$).

Main results

Prospective correlations between scales

In the previous section, contemporaneous correlations between study measures were presented. In Table 7.4, the prospective correlations between the measures are shown. Of most relevance to the present study were the correlations between the T1 bullying measure and the T2 outcome measures. Exposure to bullying at Time 1 was moderately correlated with all the outcome measures (anxiety, $r = .33, p < .001$; depression, $r = .40, p < .001$; and psychosomatic complaints, $r = .27, p < .001$) at Time 2. The correlations observed were quite similar to the cross-sectional correlations previously found (see Tables 7.2 and 7.3). Background variables such as gender, age and occupation did not influence these relationships.

The direction of correlations suggests that exposure to bullying at T1 is associated with higher levels anxiety and depression, and with more psychosomatic complaints at T2. Table 7.4 also shows that reports of bullying at Time 1 were strongly correlated with reports of bullying at

Time 2 ($r = .77, p < .001$). This degree of correlation indicates that bullying was often a chronic problem for those reporting it.

Table 7.4. Prospective (Pearson's product-moment) correlations between study measures

<i>Time 1 (T1) measures</i>	<i>Time 2 (T2) measures</i>				
	1	2	3	4	5
1. The bullying scale	.77	.33	.40	.27	.27
2. Anxiety (<i>HADS</i>)	.34	.71	.50	.48	.54
3. Depression (<i>HADS</i>)	.35	.41	.66	.29	.46
4. Psychosomatic complaints (<i>CHIPS</i>)	.21	.45	.35	.70	.31
5. Negative affectivity (NA)	.24	.50	.48	.33	.77

Note: All the above correlations were significant at the $p < .001$ level

The T1 measure of NA was moderately correlated anxiety ($r = .50, p < .001$), depression ($r = .48, p < .001$) and psychosomatic complaints ($r = .33, p < .001$) at T2. These correlations were slightly lower than the correlations previously found between the T2 measure of NA and psychological health outcomes (see Table 7.3). In addition, the T1 measure of NA was weakly correlated with reports of bullying at T2 ($r = .24, p < .001$). The relationship previously found between the T2 measure of NA and T2 reports of bullying was roughly the same ($r = .27, p < .001$; see Table 7.3).

Finally, Table 7.4 shows that the T1 measures of psychological health outcomes were significantly related to T2 reports of bullying. The respective correlations between T2 bullying and T1 anxiety and depression were $r = .34, p < .001$ and $r = .35, p < .001$ and the correlation

between T2 bullying and T1 psychosomatic complaints was $r = .21$, $p < .001$. The direction of these relationships indicates that emotional and psychosomatic problems at T1 correlate with higher levels of bullying at T2. In other words, the present findings point to a potentially reversed causation between psychological or psychosomatic health problems and reported experiences of bullying.

Patterns of bullying and psychological health outcomes

A series of hierarchical regression models were used in the study to assess the relative effects of three patterns of bullying (chronicity, onset, and remission) on psychological health outcomes. Prior to these analyses, the T2 levels of anxiety, depression and psychosomatic complaints were determined for the three patterns, and also for the fourth pattern (absence of bullying) identified in the study.

Table 7.5. Patterns of bullying experiences and mean levels of anxiety, depression and psychosomatic complaints at T2

<i>Pattern</i>	<i>Chronicity (n=88)</i>		<i>Onset (n=38)</i>		<i>Remission (n=43)</i>		<i>Absence (n=314)</i>	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Anxiety	6.1	3.9	5.3	4.0	4.1	3.0	3.2	2.7
Depression	4.0	3.7	3.5	3.1	2.6	2.7	1.8	1.9
Psychosomatic complaints	21.5	17.8	18.8	13.2	16.3	12.5	11.2	10.5

Note: The above means and standard deviations derived from time 2 scores on the HADS and CHIPS scales

The observed mean levels are shown in Table 7.5. The table also shows the number of cases representing the three patterns of bullying and absence of bullying. Three ANOVA tests were used to determine overall differences in levels of anxiety, depression and psychosomatic complaints across the four patterns. The results of these tests are shown in Table 7.6. Since significant differences were found for all the three health outcomes (see significant F-values in Table 7.6), a series of Tukey HSD post-hoc tests were used to disentangle these overall differences.

Table 7.6. Patterns of bullying and levels of anxiety, depression and psychosomatic complaints at T2: ANOVA results

	<i>df</i>	<i>N</i>	<i>F</i>	<i>p</i>
Anxiety	3	475	21.4	< .001
Depression	3	471	20.4	< .001
Psychosomatic complaints	3	411	15.8	< .001

The results from the Tukey post-hoc tests showed that mean levels of anxiety, depression and psychosomatic complaints were significantly higher for the chronic and onset patterns ($p < .01$) than for the pattern of no bullying. No differences were found between the remission pattern and the pattern of no bullying. These post-hoc results therefore suggest that only chronic exposure to bullying or recent onset of bullying influences negative health outcomes. The F-values shown in Table 7.6 indicate that the effects of the chronicity and onset patterns were quite strong.

However, in the above ANOVA tests and associated post-hoc tests, the effects of potential third variables were not taken into account. Therefore, a hierarchical regression approach was selected to test more thoroughly the effects of bullying patterns on health outcomes. In the regression models assessed (see Tables 7.7, 7.8 & 7.9), the chronicity, onset and remission patterns were represented by three dummy variables (see transformation of dichotomous variables in Tabachnick & Fidell, 1996). The control variables used in the models were prior psychological health (levels of anxiety, depression and psychosomatic complaints at T1) and T1 negative affectivity. As shown in Tables 7.7, 7.8 & 7.9, the control variables and the three dummy variables were entered into the regression models in two steps (control variables entered in a step prior to the three patterns of bullying).

Routine pre-analysis screening procedures were used to assess the key assumptions in multiple regression analysis (assumptions of normality, linearity and homoscedasticity of residuals; see Tabachnick & Fidell, 1996, p. 136). In the three regression models (predicting levels of anxiety, depression, and psychosomatic complaints at T2), these assumptions were generally met. In addition, no serious outliers were found in the data set. Finally, none of the predictor variables accounted for a tolerance problem.

A model predicting T2 levels of anxiety

The model predicting T2 levels of anxiety is presented in Table 7.7. The value of R^2 in step 1 ($R^2 = .51$, $p < .001$) indicates, as expected, that T1 anxiety and NA explained a considerable amount of the variance in T2 anxiety. A more important finding though was the significant change in R^2 when the three patterns of bullying were entered at step 2 (R^2 change = .018, $p < .01$).

Table 7.7. Hierarchical regression model predicting T2 anxiety from three patterns of bullying, controlling for T1 anxiety and T1 NA

		<i>F</i>	<i>B</i>	<i>B</i>	<i>sr</i>	<i>t</i>	<i>p</i>
<i>Model variables</i>							
<i>Step 1</i>							
T1 Anxiety			.68	.64	.500	14.7	< .001
T1 NA			.03	.11	.082	2.4	< .05
R^2	.51	222.5					< .001
<i>Step 2</i>							
T1 Anxiety			.64	.61	.455	13.6	< .001
T1 NA			.03	.11	.082	2.4	< .05
Chronicity			.83	.10	.088	2.6	< .01
Onset			1.21	.10	.099	3.0	< .01
Remission			-.39	-.03	-.032	-1.0	Ns
R^2 change	.018	5.5					< .01

Even though the increment in R^2 was only slight, two of the patterns (chronicity and onset) contributed to the prediction of anxiety. In the final regression model, chronicity and onset contributed equally to the prediction of T2 levels of anxiety (see observed *B*, beta and *sr* values in regression step 2).

A model predicting T2 levels of depression

The chronicity and onset patterns also contributed to the prediction of T2 levels of depression (see Table 7.8). Whereas, unsurprisingly, the control variables (T1 depression and T1 NA) explained most of the variance in T2 depression ($R^2 = .46$, $p < .001$), the two patterns of bullying added slightly to the prediction of depression (R^2 change = .017, $p < .01$). As shown in Table 7.8, chronicity and onset of bullying contributed quite equally to the prediction of T2 depression (see B, beta and sr values in regression step 2).

Table 7.8. Hierarchical regression model predicting T2 depression from three patterns of bullying, controlling for T1 depression and T1 NA

<i>Model variables</i>	<i>F</i>	<i>B</i>	<i>B</i>	<i>sr</i>	<i>t</i>	<i>p</i>
<i>Step 1</i>						
T1 Depression		.58	.57	.48	13.3	< .001
T1 NA		.04	.18	.15	4.2	< .001
R^2	.46	175.6				< .001
<i>Step 2</i>						
T1 Depression		.54	.53	.43	12.2	< .001
T1 NA		.04	.17	.14	4.0	< .001
Chronicity		.80	.12	.11	3.0	< .01
Onset		.78	.08	.08	2.2	< .05
Remission		-.13	-.01	-.01	-0.4	ns
R^2 change	.017	4.5				< .01

A model predicting T2 levels of psychosomatic complaints

The most interesting pattern of findings was detected in the model predicting T2 levels of psychosomatic complaints (see Table 7.9).

Table 7.9. Hierarchical regression model predicting T2 psychosomatic complaints from three patterns of bullying, controlling for T1 complaints and T1 NA

		<i>F</i>	<i>B</i>	<i>B</i>	<i>sr</i>	<i>t</i>	<i>p</i>
<i>Model variables</i>							
<i>Step 1</i>							
T1 complaints			.62	.65	.61	15.6	< .001
T1 NA			.12	.13	.12	3.1	< .01
<i>R</i> ²	.49	158.5					< .001
<i>Step 2</i>							
T1 complaints			.62	.65	.59	15.3	< .001
T1 NA			.11	.11	.10	2.7	< .01
Chronicity			2.71	.09	.08	2.1	< .05
Onset			4.35	.10	.10	2.6	< .05
Remission			-4.27	-.09	-.09	-2.4	< .05
<i>R</i> ² change	.028	6.3					< .001

As in the other models, the control variables contributed to the greatest amount of variance in the outcome variable ($R^2 = .49$, $p < .001$). Yet, in contrast to the other models, all three patterns of bullying added (although just slightly: R^2 change = .028, $p < .001$) to the prediction of T2 psychosomatic complaints. The positive *B* values for chronicity and onset indicate that these two patterns predicted increase in psychosomatic complaints (see also positive beta and *sr* values in regression step 2). However, the negative *B* value for remission

indicates that remission of bullying experiences predicted *decrease* in psychosomatic complaints (see also negative beta and sr values in regression step 2).

Analyses of reversed causal relationships

So far, the present study has focused on the potential effects of bullying experiences on adverse psychological health outcomes. In the regression analyses just described, it was found (after controlling for prior psychological health and negative affectivity) that two particular patterns of bullying (chronicity and onset) contributed to the prediction of psychological health (levels of anxiety and depression). However, the aim of the study was also to test reversed causal relationships between bullying and health outcomes. In the analyses described below, the possibility was tested that having emotional and psychosomatic problems may to some extent influence perceptions of bullying at work. This would be consistent with the idea that people who are anxious or depressed are more likely to perceive (and report) other people's behaviour as hostile, critical or demeaning. The technique used to test this possibility was binary logistic regression. This technique was selected, since the criterion variable (experiences bullying at T2) was dichotomous – bullying reported at T2 or no bullying reported at T2. Two regression models were calculated and these are shown in Tables 7.10 & 7.11.

As Table 7.10 shows, the predictor variables included in the first model were anxiety, depression and psychosomatic complaints at T1. In the second model, the T1 bullying variable (reports of bullying at T1) and T1 negative affectivity (NA) were also included. These variables were entered into the model in a block prior to the other predictor variables (see Table 7.11). In other words, the T1 bullying variable and NA were treated as control variables in this second analysis.

In logistic regression, pivotal use is made of a statistic, which is written as $-2 \log$ likelihood. This log likelihood statistic acts as chi-square, and has a large value when a model fits poorly, and a small value when it fits the data well. The regression initially finds the log likelihood for a model without the predictor variables present, and when the predictors are added to the model the log likelihood chi-square should preferably reduce. When it comes to assessing the relative importance of predictor variables, the two statistics commonly used are the Wald statistic and the Hosmer-Lemeshow statistic.

The Wald statistic is used to test the regression coefficients individually for significance. The Hosmer-Lemeshow statistic is based on the log likelihood ratios with and without the predictor variables in the model. It is a chi-square test showing the goodness-of-fit between observed and predicted number of cases for the two categories assessed – in this study, bullying reported or not reported at T2. A good model fit is indicated by a high p-value for the test.

In the regression model shown in Table 7.10, the initial -2 log likelihood value was 469.7, and when the three predictor variables (anxiety, depression and psychosomatic symptoms at T1) were added to the model the -2 log likelihood value reduced to 424.9, which was a significant change ($\chi^2 = 44.9$, $p < .001$).

Table 7.10. Binary logistic regression model predicting T2 bullying experiences from T1 health variables (anxiety, depression and psychosomatic complaints)

	<i>B</i>	<i>SE</i>	<i>Wald</i>	<i>p</i>	<i>Exp(B)</i>	<i>95% CI</i>
<i>Model variables</i>						
T1 Anxiety	.12	.05	5.3	< .05	1.12	1.02-1.24
T1 Depression	.17	.06	10.2	< .01	1.19	1.07-1.33
T1 Psychosomatic complaints	.01	.01	0.6	ns	1.01	0.99-1.03

Two of the T1 health variables (anxiety and depression) were significant predictors of bullying reports at T2 (see respective B values and significant Wald statistics in Table 7.10). The Hosmer and Lesmeshow test also indicated that the model fit was good ($\chi^2 = 10.7$, $p = .22$).

In the second model assessed (a step-wise model incorporating T1 reports of bullying and T1 NA; see Table 7.11), the initial -2 log likelihood value was 441.4, and when the control variables (T1 bullying and T1 NA) were added to the model the -2 log likelihood value reduced to 321.5, which was a significant change ($\chi^2 = 119.9$, $p < .001$). In the second step, when the T1 health variables were added, there was again a

significant reduction in the log likelihood value (-2 LogL = 306.3, $\chi^2 = 15.2$, $p < .01$).

Table 7.11. Binary logistic regression model predicting T2 bullying experiences from T1 health variables (anxiety, depression and psychosomatic complaints), controlling for T1 bullying and T1 NA

	<i>B</i>	<i>SE</i>	<i>Wald</i>	<i>p</i>	<i>Exp(B)</i>	<i>95% CI</i>
<i>Model variables</i>						
<i>Block 1</i>						
T1 Bullying reports	2.72	.29	89.4	< .001	15.13	8.61-26.57
T1 NA	.018	.01	2.8	ns	1.02	1.00-1.04
<i>Block 2</i>						
T1 Bullying	2.71	.31	78.6	< .001	14.97	8.23-27.24
T1 NA	-.015	.02	1.0	ns	.99	0.96-1.02
T1 Anxiety	.11	.07	2.5	ns	1.12	0.98-1.28
T1 Depression	.21	.07	9.0	< .01	1.24	1.08-1.42
T1 Psychosomatic complaints	-.012	.01	0.8	ns	.99	0.96-1.01

In the final regression model, T1 bullying reports and T1 depression were significant predictors of T2 reports of bullying (see respective *B* values and significant Wald statistics in block 2). The Hosmer and Lemeshow test for the final regression block also indicated that the model fit was good ($\chi^2 = 6.5$, $p = .60$). Hence, this second and more conservative test of reversed causality suggested that exposure to bullying may partly be due to previous levels of depression. However, the other two health outcomes (T1 anxiety and psychosomatic complaints) did not seem to play a causal role in bullying experiences.

Discussion

The aim of this study was to replicate and extend the finding that exposure to bullying at work associates with adverse health outcomes. That is to say, prospective panel data were used to determine the relationship between bullying and three health outcomes (anxiety, depression and psychosomatic complaints). Prospective data were used to overcome some of the problems associated with the more frequently used cross-sectional survey data. As usually noted in methodology texts, prospective study designs are more likely to clarify causal relationships between study variables. Since the prospective design is non-experimental, the question of causal inference (e.g. that bullying leads to psychological poor health) is still complex. As in other areas of research, prospective studies can only be seen to point at causal relationships – causation *cannot* be proved in these studies (Frese & Zapf, 1988; Zapf et al, 1996; see also Dwyer, 1983; Holland, 1986).

One of the criteria used when assessing causal relationships is the criterion of non-spuriousness. That is, relationships observed between study variables must persist in conditions where third variables are controlled. In the present study, three such variables (negative affectivity, prior psychological health and prior psychosomatic complaints) were incorporated. Efforts were also made to assess reversed causal relationships between bullying and psychological health outcomes. In the various analyses conducted, distinctions were made

between chronic and acute exposure to bullying. This approach was initially used in Rospenda et al's (2000) study, and was adopted here to determine the potential link between duration of bullying experiences and psychological health outcomes. The three procedures used to determine the link between bullying and health outcomes were correlational analyses, ANOVA-tests, and hierarchical regression analyses. Of the various procedures employed, the regression tests were most exhaustive, showing the respective effects of three patterns of bullying (chronicity, onset and remission) on health outcomes, when the effects of third variables (NA and prior psychological or psychosomatic health) were taken into account.

Prospective correlations between study variables

The prospective correlations between (T1) bullying experiences and (T2) psychological health outcomes supported the correlations usually found in cross-sectional studies (for review, see Ch. 3). That is, experiences of bullying at T1 associated with increased levels of anxiety, depression, and psychosomatic complaints at T2. It may be noted that the relationship between bullying reports and depression was particularly strong. This also accords with previous empirical findings (e.g. Björkqvist et al, 1994a; Einarsen et al, 1998). The results of this study showed that bullying was often a chronic problem for those reporting it. That is, respondents who reported bullying at T1 were likely to experience bullying during the period between T1 and T2 (a period of 4 months). In

line with the study of Scottish hospital employees (see Ch. 5), the measure of negative affectivity (NA) also correlated strongly or moderately with the measures of anxiety, depression and psychosomatic complaints. Hence, there was a good reason to incorporate this factor in the multivariate analyses (e.g. the hierarchical regression models).

Patterns of bullying and health outcomes: the ANOVA findings

Results from the ANOVA tests showed that levels of anxiety, depression and psychosomatic complaints varied significantly between the three patterns of bullying experiences. In particular, the results suggested that chronic exposure to bullying or recent onset of bullying associated more strongly with anxiety, depression and psychosomatic complaints (assessed at T2) than remission of bullying. Since the onset pattern was identified concurrently with the health measures, this finding may not add much to the previous cross-sectional findings. However, the results pertaining to chronicity (bullying reported at T1 *and* T2 – reflecting exposure to bullying for 16 months or more) make a stronger case for the causal role of bullying in influencing later psychological and psychosomatic poor health. An interesting finding in this study was that respondents who only reported bullying at T1 (remission of bullying) showed similar levels of anxiety, depression and psychosomatic complaints as respondents who reported no bullying throughout the study. This finding accords with Rospenda et al's (2000) study of bullying and drinking outcomes. That is, in Rospenda et al's study, remission of

bullying (exposure to bullying at T1 only) was not associated with prospective measures of problem drinking (e.g. drinking variability, escape drinking). The implication of these findings is that transitory exposure to bullying does not necessarily result in psychological damage or adverse health habits. This inference is quite important and points to the need to distinguish between enduring and temporary exposure to hostile interactions and abuse at work.

Patterns of bullying and health outcomes: a more conservative approach

As noted above, the present regression analysis yielded the most conservative test of the effects of bullying patterns (chronicity, onset, and remission) on psychological health outcomes. The control variables used in the various regression models were prior psychological or psychosomatic health (T1 levels of anxiety, depression and psychosomatic complaints) and T1 negative affectivity. Unsurprisingly, these control variables explained a great proportion of the variance in anxiety, depression and psychosomatic complaints. A more important finding was that two of the patterns (onset and chronicity) added significantly to the prediction of anxiety and depression. Moreover, all the three patterns added to the prediction of psychosomatic complaints. Interestingly, the final regression model indicated that remission of bullying predicted *reduction* in psychosomatic complaints. This finding is important in the sense that exposure to bullying does not only seem to induce adverse health outcomes, but the ultimate absence or reduction

of bullying seems to alleviate somatic stress symptoms, such as frequent headaches and stomach problems.

The issue of causality

Strictly speaking, the issue of causality has not been solved in this study. In order to demonstrate causal relationships between bullying and poor psychological health three criteria must be met (see introduction). First, the study variables must co-vary. Secondly, the relationship must not be due to any other variable or set of variables. Thirdly, the supposed cause (exposure to bullying) must precede the supposed effect (poor psychological or psychosomatic health), as indicated by the change in cause occurring *no later* than the associated change in the effect. Of the three patterns of bullying examined (remission, onset and chronicity), only one pattern satisfied this third criterion – namely, the pattern of remission. As described in the method section, remission was constructed from T1 data only whilst chronicity was constructed from T1 and T2 data and onset derived entirely from T2 data. As noted above, remission of bullying did not predict T2 levels of anxiety and depression. However, this pattern successfully predicted T2 levels of psychosomatic complaints. Hence, for this particular outcome, there seemed to be a causal effect of bullying. However, this conclusion only holds if the second criterion (the criterion of non-spuriousness) is also met (see more about this issue below).

Potential moderating and mediating processes

Whilst the current study confirmed the simple relationship between bullying and psychological health outcomes, more prospective studies are needed to test the extent to which potential stress-moderating factors, such as personality, social support, and coping style exacerbate or ameliorate the bullying-outcome relationship. Previous cross-sectional studies suggest that personality factors such as generalised self-efficacy, self-esteem and social anxiety act as moderators in this relationship (Einarsen et al, 1996; Mikkelsen & Einarsen, 2001). Other possible moderators are hardiness (Kobasa, 1979) and dispositional optimism (Scheier & Carver, 1985). A few cross-sectional studies have also demonstrated the moderating effects of support at work (Einarsen et al, 1996; Quine, 1999; see also results reported in Ch. 5). However, the moderating role of coping styles (e.g. problem focused vs. emotion focused coping; see Lazarus & Folkman, 1984) is still unknown.

More studies are also needed to determine the affective and cognitive variables that may link workplace bullying with psychological health outcomes. Theory suggests that factors such as negative mood and irritation, feelings of fear and helplessness, anger and frustration, perceptions of injustice and damaged social identity may mediate the effects of workplace bullying on outcomes such as anxiety and depression (e.g. Anderson & Pearson, 1999; Barling, 1996; Barling et al, 2001; Dormann & Zapf, 2002; Lazarus & Folkman, 1984). The above

factors may also mediate the effects of bullying on other outcome variables, such as absenteeism, lowered productivity and intentions to leave the job. The relationship between bullying and outcomes such as depression may in fact be quite complex (see Dormann & Zapf, 2002). According to Dormann and Zapf, exposure to bullying and other social stressors are likely to give rise to irritation, which in turn leads to decrease in self-esteem and increase in anxiety. Increased anxiety is then expected to give rise to depressive symptoms. According to this same model, adopted from Mohr (1986, 1991), factors such as irritation and also anxiety and depression may give rise to psychosomatic stress symptoms. A model of this kind deserves attention in future empirical work.

Reverse causal hypotheses

In addition to testing the potential effects of bullying on psychological health, the present study examined the reversed effects of psychological and psychosomatic health problems on bullying incidents. Since the study was based on questionnaire data, the results obtained must be interpreted with caution. That is, the observed effects of psychological distress may be more relevant to perceptions of bullying than actual occurrence of mistreatment. However, the literature on stress emphasises that it is people's appraisal of stressful events that are more important than the events per se (see, for example, Lazarus & Folkman, 1984, pp. 22-94). The technique used to determine the effects of

psychological and psychosomatic problems (assessed at T1) on bullying incidents (assessed at T2) was binary logistic regression. Firstly, simple regression was used to determine the effects of anxiety, depression and psychosomatic complaints. Here, it was found that T1 anxiety and depression contributed to the prediction of bullying incidents at T2. Secondly, step-wise regression was used to test more thoroughly the reversed causation hypothesis. The control variables used in the step-wise regression models were prior exposure to bullying (T1 reports of bullying) and T1 negative affectivity. The result of these tests was that only one of the health measures added to the prediction of T2 reports of bullying. This was the T1 measure of depressive symptoms. Accordingly, the hypothesis of reversed causation was somewhat supported by the data. Again, it must be noted though that the above findings were based on questionnaire data, and may not entirely correspond to actual occurrence of bullying. With this in mind, several explanations regarding reversed causation can be proposed.

One possible explanation is that depressed individuals are more likely to lack resources to cope with social conflicts at work. They may focus on the personal relation, rather than the actual problem, which may then lead to conflict escalation (Glasl, 1994, cf. Dormann & Zapf, 2002; see also Quine, 1999). Research also suggests that people tend to respond more negatively to depressed individuals (e.g. Sacco, Dumont & Dow, 1993). Accordingly, one can assume that depressive or obsessive behaviour produces a negative reaction in a work group, which may lead

to bullying after some time (Zapf & Einarsen, 2003). In addition, Felson (1992) argues that depressed individuals may violate expectations, annoy others, perform less competently, and even violate social norms describing polite and friendly interactions, and hence elicit aggressive behaviour in others (see also Felson & Tedeschi, 1993). Similarly, Berkowitz (1989) suggests that any kind of negative affect, depression and irritability may produce aggressive inclinations. Aggressive behaviour may poison the social atmosphere at work, and thereby increase the risk of bullying incidents. Finally, it is possible that depressed individuals are more likely to be victimised because others perceive them as weak and incapable of retaliating effectively against unfair treatment (Einarsen & Raknes, 1997a; Quine, 1999). However, more studies are needed to test other possible models of causality. It is quite possible that the relationship between bullying and psychological poor health is more complex than indicated in this study. In fact, it is not unlikely that workplace bullying involves features of a vicious circle – namely, that depressive symptoms increase the risk of victimisation, and that bullying in itself induces more symptoms, which in turn increase the likelihood of more victimisation.

Methodological limitations

The present study had several methodological limitations. Firstly, the inherent nature of the survey method does not allow for objective assessment of bullying at work. Some critics may see this as a serious

limitation of the questionnaire method. However, the behaviours involved in bullying are frequently of a subtle and discrete nature (see, for example, results reported in Ch.'s 4 & 6) and are sometimes even exhibited in private (Einarsen, 1999; Neuberger, 1999). Therefore, they may not necessarily be observable to others, and hence objective assessment may not be viable. In addition, Einarsen et al (2003) note that the meaning and impact of a particular behaviour may only be known to the perpetrator and the recipient. Similarly, Hoel et al (1999) note that the fact that the parties have a past and future together must have a bearing on the perceptions and interpretations of the exhibited behaviours. The feature of imbalance in power is also more evident from the perspective of those experiencing a lack of power (Einarsen et al, 2003). Given all this, it is perhaps justifiable to use employee reports of bullying instead of more objective assessments of bullying (e.g. peer nominations, reports from external observers).

Despite the argument that employee reports of bullying are not necessarily problematic, it is important to note that reports of bullying may be systematically biased. Although the present study incorporated the factor of negative affectivity – a factor regarded as a potential source of response bias (e.g. Quine, 1999; Mikkelsen & Einarsen, 2001) – a number of other factors may play a similar role (e.g. social desirability, locus of control). Accordingly, it is possible that factors other than NA influence the relationships observed between bullying and psychological

health outcomes. The result of this is that one cannot be sure whether or not a causal interpretation of the above relationships is viable.

It is also questionable whether the time lag selected in the study (a time lag of 4 months) was appropriate to demonstrate effects among study variables. It is possible that shorter or longer time lags (e.g. 2 months versus 1 year) revealed stronger effects among the variables. Hence, there is a clear need for studies which systematically test the most adequate time lag for bullying to induce anxiety, depression and psychosomatic complaints. Given that the present study demonstrated a relationship between extended experiences of bullying (chronicity of bullying) and reduced psychological health, the above proposal can be implemented to examine duration over shorter and longer time spans.

Apart from the possibility of inappropriate time lag, a second reason for attenuated relationships between study variables is the healthy worker effect (see Waldron, Herold, Dunn & Staum, 1982). Because it is likely that workers who are seriously ill will stop working (or be on long-term sick leave), there is a restriction of range in the outcome variables (reflecting psychological and psychosomatic health). A similar effect occurs when a worker quits the job because he or she feels that the job is too stressful (Kessler, 1987). In fact, this particular effect is frequently seen as an obstacle in occupational stress research (see Zapf et al, 1996).

An additional limitation is the response rate achieved in the study (e.g. 31% at T1). It was not possible to compare respondents with non-respondents in terms of exposure to bullying. Neither was it possible to assess whether the final sample was biased in other respects. However, the initial response rate of 31% was not unexpected. Intuitively, this response rate reflects the use of a mailed questionnaire that focuses on highly sensitive personal information combined with identifiers for impending follow-up.

While this study suggests that persistent and ongoing exposure to bullying associates with psychological poor health, it may be argued that severe experiences of bullying in the past may also induce psychological and psychosomatic health problems. For example, a single experience of physical assault may lead to severe anxiety and depression. However, as noted by other researchers (e.g. Björkqvist, 1992; Leymann, 1990, 1996) severe forms of bullying rarely occur in the absence of milder forms of harassment. In other words, it is unlikely that isolated incidents of severe bullying were overlooked in this study.

Conclusion

In line with previous empirical work, the present study demonstrated a relationship between exposure to bullying at work and adverse health outcomes. The data reported here were prospective in nature, indicating

that recent onset and chronicity of bullying are predictive of psychological and psychosomatic health problems – even when prior health problems and negative affectivity are taken into account. Since onset of bullying was identified concurrently with the psychological health measures, this finding may not add much to previous cross-sectional findings – that is, in terms of causal inference.

However, the results pertaining to chronicity (bullying reported at T1 *and* T2 – reflecting exposure to bullying for 16 months or more) make a stronger case for the causal role of bullying in influencing later psychological and psychosomatic health problems. A third pattern of bullying – remission of bullying – was also predictive of psychosomatic complaints. Interestingly, this pattern predicted *reduction* in psychosomatic complaints. This finding is important in the sense that bullying at work does not only seem to induce adverse health outcomes, but the ultimate absence of bullying seems to alleviate somatic stress symptoms.

While the present study confirmed the simple relationship between bullying and psychological health outcomes, more prospective studies are needed to test the extent to which stress-moderating factors, such as personality, social support, and coping style exacerbate or ameliorate the bullying-outcome relationship. More studies are also needed to determine the affective and cognitive variables that may link workplace bullying with psychological health outcomes.

In addition to testing the potential effects of bullying on psychological health, the present study examined the reversed effects of psychological and psychosomatic problems on bullying incidents. The results of binary logistic regression indicated that depressive symptoms were predictive of bullying – even when prior exposure to bullying and negative affectivity was taken into account. Hence, the hypothesis of reversed causation was somewhat supported by the data. However, since the study was based on questionnaire data, the above finding must be interpreted with caution. That is, the observed effects of psychological distress may be more relevant to *perceptions* of bullying than actual occurrence of mistreatment.

In general, the present study does not allow for definite causal inferences. As in other areas of research, prospective studies can only be seen to point at causal relationships – causation *cannot* be proved in these studies. One of the problems faced in this study is that factors others than NA may influence reports of bullying and psychological health problems. That is, some external mechanisms may be responsible for the relationships observed between bullying and health outcomes. A second potential limitation of the study is the time lag of 4 months. It is possible that shorter or longer time lags revealed stronger effects among study variables. More studies are needed to systematically test the most adequate time lag to induce anxiety, depression and psychosomatic complaints.

CHAPTER 8

SUMMARY – IMPLICATIONS FOR THEORY AND RESEARCH – PRACTICAL ISSUES

The concept of bullying revisited

This thesis started with a thorough description of the bullying concept. The terminology for the concept is extensive. In the UK and Ireland the term bullying at work is normally used, whereas in Scandinavia and Germany the term mobbing is typically used. Still other terms, such as workplace harassment and emotional abuse are utilised in the US. Regardless of the label used, the concept refers to the situation when a person is persistently and over a period of time exposed to hostile and demeaning behaviours or acts at work (Björkqvist et al, 1994a; Einarsen et al, 1994b; Leymann, 1996; Rayner et al, 2002; Vartia, 1996). Specifically, bullying at work is about actions that are negative in nature, actions that may be carried out deliberately or unconsciously, but are likely to cause humiliation, offence and distress to the target person.

In contrast to concepts such as workplace aggression or violence, bullying at work is rarely about single and isolated events. Instead, it is about repeated and prolonged infringements of a worker's dignity and respect. In addition, bullying at work involves an imbalance in actual or perceived

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power between the perpetrator and the target. That is, the person on the receiving end of persistent negative acts usually feels unable to defend him or herself. An imbalance in power may arise from the formal relative positions of the two parties or from informal sources, such as previous experience, personal contacts and ability to influence others (Rayner et al, 2002).

Studies of prevalence rates: A brief summary

The prevalence of bullying has been studied in various work settings in Denmark, Sweden, Norway, Finland and the UK. In one of the opening chapters, the results from these countries were systematically reviewed. Given the divergence in definition and measurement of bullying, cross-cultural comparisons tend to be quite complex. However, the rates of bullying observed in the UK seem to be somewhat higher than the rates observed in Scandinavia (see prevalence findings in Ch. 2). The concept of power distance (Hofstede, 1980) and discrepancies in work-related values and attitudes may possibly help to explain this divergence in prevalence rates. Specifically, it may be theorised that lower levels of bullying in Scandinavian countries are due to more prevailing egalitarian and feminine-oriented values in these countries (see Einarsen, 2000, in conjunction with Hofstede, 1980; see also Ch. 2).

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Apart from cross-cultural variations in prevalence rates, there also seem to be variations between work sectors. For example, results from Sweden point to especially high levels of bullying in the health sector (Leymann, 1996). Results from other countries also point to high levels of bullying in the health and social sector (see Niedl, 1995; Quine, 1999; Vartia, 1993). Indeed, the results reported in this thesis suggest that workplace bullying is a critical problem in Scottish and Icelandic hospitals.

Bullying in the health sector: A summary of current prevalence findings

In the first study reported (a study of Scottish hospital staff; see Ch. 4), it was found that 48% of respondents reported experiencing one or more types of bullying acts in the past 12 months. This prevalence rate compared with a rate of 38% in an NHS community service (Quine, 1999) and a rate of 26.6% in an Austrian public hospital (Niedl, 1995). In the Scottish study, the categories of bullying most frequently reported were work-related bullying (e.g. undue pressure to produce work, shifting goalposts without telling the person) and personal derogation/isolation (e.g. excluding or ignoring the person). Importantly, the factor of negative affectivity (NA; a dispositional trait reflecting negative emotionality and cognitive style) did not have a strong influence on these reports. Apart from being asked about exposure to distinct bullying acts, respondents were asked whether they

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regarded themselves to have been bullied at work in the past 12 months. When this self-report measure of bullying was used, a prevalence of 27% was observed.

The above findings suggest that the two methods normally used to assess prevalence rates – namely, the operational method and the self-report method – yield highly divergent prevalence rates. Specifically, the operational method yielded a much higher prevalence rate (48%) than did the self-report method (27%). Importantly, two other studies have shown similar contrasts in prevalence rates (see Mikkelsen & Einarsen, 2001; Salin, 2001). Various reasons were proposed in the thesis to explain this divergence in prevalence data (see Ch. 4). First, it was proposed that operational criteria are less sensitive to variations in personal perceptions or vulnerability. Secondly, it was argued that operational criteria are less receptive to features such as imbalance of power. Thirdly, it was suggested that operational measures are less sensitive to cultural norms of acceptable and unacceptable work practices.

Because of the above reasons, it is possible that the operational method resulted in unrealistically high levels of bullying. However, the second possibility proposed was that self-report criteria produce certain degree of underreporting. That is, some respondents may not wish to label themselves as bullied, e.g. since the label implies weakness, passivity and

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failure. In any case, the self-report method seems to yield more conservative assessment of bullying than does the operational method.

A number of other findings were reported in Ch. 4. One important finding was that the number of bullying acts reported was to some extent linked to the duration of bullying episodes. That is, the data showed that respondents who reported somewhat extended episodes of bullying (4-6 months) experienced more bullying acts than respondents who reported brief episodes of bullying (1-3 months). In this respect, the present study supported the notion that bullying is an escalating conflict situation (see Björkqvist, 1992; Leymann, 1990). However, the number of acts reported did not increase (on average) after 6 months and onwards.

In the second study reported (a study of Icelandic hospital staff; see Ch. 6), the prevalence rate observed was somewhat lower than in Scotland. Yet, almost a third of respondents (28%) reported experiencing one or more types of bullying acts in the past 12 months. When using the self-report criterion, a prevalence of 13% was observed. That is, 13% of respondents regarded themselves to have been bullied at work in the past 12 months. Hence, the prevalence was again lower than in Scotland. However, the levels of bullying seemed to be higher in Iceland than in countries such as Denmark and Finland. For instance, in Kivimäki et al's (2000) study of

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Finnish hospital employees, 5% of respondents regarded themselves to have been bullied at work in the past 6 months.

In general, the current empirical findings suggest that the health sector is a high-risk setting in terms of bullying. In line with the study of Scottish hospital staff, the categories of bullying most frequently reported were work-related bullying (e.g. shifting goalposts without telling the person, withholding necessary information from the person) and personal derogation/isolation (e.g. excluding or ignoring the person). Again, the factor of negative affectivity (NA) had only a minor influence on these reports. Overall, the present findings accorded with the view that rational-appearing aggression and other forms of covert aggression are more frequently used in the workplace than are overt forms of aggression (Baron & Neuman, 1996; Björkqvist et al, 1992; see Ch. 1).

In the Icelandic study, an interesting link was also observed between self-reports of bullying and reports of distinct bullying acts. In the analyses conducted, the two groups compared were labelled “the bullied” group (respondents who reported bullying acts *and* regarded themselves to have been bullied) and the “non-bullied group” (respondents who reported bullying acts but *did not* regard themselves to have been bullied). The results showed that the group of bullied respondents were more likely to have experienced personal derogation and/or isolation than the group of

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non-bullied respondents. They were also more likely to report threats and verbal abuse, teasing and ridicule, and finally physical violence. However, the two groups were just as likely to report work-related bullying. A possible explanation for this finding is that acts such as withholding information and undue pressure to produce work are frequently regarded as “normal” work practices. Hence, many people may think of these acts as part of the work culture, and hence not signs of bullying.

In addition to the above findings, the study showed that “bullied” respondents reported more types of bullying acts than did the “non-bullied” respondents. This latter finding suggests that peoples’ perceptions of bullying are to some extent dependent on the number of acts experienced. A second interesting finding was that duration of bullying was to some extent related to the number of acts experienced. That is, in line with the Scottish study, the Icelandic data showed that respondents who reported somewhat extended episodes of bullying (4-6 months) experienced more bullying acts than respondents who reported brief episodes of bullying (1-3 months). Again however, the number of acts reported did not increase (on average) after 6 months and onwards.

The main limitation of the Icelandic study was the low response rate (a response rate of 31%). Because of the large proportion of non-respondents, it is unclear whether the observed prevalence rates reflected the actual

prevalence of bullying in the hospital trust. It is possible that people who actually experienced bullying were more inclined to respond to the study questionnaire, e.g. because of its personal relevance. However, the finding that more people reported having witnessed bullying at work (34%) than experienced bullying themselves (13%) indicates that the study sample was not biased in this way. On the other hand, it is possible that the prevalence was higher than the study indicates.

**Bullying and occupational health outcomes:
A summary of findings and implications for future research**

The study of Scottish hospital staff also focused on the relationship between bullying and occupational health outcomes (see Ch. 5). The outcomes assessed in the study were: anxiety, depression, general health status, sickness absence, increase in drinking and smoking, job satisfaction and propensity to leave. Since the study was based on self-report data, the factor of negative affectivity (NA) was also incorporated and systematically controlled for (see more about this issue in Ch. 5). The relationship between bullying and occupational health outcomes was mostly tested through analysis of covariance (ANCOVA).

The results showed that employees who had experienced bullying acts at work had higher levels of anxiety and depression than did other employees.

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They also reported more days off work for sickness and had poorer general health than other employees. In addition, they were less satisfied with their jobs and more likely to contemplate leaving.

These findings were in line with six of the study hypotheses (hypotheses 1 to 4 and 7 to 8; see Ch. 5) and replicated previous findings in the field (e.g. Einarsen & Raknes, 1991, 1997a; Hoel & Cooper, 2000; Quine, 1999, 2003; see also Ch. 3). Most importantly, the relationship between bullying and outcomes was observed, even when NA was controlled for. This is a critical finding, since several authors (e.g. Quine, 2001; Mikkelsen & Einarsen, 2001) have proposed that NA is likely to spuriously inflate the relationship between bullying and adverse occupational health outcomes.

Study hypotheses 5 and 6 were also supported by the data. These hypotheses focused on behavioural outcomes (increase in drinking and smoking), and the results showed that employees who reported one or more types of bullying acts were more likely to report increase in drinking or smoking in the past 12 months than other employees. Whilst the present study tested the direct relationship between bullying and increase in drinking and smoking behaviours, it is quite possible that adverse emotional states and other factors (e.g. lowered self-esteem) play a mediating role in these relationships. This particular issue deserves attention in future research.

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The study confirmed the hypothesis that a supportive work environment can act as a buffer, ameliorating the effects of bullying on job attitudes and psychological health (see Ch. 3). That is, the results showed that employees who reported one or more types of bullying acts, but experienced good support had lower scores on the scales measuring anxiety, depression and propensity to leave than did those who reported bullying, but experienced poor support. However, the second factor assessed in the study – generalised self-efficacy (GSE) – did not seem to play this protective role.

In contrast, studies of occupational stress have shown that people with a strong sense of self-efficacy show less psychological and physical strain in response to work stressors than those with a weak sense of self-efficacy (e.g. Jex & Bliese, 1999; Jimmieson, 2000). Therefore, the concept of self-efficacy deserves more examination in future research. Instead of using a general measure of self-efficacy, it may be valuable to use a more domain specific measure. For instance, a scale measuring a person's perceived abilities to cope with interpersonal conflicts and aggression at work.

Finally, the study confirmed the idea of “ripple effects” of bullying at work (see Ch. 3). That is, the results showed that observers of bullying had higher levels of anxiety and depression than non-observers. In addition, it

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was found that observers were less satisfied with their jobs and more inclined to leave their jobs than were non-observers. Although not tested directly in this study, it is quite plausible that the effects of bullying on observers result from negative cognitions and emotions, such as fear of being the next target and frustration over not being able to intervene.

Alternatively, it is possible that the observers' reduced well-being results from a generally hostile work environment. These issues merit attention in future empirical work. It may also be valuable to study a more extended "ripple effect". That is, the effect on those who share their life with people involved in bullying at work, such as partners, close relatives and friends. Anecdotal evidence (e.g. Adams, 1992a) suggests that this may be dramatic.

When interpreting the above findings, it is important to note that these findings were based on cross-sectional survey data. Accordingly, the relationships reported can be explained in several ways. One possibility is that bullying does indeed lead to lowered job satisfaction, increased levels of psychological distress and declined general health. However, a second possibility is that poor health status places the person at a more risk of being victimised. A third possibility is that bullying and adverse health outcomes are reciprocally related. In brief, the design of the study does not allow for inference about causal relationships.

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A second reason for caution is that all the data were based on self-reports. It is possible that response bias influenced the relationship between bullying and occupational health outcomes. However, several features of the study reduce the likelihood that the relationships observed were strictly spurious (see review of these features in Ch. 5, p. 168).

In the second study reported, a more meticulous approach was used to determine the relationship between bullying and psychological health outcomes (see study of Icelandic hospital staff, Ch. 7). That is, prospective panel data (*T1* and *T2* data) were used to assess the link between bullying and three health outcomes: anxiety, depression and psychosomatic complaints. It is generally accepted that prospective study designs are more suitable than cross-sectional designs to reveal causal relationships between study variables (see Menard, 1991). However, it is worth noting that prospective studies can only be seen to point at causal relationships – causation *cannot* be proved in these studies (see Zapf et al, 1996).

The prospective correlations observed in the study supported the correlations usually found in cross-sectional studies. That is, experiences of bullying (assessed at *T1*) correlated with increased levels of anxiety, depression and psychosomatic complaints (assessed at *T2*). Also in line with other findings, these correlations were moderately strong. Results from

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ANOVA tests showed that mean levels of anxiety, depression and psychosomatic complaints varied between three patterns of bullying experiences (chronicity, onset and remission). Namely, the tests showed that chronic exposure to bullying acts and recent onset of bullying associated more strongly with the T2 health measures (anxiety, depression, and psychosomatic complaints) than did remission of bullying.

A second method used to assess the relationship between bullying patterns and health outcomes (T2 levels of depression, anxiety and psychosomatic complaints) was hierarchical regression analysis. The regression method yielded a more conservative test of the health effects of bullying patterns (chronicity, onset and remission), since two critical variables (prior health status and negative affectivity) were routinely controlled for. That is, in the three regression models assessed, these variables were entered in a step prior to the three patterns of bullying.

This time, it was found that two of the patterns (chronicity and onset of bullying) added significantly to the prediction of T2 anxiety and depression. Moreover, all the three patterns (chronicity, onset and remission) added to the prediction of T2 psychosomatic complaints. The beta values observed suggested that chronicity and onset predicted increased levels of anxiety, depression and psychosomatic complaints. In contrast, the remission pattern predicted *reduced* levels of psychosomatic complaints.

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However, the issue of causality was not entirely solved in the Icelandic study. In order to demonstrate causal relationships between two variables, a criterion of time-order must be met (plus the criteria of co-variation and non-spuriousness; see Ch. 7). Of the three patterns of bullying examined (chronicity, remission, and onset), only one pattern – namely, the remission pattern – satisfied this criterion. Specifically, remission was the only pattern entirely based on T1 data (for more detail, see Ch. 7). In the study, remission of bullying did not predict T2 levels of anxiety and depression. However, this pattern successfully predicted T2 levels of psychosomatic complaints. Hence, for this particular outcome, the study pointed to causal effects of bullying at work. In order to demonstrate other effects of bullying on health, more prospective studies are requested.

In addition to testing the effects of bullying patterns on psychological and psychosomatic health, the Icelandic study examined the reversed effects of poor psychological health on bullying experiences. The method used in this part of the study was binary logistic regression. Firstly a simple regression was carried out, and secondly a step-wise regression was conducted (T1 exposure to bullying and negative activity entered in a step prior to the T1 health measures). The step-wise regression models suggested that symptoms of depression (assessed at T1) predicted later reports of bullying at work (assessed at T2). However, similar effects of anxiety and psychosomatic complaints were not observed. When interpreting above

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finding (regarding the impact of depression) it is important to note that the criterion variable (exposure to bullying at T2) may be more pertinent to *perceptions* of bullying than actual occurrence of mistreatment. However, the literature on stress emphasises that it is people's appraisal of stressful events that are more important than the events per se (Lazarus & Folkman, 1984, pp. 22-94). The reasons why depressed people may be more likely to experience bullying at work are thoroughly addressed in Ch. 7.

As the study reported in Ch. 5, the Icelandic study had several methodological limitations. Since the study was also based on questionnaire data, it is possible that reports of bullying were systematically biased. Similarly, it is possible that the measures of psychological health were biased. Although the factor of NA was incorporated in most analyses, some other factors (e.g. social desirability) may induce systematic response bias. It is also questionable whether the time lag selected in the study – a time lag of 4 months – was appropriate to demonstrate real effects among study variables. As noted in Ch. 7, it is possible that shorter or longer time lags (e.g. 2 months vs. 1 year) revealed stronger effects among the variables. This is an issue worth studying in future research. An additional limitation is the low response rate achieved in the study. However, a response rate of 31% may not be surprising, given the nature and design of the study – namely, the use of a mailed questionnaire that focused on

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highly personal information combined with identifiers for impending follow-up.

While the Icelandic study tested the relationship between bullying and health outcomes, more prospective studies are needed to test the extent to which potential stress-moderating factors, such as personality, social support, and coping style exacerbate or ameliorate the bullying-outcome relationship. Some of the factors that have been included in cross-sectional studies are: generalised self-efficacy (GSE), self-esteem and social anxiety. Cross-sectional studies have also confirmed the moderating role of support at work (see also results in Ch. 5). However, the moderating role of coping styles (e.g. problem focused vs. emotion focused coping) is still unknown.

More studies are also needed to determine the affective and cognitive variables that may link workplace bullying with psychological health outcomes. In the current thesis, the factors proposed to play this mediating role were negative mood and irritation, feelings of fear and helplessness, anger and frustration, perceptions of injustice and damaged social identity. These factors may also mediate the effects of bullying on other outcome variables, such as absenteeism, lowered productivity and intentions to leave the job.

Bullying and health outcomes: Causal interpretation

In one of the opening chapters, it was noted that one of the project's unique features is the in-depth analysis of the link between bullying and occupational health outcomes (see final section in Ch. 3). When looking at other projects in the field, it is usually assumed that bullying at work leads to negative job affect and adverse health outcomes. What makes the current project important is that more complex mechanisms, for instance reverse causal mechanisms, were detected. Certainly, it is reasonable to assume that bullying at work has various adverse effects on employees' health and well-being. This may especially be the case when the bullying is a relentless and chronic situation. Yet, other mechanisms must also be taken into account. This is particularly important when it comes to preventive actions. That is, actions and strategies selected to prevent bullying and harassment at work. The current findings suggest that depressed individuals are especially vulnerable when it comes to bullying and mistreatment at work. Later in the chapter, the issue of preventive measures will be addressed in more detail (see recommendations for practitioners). Apart from this, it is important to consider more complex explanations for the relationship observed between bullying and health outcomes. In the end, it is not unlikely that the relationship between bullying and health outcomes is highly dynamic – for instance, that depressive symptoms increase the risk of

victimisation, and that bullying in itself induces more symptoms, which in turn increase the risk of more victimisation.

Alternative ways of studying bullying at work

The methodology used in the current project was selected from a range of possible methodologies. At this point, it is important to consider the alternative ways of studying bullying at work – for instance, if the current project was to be re-conducted. Since the project focused on prevalence rates the questionnaire method was probably the most appropriate method (examples of alternative methods are: interviews and individual case studies).¹ Yet, the kind of measurement used in the project was not necessarily the best possible. This remark does especially apply to the 21-item bullying scale. The data obtained through the scale was dichotomous in nature (see description of the scale and manipulation of scores in Ch's 4 and 6). Perhaps, a more advantageous approach is to employ an interval scale to assess prevalence rates. For example, employees may be asked to indicate on a five-point Likert scale how frequently they are exposed to the distinct bullying acts. Through this method, the researcher is able to identify those who are bullied on a regular basis (e.g. several times a week or daily)

¹ In order to adequately test prevalence rates, a rather large sample is needed. The main advantage of the questionnaire method (compared to other methods, e.g. in-depth interviews) is that one can collect large amounts of data in a relatively short time period (see Cowie et al, 2002).

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and those who are occasionally or rarely bullied. According to some theorists (e.g. Leymann, 1996), the concept of bullying should only apply to those who report daily or weekly exposure to bullying acts at work. Yet, other theorists (e.g. Einarsen & Raknes, 1997a) suggest that occasional exposure should also be taken into account. In any case, a rating scale offers a more thorough analysis of prevalence rates.

Also, the Likert scale offers the possibility to assess various aspects of the bullying concept (see description of these aspects in Ch. 1). Apart from the feature of frequency, the scale may be used to assess features such as duration of bullying and reaction of the target. That is, workers who report exposure to bullying acts may be asked about the duration of these acts (e.g. less than six months, between 6 and 12 months, between 1 and 2 years, and more than 2 years) and also about their perceived severity or impact (e.g. the degree of humiliation, offence or distress experienced). This time, the scale enables the researcher to distinguish those who report extended exposure to bullying acts (e.g. between 1 and 2 years or more than 2 years) or strong reaction to acts (e.g. great humiliation or offence) and those who report short-term exposure to bullying acts or slight reaction to acts.

Whether the scale is used to assess frequency, duration or experiences of individual acts, it may ultimately help to assess more precisely the

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relationship between bullying and occupational health outcomes. For instance, it may help to test whether frequent exposure to negative acts associates more strongly with adverse outcomes (e.g. anxiety, depression and negative job attitudes) than infrequent exposure to acts. Similarly, it may help to test whether extended exposure (or severe reaction) to acts correlates more strongly with adverse outcomes than short-term exposure (or mild reaction) to acts.

In spite of the arguments made in this section, it was interesting to see (in the current project) that a dichotomous measure of bullying at work was significantly related to a wide range of occupational health outcomes (for review, see Ch. 5; see also summary of findings in this chapter). This suggests that a nominal measure of bullying at work is far from being unconstructive. Still, when it comes to re-conducting a project of this kind, it is certainly important to consider alternative (and perhaps more productive) ways of studying the subject matter.

Bullying in the hospital setting: A final inference

In conclusion, the studies reported in this thesis indicate that high levels of bullying and mistreatment are part of many employees' perceptions and experiences. Indeed, the results from the Scottish and Icelandic study support the notion that the health sector is a high-risk setting in terms of bullying. The results from the two studies also indicate that bullying at work may have serious effects on those experiencing it. The results from the Scottish study showed that reports of bullying associated with a wide range of adverse health outcomes (e.g. anxiety, depression, declined health status). In addition, the results suggest that the organisation itself may also suffer from the problem of workplace bullying (e.g. due to lowered job satisfaction, increased absenteeism). Finally, the Icelandic study suggests that bullying at work may adversely influence people's psychological and psychosomatic health.

Several European countries, including Great Britain, Sweden, Norway and Finland have implemented general preventive actions against workplace bullying (Quine, 1999; Vartia, 1996). In view of the findings reported in this thesis, a reduction of the problem is not only likely to help individual employees. It is also likely to bring benefits to the organisation. In recent years, several authors have produced useful guidelines for possible preventive actions and intervention strategies (Einarsen et al, 1994b;

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Hubert, 2003; Ishmael, 1999; Rayner et al, 2002; Richards & Daley, 2003). The findings reported in this thesis may also point to important intervention measures. To complete the thesis, several suggestions will be made. It is the authors' hope that these recommendations can help practitioners (e.g. occupational health psychologists, counsellors, human resources managers) to reduce and even overcome the problem of bullying at work. Of course these suggestions need thorough testing, preferably through systematic intervention studies. As in all other disciplines, good intervention programmes are based on comprehensive and reliable studies, showing the best ways of tackling the problem of bullying and harassment at work.

How to reduce the levels of bullying in hospitals: Recommendations

Aspects of the work culture

In order to reduce the levels of workplace bullying, the practitioner must look into the norms that influence every day social interaction at work. One must realise that bullying can only prosper when it is condoned (and even encouraged) by managers and others working in the hospital sphere. In the two studies reported (see Ch. 4 & 6), it was found that work-related abuse was highly prevalent. The results reported in Ch. 6 also suggested that

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hospital employees do not necessarily identify work-related abuse with bullying (see more about this in the summary of prevalence findings). Perhaps it may be argued that work-related harassment is simply seen as a normal part of the work culture. If this is the case, all employees must be informed that work-related abuse (in any form) is not to be accepted. Whilst this is an important step, it may also be useful to conduct additional surveys, e.g. surveys that focus on the employees' views and opinions about daily social interactions. These additional surveys may inform the practitioner about various aspects of the work culture and also every day work practices. Indeed, changes in work practices may be necessary, e.g. if role and command structures are unclear or if requirements for co-operation are unnecessarily high (see more about this issue in Ch. 6).

Leadership and management styles

Leadership and management styles play a vital part in creating the right climate for the prevention of bullying and harassment. In order to tackle bullying and mistreatment, managers and immediate supervisors must critically examine their own practices, which may contribute directly or indirectly to the problem. For instance, managers must realise that ignorance and failure to recognise and intervene in bullying incidents may indirectly contribute to bullying. That is, managers who fail to intervene are indirectly sending out the message that bullying at work is acceptable.

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Hence, instead of neglecting the problem, managers must play an active role in discouraging negative interaction at work. For instance, they must overtly express the view that bullying at work is not to be accepted. They must also act as good role models (e.g. show other people consideration and respect).

As noted in this thesis, managers are quite frequently reported as perpetrators of bullying (see Ch. 2; see also empirical findings in Ch's 4 & 6). It is not unlikely that some leadership and management styles are themselves forms of bullying (e.g. the autocratic style of management). If this is the case, it is extremely important to encourage managers to scrutinise their own behaviour and (if necessary) to alter their usual management styles. Managers should also be offered training in these matters, i.e. guidance in good managerial skills. As regards daily social interactions, managers must realise the importance of treating all staff with dignity and respect. In general, managers must adopt management styles based on qualities such as integrity and consideration for the needs of the individual and the group.

The social work environment

When dealing with bullying at work, practitioners must thoroughly assess various features of the social work environment. It must be noted that this

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issue is highly related to the issues already discussed – that is, the issues of work culture and leadership behaviour. The social climate should be assessed in terms of daily social interactions, the everyday stress levels, and daily management practices. It is reasonable to assume that bullying is less likely to take place if the climate entails the following features:

- A high level of trust and support exists at all levels in the organisation.
- Unhealthy stress levels (due to unrealistic work demands, ambiguous work roles etc.) are low.
- The climate is warm and friendly (e.g. a climate reflecting tolerance and mutual help).
- The behaviour of managers and leaders is appropriate and reflects care on behalf of all staff.
- Conflict is discussed openly and resolved speedily.

As regards the first feature (levels of trust and support), the study reported in this thesis showed that support at work may not only reduce levels of bullying – it may also act as a crucial buffer, ameliorating the (potentially) detrimental effects of bullying (see results reported in Ch. 5). For instance, employees who experience bullying at work but receive (at the same time) good support may be more able to cope with the bullying, and hence less likely to feel anxious and depressed. These same individuals may also be

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more able to deal with their daily work routine and, hence may be more inclined to stay in their job.

Policy issues

As already noted, results reported in this thesis suggest that bullying is highly prevalent in hospitals. In order to curb these high levels of bullying, it may not suffice to modify the existing culture and work climate. Indeed, it may also be necessary to develop and implement a policy on the issue. That is, a policy stating that bullying and harassment at work is not to be tolerated. Accompanying procedures may also be needed, e.g. safe and effective grievance procedures. Certainly, the organisation must adopt the view that bullying is an issue that can be dealt with. In addition, the contents of a policy must be properly disseminated. That is, all members of staff must be thoroughly informed about the organisation's stance on bullying at work.²

Whilst a bullying policy may help to reduce levels of bullying, it may serve an additional purpose – namely, to bring about changes in existing cultural values and norms. Specifically, a policy can describe the expected organisational culture and cover the most important values of this desirable culture (e.g. respect, helpfulness and tolerance). A policy can also cover

² For more information regarding policy issues, see Richards & Daley (2003) and Ishmael (1999).

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other important issues, such as desired leadership behaviour and management styles.

Awareness-raising

So as to really tackle the problem of bullying at work, practitioners must realise the importance of thorough education and training. In all organisations, employees must be thoroughly informed about the problem and made aware of possible remedial actions. Workers who experience bullying may not necessarily identify it as such and workers who bully others may not always be aware of how their behaviour appears to others. This lack of awareness must certainly be overcome. That is, through systematic training, employees must be informed about the nature of the problem and also about the possible causes and effects of bullying at work. In addition, they must be trained in areas such as how to report bullying incidents and how to seek professional help and support.

In the two studies reported in this thesis, it is possible that divergence in prevalence rates (see Ch's 4 & 6) was partly due to lack of awareness. If this was the case, it certainly gives hospital authorities a reason to implement effective education and training programmes. Apart from organised training sessions, employees can be educated about bullying through mediums such as brochures and local news letters.

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Support at the individual level

Whilst modification of culture and climate, creation of a policy and thorough education may reduce levels of bullying, one additional approach may be necessary – namely, support to individual employees. Whilst there is some disagreement whether individual traits and states increase the risk of bullying (see Zapf & Einarsen, 2003), the results reported in this thesis suggest that depressed individuals are somewhat more likely than other employees to experience bullying at work (see Ch. 7). In the thesis, various reasons were also proposed to explain this relationship between bullying and depression. For instance, it was proposed that depressed individuals may lack resources to cope efficiently with social conflicts at work. In addition, it was proposed that depressed individuals may be selected as targets, since others perceive them as weak and unable to retaliate against unfair treatment. A third explanation offered was that depressed individuals may be more likely to violate expectations, annoy others and even violate social norms describing polite and friendly interactions. Finally, it was suggested that people generally tend to respond negatively to depressed individuals. For instance, people may be less tolerant to people who are low on self-esteem and show various signs of negative affect.

In view of the first explanation, it seems essential to help depressed individuals to cope adequately with everyday social conflicts. This is

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important since occasional conflicts take place in all work settings. The organisation may offer depressed individuals (and other groups of employees, e.g. employees low on self-esteem) special training in conflict management skills. The training may be organised by professional counsellors or occupational health therapists. Depressed individuals may also need more general support and training. For instance, special training sessions may be used to help them to enhance their social competence and skills in social interactions. If successful, these training programmes may reduce the likelihood that depressed individuals are regarded as weak and deserving targets of bullying and mistreatment. Of course, there is also a good reason to implement programs to help depressed individuals to overcome their emotional health problems. This may be accomplished through organised group meetings or individual based counselling.

So far, the focus has been on the individual employee. Yet, there is also a reason to focus on other people in the work group. Specifically, there is a need to inform all members of staff about emotional problems, such as anxiety and depression. Special education programmes may be implemented to inform people about the symptoms of depression and also about the way depressive symptoms affect a person's daily functioning. It is not unlikely that lack of awareness plays a big role in people's attitudes and behaviours towards depressed individuals. Through systematic training,

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people may learn to treat depressed individuals with more tolerance and respect. An expected outcome of this is that levels of bullying diminish.

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APPENDIX I

**A Survey Study in a Scottish Hospital Trust:
The Covering Letter**

The Hospital Trust has asked us to conduct a survey among all employees on the prevalence of bullying and its effects on staff. This is an opportunity to tell us about your experiences and make your views known. The results of the survey, which will be presented in a report next year, will help the Trust to carry out its commitment to tackle the issues you show are important.

Please be assured that the information you provide will be treated confidentially. Your answers will be anonymous and **no-one** in the Trust will see your questionnaire. You should not put your name anywhere on the questionnaire. At the time you return your questionnaire, please also return to us the enclosed postcard, signed, to tell us that you have posted the questionnaire back to us. This will enable us to chase up and remind people who have not yet responded.

When answering the questions please tick the answer that comes closest to your own opinion or applies to you. Please be as frank as you can with your answers. The questionnaire should take about thirty minutes to complete.

When completed, please return the questionnaire to Dr Lyn Quine, Reader in Health Psychology, Centre for Research in Health Behaviour, Department of Psychology, Keynes College, The University, Canterbury, Kent, CT2 7NP.

Please take part and give us your views. If you have any queries about this survey please contact Lyn Quine on 01227 823078. We shall be happy to answer your questions.

APPENDIX II

**A Survey Study in a Scottish Hospital Trust:
The Questionnaire**

SECTION 1: SOME QUESTIONS ABOUT YOUR JOB

1. Please indicate your professional group:

- 1 Nurse/midwife: qualified
- 2 Nurse: unqualified
- 3 Outpatient assistant
- 4 Doctor: junior (e.g. house officer, senior house officer, specialist registrar, senior registrar)
- 5 Doctor: career grade (e.g. staff grade, associate specialist, consultant)
- 6 Administrative and clerical
- 7 Ancillary and maintenance (e.g. laundry worker, cleaner, catering staff, porter, works staff)
- 8 Professions allied to medicine (e.g. radiographer, physiotherapist, occupational therapist, dietician)
- 9 Technical staff (e.g. laboratory staff, dental technician)
- 10 Scientific and professional (e.g. clinical scientist, pharmacist)
- 11 Manager
- 12 Other (please specify): _____

2. Are you employed

- 1 Full-time
- 2 Part-time

The following questions have been designed to assess how satisfied you are with your job. For each question please circle the number that most closely applies to you.

3. All in all, how satisfied would you say you are with your job?

- 1 Very satisfied
- 2 Somewhat satisfied
- 3 Not very satisfied
- 4 Not at all satisfied

4. If you were free to go into any type of job you wanted, what would your choice be?
 - 1 Would want the job you have now
 - 2 Would want to retire and not work at all
 - 3 Would prefer some other job to the job you have right now

5. Knowing what you know now, if you had to decide all over again whether to take the job you now have, what would you decide?
 - 1 Decide without hesitation to take the same job
 - 2 Have some second thoughts
 - 3 Decide definitely not to take the same job

6. In general, how well would you say that the job measures up to the sort of job that you wanted when you took it?
 - 1 Very much like the job you wanted
 - 2 Somewhat like the job you wanted
 - 3 Not very much like the job you wanted

7. If a good friend of yours told you he or she was interested in working in a job like yours for your employer, what would you tell him or her?
 - 1 Would strongly recommend it
 - 2 Would have doubts about recommending it
 - 3 Would advise the friend against it

8. How concerned would you be if you had to take some other form of employment?
 - 1 Not at all concerned
 - 2 Not concerned
 - 3 Unsure
 - 4 Concerned
 - 5 Very concerned

9. How likely is it that you will actively look for a new job in the next year?

- | | |
|--------------------|----------------------|
| 1 Extremely likely | 4 Quite unlikely |
| 2 Quite likely | 5 Extremely unlikely |
| 3 Unsure, maybe | |

10. How often do you think about leaving your job?

- | | |
|-----------------------|----------|
| 1 Nearly all the time | 4 Rarely |
| 2 Rather often | 5 Never |
| 3 Sometimes | |

11. Now we want to ask you some questions about support at work. This refers to overall levels of helpful social interaction available while doing the job from colleagues and line managers/supervisors. Please circle the number that best reflects your feelings about support at work.

	Never	Seldom	Some-times	Often
1. I get help and support from my colleagues	1	2	3	4
2. My colleagues are willing to listen to my work-related problems	1	2	3	4
3. I get help and support from my supervisor/line manager/ team leader	1	2	3	4
4. My supervisor/line manager/team leader is willing to listen to my problems	1	2	3	4
5. I get sufficient information from my line management	1	2	3	4
6. I get consistent information from my line management	1	2	3	4
7. I feel adequately supported by my colleagues	1	2	3	4
8. I feel adequately supported by my line management	1	2	3	4
9. Overall, I feel that I work in a supportive environment	1	2	3	4

SECTION 2: HEALTH

1. How would you describe your health?

- | | |
|--------------|-------------|
| 1 Very poor | 4 Good |
| 2 Poor | 5 Very good |
| 3 In between | |

2. How many days have you had off work for illness in the last 12 months?

(Please estimate:) _____

3. Please read each item and circle the reply that comes closest to how you have been feeling in general in the last few weeks.

1. I feel tense or 'wound up'

- | | | | |
|---------------------|----------------------|------------------------------------|---------------|
| Most of
the time | A lot of
the time | From time to time,
occasionally | Not at
all |
| 1 | 2 | 3 | 4 |

2. I still enjoy the things I used to enjoy

- | | | | |
|-----------------------|----------------------|------------------|------------------|
| Definitely
as much | Not quite
so much | Only
a little | Hardly
at all |
| 1 | 2 | 3 | 4 |

3. I get a sort of frightened feeling as if something awful is about to happen

- | | | | |
|------------------------------------|---------------------------|--------------------------------------|---------------|
| Very definitely
and quite badly | Yes, but not
too badly | A little, but
it doesn't worry me | Not at
all |
| 1 | 2 | 3 | 4 |

4. I can laugh and see the funny side of things

As much as I always could	Not quite so much now	Definitely not so much now	Not at all
1	2	3	4

5. Worrying thoughts go through my mind

A great deal of the time	A lot of the time	From time to time but not too often	Only occasionally
1	2	3	4

6. I feel cheerful

Not at all	Not often	Sometimes	Most of the time
1	2	3	4

7. I can sit at ease and feel relaxed

Definitely	Usually	Not often	Not at all
1	2	3	4

8. I feel as if I am slowed down

Nearly all the time	Very often	Sometimes	Not at all
1	2	3	4

9. I get a sort of frightened feeling like 'butterflies' in the stomach

Not at all	Occasionally	Quite often	Very often
1	2	3	4

10. I have lost interest in my appearance

Definitely	I don't take as much care as I should	I don't take quite as much care	I take just as much care as ever
1	2	3	4

11. I feel restless as if I have to be on the move

Very much indeed	Quite a lot	Not very much	Not at all
1	2	3	4

12. I look forward with enjoyment to things

As much as I ever did	Rather less than I used to	Definitely less than I used to	Hardly at all
1	2	3	4

13. I get sudden feelings of panic

Very often indeed	Quite often	Not very often	Not at all
1	2	3	4

14. I can enjoy a good book or radio or TV programme

Often	Sometimes	Not often	Very seldom
1	2	3	4

4. The questions below refer to your feelings and emotions. Please read each statement and then circle the number that best reflects your response.

	Disagree strongly	Disagree	Disagree slightly	Agree slightly	Agree	Agree strongly
1. After an embarrassing experience I worry about it for days	1	2	3	4	5	6
2. I know that things will continually improve in my life	1	2	3	4	5	6
3. I feel that I have a great deal to be proud of	1	2	3	4	5	6
4. I often feel restless and jittery for no apparent reason	1	2	3	4	5	6

	Disagree strongly	Disagree	Disagree slightly	Agree slightly	Agree	Agree strongly
5. Things rarely work out the way I want them to	1	2	3	4	5	6
6. I am not as well liked as most other people	1	2	3	4	5	6
7. Every day seems exciting, new, and different	1	2	3	4	5	6
8. My feelings are more easily hurt than most other people's	1	2	3	4	5	6
9. I can easily concentrate on things for as long as I like	1	2	3	4	5	6
10. Whenever someone criticises me I think about it for days	1	2	3	4	5	6
11. I am hopeful and optimistic about the future	1	2	3	4	5	6
12. When things go wrong I blame myself	1	2	3	4	5	6
13. I rarely lose sleep over worrying about something	1	2	3	4	5	6
14. I am a person of worth, at least as good as other people	1	2	3	4	5	6
15. I always expect the worst to happen	1	2	3	4	5	6
16. I am more content and happy than most other people	1	2	3	4	5	6
17. Happy endings only occur in films and in fairy tales	1	2	3	4	5	6
18. I am not as self-confident as most other people	1	2	3	4	5	6
19. When I meet people for the first time I am tense and uptight	1	2	3	4	5	6
20. If I could live my life again I would do many things differently	1	2	3	4	5	6
21. The future seems rather bleak and unpromising	1	2	3	4	5	6

SECTION 3: BULLYING AT WORK

In this section we would like to ask some questions about harassment and bullying at work. **Workplace bullying** constitutes 'persistent, offensive, abusive, intimidating, malicious or insulting behaviour, abuse of power or unfair penal sanctions, which makes the recipient feel upset, threatened, humiliated or vulnerable, which undermines their self-confidence and which may cause them to suffer stress'.

1. In the past 12 months, have you experienced the following behaviours in the workplace from peers, senior staff, or managers?

1.	Persistent unjustified criticism or monitoring of your performance	Yes	No
2.	Persistent teasing	Yes	No
3.	Persistent attempts to belittle and undermine your work	Yes	No
4.	Persistent attempts to demoralise you	Yes	No
5.	Persistent attempts to humiliate you in front of colleagues	Yes	No
6.	Destructive innuendo and sarcasm	Yes	No
7.	Undue pressure to produce work	Yes	No
8.	Intimidatory use of discipline/competence procedures	Yes	No
9.	Shifting of goalposts without telling you	Yes	No
10.	Making inappropriate jokes about you	Yes	No
11.	Undermining your personal integrity	Yes	No
12.	Verbal and non-verbal threats	Yes	No
13.	Removal of areas of responsibility without consultation	Yes	No
14.	Violence to property	Yes	No
15.	Physical violence	Yes	No
16.	Setting of impossible deadlines	Yes	No
17.	Withholding necessary information from you	Yes	No
18.	Constant undervaluing of your efforts	Yes	No
19.	Freezing you out/ignoring you/excluding you	Yes	No

20.	Unreasonable refusal of applications for leave, training, or promotion	Yes	No
21.	Malicious rumours/allegations spread about you	Yes	No
22.	Unwelcome sexual advances	Yes	No
23.	Unfounded threats about your job security	Yes	No
24.	Discrimination on racial, gender, or disability grounds	Yes	No
25.	Displays of open hostility towards you	Yes	No
26.	Use of abuse, swearwords, and obscenities	Yes	No

2. According to the definition given above, do you consider yourself to have been subjected to workplace bullying **from peers, senior staff, or managers** at any time **during the last twelve months**?

- | | |
|----------|---------------|
| 1 Never | 3 A few times |
| 2 Rarely | 4 Frequently |

3. Have you witnessed **work colleagues** being subjected to workplace bullying **from peers, senior staff, or managers** during **the last twelve months**?

- | | |
|----------------|--------------|
| 1 Never | 3 Frequently |
| 2 Occasionally | |

If you answered 'Never' to question 2, please go to Section 4.

4. If you have been bullied, for how long a period did it last/has it lasted?

- | | |
|--------------|---------------|
| 1 1-3 months | 3 7-12 months |
| 2 4-6 months | |

5. Are you currently suffering bullying?

- | | |
|-------|------|
| 1 Yes | 2 No |
|-------|------|

6. If you have been bullied in the last 12 months, please briefly describe a recent incident.

7. In this incident, who subjected you to the bullying?

- 1 Colleagues in your own work group
- 2 People outside your own work group
- 3 Your immediate supervisor/line manager/team leader
- 4 A senior manager
- 5 Other

8. Was the person involved in the bullying

- 1 Male
- 2 Female

9. Was the person

- 1 The same sex as you
- 2 The opposite sex

10. Was the person

- 1 Older than you
- 2 About the same age as you
- 3 Younger than you

11. Were you bullied as part of a group, or were you singled out personally?

- 1 Singled out
- 2 Bullied as part of a group

12. Did you try to do something about the bullying when it occurred?

1 Yes

2 No

If no, please go to Section 4.

If yes, did you

Ignore the bully?	Yes	No
Ask for a transfer?	Yes	No
Confront the bully/ask them to stop?	Yes	No
Threaten to tell others?	Yes	No
Talk to a friend or colleague?	Yes	No
Report it to Personnel?	Yes	No
Report it to your line manager?	Yes	No
Report it to your union representative?	Yes	No
Make a formal complaint?	Yes	No
Take some other action?	Yes	No
(Please specify:)	_____	

13. Do you feel that a satisfactory outcome was reached?

1 Yes

2 No

3 Uncertain

SECTION 4: PERSONAL RESOURCES

The following questions refer to your personal resources.

1. For each of the following statements, please circle the number that best reflects your response.

	Not at all true	Barely true	Moderat ely true	Exactly true
1. I can always manage to solve difficult problems if I try hard enough	1	2	3	4
2. If someone opposes me, I can find ways and means to get what I want	1	2	3	4
3. It is easy for me to stick to my aims and accomplish my goals	1	2	3	4
4. I am confident that I could deal efficiently with unexpected events	1	2	3	4
5. Thanks to my resourcefulness, I know how to handle unforeseen situations	1	2	3	4
6. I can solve most problems if I invest the necessary effort	1	2	3	4
7. I can remain calm when facing difficulties because I can rely on my coping abilities	1	2	3	4
8. When I am confronted with a problem, I can usually find several solutions	1	2	3	4
9. If I am in a bind, I can usually think of something to do	1	2	3	4
10. No matter what comes my way, I'm usually able to handle it	1	2	3	4

SECTION 5: SOME DETAILS ABOUT YOU

Now some background information about you.

1. Are you
 - 1 Male
 - 2 Female

2. What is your age? (Please write in:) _____

3. Over the past year, which of the following best describes your typical drinking habits? (One drink is a single whisky, gin, or brandy, a glass of wine, sherry, or port, or a half pint of beer)
 - 1 Teetotal
 - 2 An occasional drink
 - 3 Several drinks a week, but not every day
 - 4 Regularly, 1 or 2 drinks a day
 - 5 Regularly, 3 to 6 drinks a day
 - 6 Regularly, more than 6 drinks a day

4. If you are not teetotal, has the quantity of alcohol consumed increased or decreased over the past year?
 - 1 Increased substantially
 - 2 Increased
 - 3 Remained the same
 - 4 Decreased
 - 5 Decreased substantially
 - 6 Stopped
 - 7 I don't drink

5. Re cigarette smoking, which of the following statements is most nearly true of you?
 - 1 I have never smoked
 - 2 I have given up smoking
 - 3 I am currently smoking

6. If you are currently smoking, please circle the number that constitutes your average daily consumption of cigarettes.

- | | |
|---------------|-----------------|
| 1 0-5 a day | 5 20-30 a day |
| 2 5-10 a day | 6 30-40 a day |
| 3 10-15 a day | 7 40 plus a day |
| 4 15-20 a day | 8 I don't smoke |

7. If you are a smoker, has the quantity smoked increased or decreased over the past year?

- | | |
|---------------------------|---------------------------|
| 1 Increased substantially | 5 Decreased substantially |
| 2 Increased | 6 Stopped |
| 3 Remained the same | 7 I don't smoke |
| 4 Decreased | |

This is the end of the questionnaire. Thank you very much for your help. If there are any comments you would like to make, please write them below.

**PLEASE RETURN THE QUESTIONNAIRE AS SOON AS POSSIBLE
IN THE ENVELOPE PROVIDED**

APPENDIX III

**A Survey Study in an Icelandic Hospital Trust:
The T1 Covering Letter**

Bullying at work: A survey study among Icelandic hospital staff

This survey study is part of a research project carried out by researchers at the University of Kent at Canterbury (UKC). The person in charge of the project is Brynja Bragadóttir, a PhD student in health psychology at the UKC.

The theme of the survey is bullying in the workplace. The two issues addressed in the study are: (1) the prevalence of bullying in the hospital, and (2) the effects of workplace bullying on staff.

The questionnaire has been sent to a random sample of 2,460 staff members. The study sample was generated in such a way that all staff had an equal chance of being selected. You were one of those selected.

Please be aware that your reply is very important to us. The general success of the study depends on the good will and cooperation of those asked to take part.

The questionnaire should take about fifteen minutes to complete. When answering the questions, please tick the answers that best apply to you. Please be as frank as you can with your answers.

Once completed, please return it to one of the hospital's local mailboxes. For this end, please use the envelope provided and make sure that it is properly sealed.

Please be assured that all your answers will be treated with complete confidentiality. You are not expected to write your name on the questionnaire, and only researchers at the UKC will have access to your answers.

If you have any queries about the survey, please feel free to contact Brynja Bragadóttir at the e-mail address bb16@ukc.ac.uk.

This survey has received a formal approval from the National Bioethics Committee

APPENDIX IV

**A Survey Study in an Icelandic Hospital Trust:
The T1 Questionnaire**

SECTION 1: SOME QUESTIONS ABOUT YOUR JOB

In this section, we would like to ask you some questions about your job.

1. Please indicate your professional group:

- 1 Doctor (junior or career grade)
- 2 Nurse
- 3 Midwife
- 4 Nurse assistant
- 5 Therapist (e.g. physiotherapist, occupational therapist)
- 6 Laboratory (e.g. lab technician, radiographer)
- 7 Counselling (e.g. psychology, social worker, nutritionist)
- 8 Clerical work
- 9 Pharmacy (e.g. pharmacist, pharmaceutical assistant)
- 10 Technology (e.g. technologist, engineer)
- 11 Office (e.g. business administration, systems analyst)
- 12 Management
- 13 Other (please specify): _____

2. Are you employed

- 1 Full-time
- 2 Part-time

SECTION 2: HEALTH

Now we would like you to ask you some questions about your health.

1. The following list describes various stress-related symptoms. We would like you to read the list carefully and indicate how much these symptoms have bothered you **in the past two weeks**, including today (see response options below). It is important that you **mark only one number** for each of the items listed.

- 0 = Has not bothered me at all
 1 = Has hardly bothered me,
 2 = Has bothered me to some extent
 3 = Has bothered me considerably much
 4 = Has bothered me a lot

	Not at all	Hardly	To some extent	Considerably much	A lot
1. Sleep problems	0	1	2	3	4
2. Weight change	0	1	2	3	4
3. Back pain	0	1	2	3	4
4. Constipation	0	1	2	3	4
5. Dizziness	0	1	2	3	4
6. Diarrhoea	0	1	2	3	4
7. Faintness	0	1	2	3	4
8. Constant fatigue	0	1	2	3	4
9. Headache	0	1	2	3	4
10. Migraine headache	0	1	2	3	4
11. Nausea and/or vomiting	0	1	2	3	4
12. Acid stomach or indigestion	0	1	2	3	4
13. Stomach pain (e.g. cramps)	0	1	2	3	4
14. Hot or cold spells	0	1	2	3	4
15. Hands trembling	0	1	2	3	4
16. Heart pounding or racing	0	1	2	3	4
17. Poor appetite	0	1	2	3	4
18. Shortness of breath	0	1	2	3	4
19. Numbness or tingling in parts of your body (e.g. in hands or feet)	0	1	2	3	4
20. Felt weak all over	0	1	2	3	4

	Not at all	Hardly	To some extent	Consider-ably much	A lot
21. Pains in heart or chest	0	1	2	3	4
22. Feeling low in energy	0	1	2	3	4
23. Stuffy head or nose	0	1	2	3	4
24. Blurred vision	0	1	2	3	4
25. Muscle tension or soreness	0	1	2	3	4
26. Muscle cramps	0	1	2	3	4
27. Severe aches and pains	0	1	2	3	4
28. Acne	0	1	2	3	4
29. Bruises	0	1	2	3	4
30. Nosebleed	0	1	2	3	4
31. Pulled (strained) muscles	0	1	2	3	4
32. Pulled (strained) ligaments	0	1	2	3	4
33. Cold or cough	0	1	2	3	4

2. Please read each item and circle the reply that comes closest to how you have been feeling in general in the last few weeks.

1. I feel tense or 'wound up'

Most of the time	A lot of the time	From time to time, occasionally	Not at all
1	2	3	4

2. I still enjoy the things I used to enjoy

Definitely as much	Not quite so much	Only a little	Hardly at all
1	2	3	4

3. I get a sort of frightened feeling as if something awful is about to happen

Very definitely and quite badly	Yes, but not too badly	A little, but it doesn't worry me	Not at all
1	2	3	4

4. I can laugh and see the funny side of things

As much as I always could	Not quite so much now	Definitely not so much now	Not at all
1	2	3	4

5. Worrying thoughts go through my mind

A great deal of the time	A lot of the time	From time to time but not too often	Only occasionally
1	2	3	4

6. I feel cheerful

Not at all	Not often	Sometimes	Most of the time
1	2	3	4

7. I can sit at ease and feel relaxed

Definitely	Usually	Not often	Not at all
1	2	3	4

8. I feel as if I am slowed down

Nearly all the time	Very often	Sometimes	Not at all
1	2	3	4

9. I get a sort of frightened feeling like 'butterflies' in the stomach

Not at all	Occasionally	Quite often	Very often
1	2	3	4

10. I have lost interest in my appearance

Definitely	I don't take as much care as I should	I don't take quite as much care	I take just as much care as ever
1	2	3	4

11. I feel restless as if I have to be on the move

Very much indeed	Quite a lot	Not very much	Not at all
1	2	3	4

12. I look forward with enjoyment to things

As much as I ever did	Rather less than I used to	Definitely less than I used to	Hardly at all
1	2	3	4

13. I get sudden feelings of panic

Very often indeed	Quite often	Not very often	Not at all
1	2	3	4

14. I can enjoy a good book or radio or TV programme

Often	Sometimes	Not often	Very seldom
1	2	3	4

4. The questions below refer to your feelings and emotions. Please read each statement and then circle the number that best reflects your response.

	Disagree strongly	Disagree	Disagree slightly	Agree slightly	Agree	Agree strongly
1. After an embarrassing experience I worry about it for days	1	2	3	4	5	6
2. I know that things will continually improve in my life	1	2	3	4	5	6
3. I feel that I have a great deal to be proud of	1	2	3	4	5	6
4. I often feel restless and jittery for no apparent reason	1	2	3	4	5	6
5. Things rarely work out the way I want them to	1	2	3	4	5	6

	Disagree strongly	Disagree	Disagree slightly	Agree slightly	Agree	Agree strongly
6. I am not as well liked as most other people	1	2	3	4	5	6
7. Every day seems exciting, new, and different	1	2	3	4	5	6
8. My feelings are more easily hurt than most other people's	1	2	3	4	5	6
9. I can easily concentrate on things for as long as I like	1	2	3	4	5	6
10. Whenever someone criticises me I think about it for days	1	2	3	4	5	6
11. I am hopeful and optimistic about the future	1	2	3	4	5	6
12. When things go wrong I blame myself	1	2	3	4	5	6
13. I rarely lose sleep over worrying about something	1	2	3	4	5	6
14. I am a person of worth, at least as good as other people	1	2	3	4	5	6
15. I always expect the worst to happen	1	2	3	4	5	6
16. I am more content and happy than most other people	1	2	3	4	5	6
17. Happy endings only occur in films and in fairy tales	1	2	3	4	5	6
18. I am not as self-confident as most other people	1	2	3	4	5	6
19. When I meet people for the first time I am tense and uptight	1	2	3	4	5	6
20. If I could live my life again I would do many things differently	1	2	3	4	5	6
21. The future seems rather bleak and unpromising	1	2	3	4	5	6

SECTION 3: BULLYING AT WORK

In this section we would like to ask some questions about harassment and bullying at work. **Workplace bullying** constitutes 'persistent, offensive, abusive, intimidating, malicious or insulting behaviour, abuse of power or unfair penal sanctions, which makes the recipient feel upset, threatened, humiliated or vulnerable, which undermines their self-confidence and which may cause them to suffer stress'.

1. In the past 12 months, have you experienced the following behaviours in the workplace from peers, senior staff, or managers?

1.	Persistent unjustified criticism or monitoring of your performance	Yes	No
2.	Persistent teasing	Yes	No
3.	Persistent attempts to belittle and undermine your work	Yes	No
4.	Persistent attempts to demoralise you	Yes	No
5.	Persistent attempts to humiliate you in front of colleagues	Yes	No
6.	Destructive innuendo and sarcasm	Yes	No
7.	Undermining your personal integrity	Yes	No
8.	Verbal and non-verbal threats	Yes	No
9.	Removal of areas of responsibility without consultation	Yes	No
10.	Physical violence	Yes	No
11.	Setting of impossible deadlines	Yes	No
12.	Making inappropriate jokes about you	Yes	No
13.	Withholding necessary information from you	Yes	No
14.	Constant undervaluing of your efforts	Yes	No
15.	Freezing you out/ignoring you/excluding you	Yes	No
16.	Unfounded threats about your job security	Yes	No
17.	Displays of open hostility towards you	Yes	No
18.	Violence to property	Yes	No
19.	Undue pressure to produce work	Yes	No
20.	Shifting of goalposts without telling you	Yes	No
21.	Use of abuse, swearwords, and obscenities	Yes	No

2. According to the definition given above, do you consider yourself to have been subjected to workplace bullying **from peers, senior staff, or managers** at any time **during the last twelve months**?

- | | |
|----------|---------------|
| 1 Never | 3 A few times |
| 2 Rarely | 4 Frequently |

3. Have you witnessed **work colleagues** being subjected to workplace bullying **from peers, senior staff, or managers during the last twelve months**?

- | | |
|----------------|--------------|
| 1 Never | 3 Frequently |
| 2 Occasionally | |

If you answered 'Never' to question 2, please go to Section 4.

4. If you have been bullied, for how long a period did it last/has it lasted?

- | | |
|--------------|-----------------------|
| 1 1-3 months | 3 7-12 months |
| 2 4-6 months | 4 More than 12 months |

5. Are you currently suffering bullying?

- | | |
|-------|------|
| 1 Yes | 2 No |
|-------|------|

6. If you have been bullied in the last 12 months, please briefly describe a recent incident.

7. In this incident, who subjected you to the bullying?
- 1 Colleagues in your own work group
 - 2 People outside your own work group
 - 3 Your immediate supervisor/line manager/team leader
 - 4 A senior manager
 - 5 Other
8. Was the person involved in the bullying
- 1 Male
 - 2 Female
9. Was the person
- 1 The same sex as you
 - 2 The opposite sex
10. Was the person
- 1 Older than you
 - 2 About the same age as you
 - 3 Younger than you
11. Were you bullied as part of a group, or were you singled out personally?
- 1 Singled out
 - 2 Bullied as part of a group
12. Did you try to do something about the bullying when it occurred?
- 1 Yes
 - 2 No

If no, please go to Section 4.

If yes, did you

Ignore the bully?	Yes	No
Ask for a transfer?	Yes	No

Confront the bully/ask them to stop?	Yes	No
Threaten to tell others?	Yes	No
Talk to a friend or colleague?	Yes	No
Report it to Personnel?	Yes	No
Report it to your line manager?	Yes	No
Report it to your union representative?	Yes	No
Make a formal complaint?	Yes	No
Take some other action?	Yes	No
(Please specify:) _____		

13. Do you feel that a satisfactory outcome was reached?
- 1 Yes 2 No 3 Uncertain

SECTION 4: SOME DETAILS ABOUT YOU

In this final section, we would like you to give us some details about you.

1. Are you
- 1 Male 2 Female
2. What is your age? (Please write in:) _____

This is the end of the questionnaire. Thank you very much for your help. If there are any comments you would like to make, please write them below.

**PLEASE RETURN THE QUESTIONNAIRE AS SOON AS POSSIBLE
IN THE ENVELOPE PROVIDED**

APPENDIX V

**A Survey Study in an Icelandic Hospital Trust:
The T2 Covering Letter**

Bullying at work: A survey study among Icelandic hospital staff

In September last year (2001), a questionnaire survey – focusing on the issue of workplace bullying – was sent to you and many other trust employees. This survey was part of a research project carried out by researchers at the University of Kent at Canterbury (UKC).

The current survey study is a second part of this same project. Thus, for the second time, we would like to ask you to take part in our study. The questionnaire should take 5 to 10 minutes to complete. When answering the questions, please tick the answers that best apply to you.

Once completed, please return the questionnaire to one of the hospital's local mailboxes. For this end, please use the envelope provided and make sure that it is properly sealed.

Surely, the ultimate success of the study depends on the good will and cooperation of those asked to take part. Accordingly, your reply is very important to us.

Please be assured that all your answers will be treated with complete confidentiality. You are not expected to write your name on the questionnaire, and only researchers at the UKC will have access to your answers.

If you have any queries about this part of the survey, please feel free to contact Brynja Bragadottir at the e-mail address bb16@ukc.ac.uk.

This survey has received a formal approval from the National Bioethics Committee

APPENDIX VI

**A Survey Study in an Icelandic Hospital Trust:
The T2 Questionnaire**

SECTION 1: HEALTH

In this section, we would like to ask you some questions about your health.

1. The following list describes various stress-related symptoms. We would like you to read the list carefully and indicate how much these symptoms have bothered you **in the past two weeks**, including today (see response options below). It is important that you **mark only one number** for each of the items listed.

- 0 = Has not bothered me at all
- 1 = Has hardly bothered me,
- 2 = Has bothered me to some extent
- 3 = Has bothered me considerably much
- 4 = Has bothered me a lot

	Not at all	Hardly	To some extent	Considerably much	A lot
1. Sleep problems	0	1	2	3	4
2. Weight change	0	1	2	3	4
3. Back pain	0	1	2	3	4
4. Constipation	0	1	2	3	4
5. Dizziness	0	1	2	3	4
6. Diarrhoea	0	1	2	3	4
7. Faintness	0	1	2	3	4
8. Constant fatigue	0	1	2	3	4
9. Headache	0	1	2	3	4
10. Migraine headache	0	1	2	3	4
11. Nausea and/or vomiting	0	1	2	3	4
12. Acid stomach or indigestion	0	1	2	3	4
13. Stomach pain (e.g. cramps)	0	1	2	3	4
14. Hot or cold spells	0	1	2	3	4
15. Hands trembling	0	1	2	3	4
16. Heart pounding or racing	0	1	2	3	4
17. Poor appetite	0	1	2	3	4
18. Shortness of breath	0	1	2	3	4
19. Numbness or tingling in parts of your body (e.g. in hands or feet)	0	1	2	3	4
20. Felt weak all over	0	1	2	3	4

	Not at all	Hardly	To some extent	Consider-ably much	A lot
21. Pains in heart or chest	0	1	2	3	4
22. Feeling low in energy	0	1	2	3	4
23. Stuffy head or nose	0	1	2	3	4
24. Blurred vision	0	1	2	3	4
25. Muscle tension or soreness	0	1	2	3	4
26. Muscle cramps	0	1	2	3	4
27. Severe aches and pains	0	1	2	3	4
28. Acne	0	1	2	3	4
29. Bruises	0	1	2	3	4
30. Nosebleed	0	1	2	3	4
31. Pulled (strained) muscles	0	1	2	3	4
32. Pulled (strained) ligaments	0	1	2	3	4
33. Cold or cough	0	1	2	3	4

2. Please read each item and circle the reply that comes closest to how you have been feeling in general in the last few weeks.

1. I feel tense or 'wound up'

Most of the time	A lot of the time	From time to time, occasionally	Not at all
1	2	3	4

2. I still enjoy the things I used to enjoy

Definitely as much	Not quite so much	Only a little	Hardly at all
1	2	3	4

3. I get a sort of frightened feeling as if something awful is about to happen

Very definitely and quite badly	Yes, but not too badly	A little, but it doesn't worry me	Not at all
1	2	3	4

4. I can laugh and see the funny side of things

As much as I always could	Not quite so much now	Definitely not so much now	Not at all
1	2	3	4

5. Worrying thoughts go through my mind

A great deal of the time	A lot of the time	From time to time but not too often	Only occasionally
1	2	3	4

6. I feel cheerful

Not at all	Not often	Sometimes	Most of the time
1	2	3	4

7. I can sit at ease and feel relaxed

Definitely	Usually	Not often	Not at all
1	2	3	4

8. I feel as if I am slowed down

Nearly all the time	Very often	Sometimes	Not at all
1	2	3	4

9. I get a sort of frightened feeling like 'butterflies' in the stomach

Not at all	Occasionally	Quite often	Very often
1	2	3	4

10. I have lost interest in my appearance

Definitely	I don't take as much care as I should	I don't take quite as much care	I take just as much care as ever
1	2	3	4

11. I feel restless as if I have to be on the move

Very much indeed	Quite a lot	Not very much	Not at all
1	2	3	4

12. I look forward with enjoyment to things

As much as I ever did	Rather less than I used to	Definitely less than I used to	Hardly at all
1	2	3	4

13. I get sudden feelings of panic

Very often indeed	Quite often	Not very often	Not at all
1	2	3	4

14. I can enjoy a good book or radio or TV programme

Often	Sometimes	Not often	Very seldom
1	2	3	4

4. The questions below refer to your feelings and emotions. Please read each statement and then circle the number that best reflects your response.

	Disagree strongly	Disagree	Disagree slightly	Agree slightly	Agree	Agree strongly
1. After an embarrassing experience I worry about it for days	1	2	3	4	5	6
2. I know that things will continually improve in my life	1	2	3	4	5	6
3. I feel that I have a great deal to be proud of	1	2	3	4	5	6
4. I often feel restless and jittery for no apparent reason	1	2	3	4	5	6
5. Things rarely work out the way I want them to	1	2	3	4	5	6

	Disagree strongly	Disagree	Disagree slightly	Agree slightly	Agree	Agree strongly
6. I am not as well liked as most other people	1	2	3	4	5	6
7. Every day seems exciting, new, and different	1	2	3	4	5	6
8. My feelings are more easily hurt than most other people's	1	2	3	4	5	6
9. I can easily concentrate on things for as long as I like	1	2	3	4	5	6
10. Whenever someone criticises me I think about it for days	1	2	3	4	5	6
11. I am hopeful and optimistic about the future	1	2	3	4	5	6
12. When things go wrong I blame myself	1	2	3	4	5	6
13. I rarely lose sleep over worrying about something	1	2	3	4	5	6
14. I am a person of worth, at least as good as other people	1	2	3	4	5	6
15. I always expect the worst to happen	1	2	3	4	5	6
16. I am more content and happy than most other people	1	2	3	4	5	6
17. Happy endings only occur in films and in fairy tales	1	2	3	4	5	6
18. I am not as self-confident as most other people	1	2	3	4	5	6
19. When I meet people for the first time I am tense and uptight	1	2	3	4	5	6
20. If I could live my life again I would do many things differently	1	2	3	4	5	6
21. The future seems rather bleak and unpromising	1	2	3	4	5	6

SECTION 2: BULLYING AT WORK

In this section we would like to ask some questions about harassment and bullying at work. **Workplace bullying** constitutes ‘**persistent, offensive, abusive, intimidating, malicious or insulting behaviour, abuse of power or unfair penal sanctions, which makes the recipient feel upset, threatened, humiliated or vulnerable, which undermines their self-confidence and which may cause them to suffer stress**’.

1. In the past four months, have you experienced the following behaviours in the workplace from peers, senior staff, or managers?

1.	Persistent unjustified criticism or monitoring of your performance	Yes	No
2.	Persistent teasing	Yes	No
3.	Persistent attempts to belittle and undermine your work	Yes	No
4.	Persistent attempts to demoralise you	Yes	No
5.	Persistent attempts to humiliate you in front of colleagues	Yes	No
6.	Destructive innuendo and sarcasm	Yes	No
7.	Undermining your personal integrity	Yes	No
8.	Verbal and non-verbal threats	Yes	No
9.	Removal of areas of responsibility without consultation	Yes	No
10.	Physical violence	Yes	No
11.	Setting of impossible deadlines	Yes	No
12.	Making inappropriate jokes about you	Yes	No
13.	Withholding necessary information from you	Yes	No
14.	Constant undervaluing of your efforts	Yes	No
15.	Freezing you out/ignoring you/excluding you	Yes	No
16.	Unfounded threats about your job security	Yes	No
17.	Displays of open hostility towards you	Yes	No
18.	Violence to property	Yes	No
19.	Undue pressure to produce work	Yes	No
20.	Shifting of goalposts without telling you	Yes	No
21.	Use of abuse, swearwords, and obscenities	Yes	No

2. According to the definition given above, do you consider yourself to have been subjected to workplace bullying **from peers, senior staff, or managers** at any time **during the last four months**?

- 1 Never
- 2 Rarely
- 3 A few times
- 4 Frequently

3. Have you witnessed **work colleagues** being subjected to workplace bullying **from peers, senior staff, or managers during the last four months**?

- 1 Never
- 2 Occasionally
- 3 Frequently

4. If you answered '**rarely**', '**a few times**', or '**frequently**' to **question 2**, did you try to do something about the bullying when it occurred?

- 1 Yes
- 2 No

If yes, did you

Ignore the bully?	Yes	No
Ask for a transfer?	Yes	No
Confront the bully/ask them to stop?	Yes	No
Threaten to tell others?	Yes	No
Talk to a friend or colleague?	Yes	No
Report it to Personnel?	Yes	No
Report it to your line manager?	Yes	No
Report it to your union representative?	Yes	No
Make a formal complaint?	Yes	No
Take some other action?	Yes	No

(Please specify:) _____

This is the end of the questionnaire. Thank you very much for your help. If there are any comments you would like to make, please write them below.

**PLEASE RETURN THE QUESTIONNAIRE AS SOON AS POSSIBLE
IN THE ENVELOPE PROVIDED**

APPENDIX VII

Study among Icelandic Hospital Staff:

Application for ethical approval

Study among Icelandic hospital staff: Request for ethical approval

Due to regulations in Icelandic health research, the author was requested to apply for formal approval of the study from the National Bioethics Committee (NBC). Thus, in the study's preparation stage the author completed a detailed application form, formulated by the NBC. In the following paragraphs, the content of the form will be described. In the text provided, a special attention will be paid to ethical issues such as protection of potential participants (e.g. protection of their mental well-being) and intended use/handling of research data.

The NBC application form

The NBC form consisted of twenty-three sections (see sections below):

1. Working title of the project

2. Outline of the project:

A 200-word summary, describing the aims of the study, planned methodology (intended selection of participants, planned design of the study, planned statistical analyses etc.) and the possible use and value of final results.

See description of study in Ch's 6 & 7.

3 – 5. Names of researchers and academic/supporting institution

Other information requested: Position of researchers, their place of work and contact details.

6. The role of individual researchers

Information provided regarding the design of study material, distribution of questionnaires, collection of questionnaire data, data entry and data analysis.

Note: The author was responsible for all these tasks.

7. Expected number of participants and sampling method used

See Ch. 6: Description of study method.

8. Benefits and risks for potential participants

Information provided:

Benefits:

“The results of the study will provide hospital employees (managers and general staff) with vital information about the prevalence of bullying. In case the problem is pervasive, the results should encourage managers to find ways to tackle bullying at work. In addition, managers and other staff may realise that bullying is a significant health risk, which must be thoroughly dealt with. Moreover, the study may help people to realise the nature of the problem and identify their potential role as targets or perpetrators of bullying at work”.

Potential risks:

“It is possible that potential participants feel unsafe about participating in a survey of this kind. For instance, they may fear that hospital authorities will see their answers and as a result, that their job security will be at risk. In addition, they may fear that results will be presented in a way so that individual responses can be traced. Still, efforts will be made to ensure all staff that answers to the survey will be treated with full confidentiality”.

9. Other ethical issues

Information provided:

“Current victims of bullying at work may possibly experience discomfort and distress when answering the survey questions. For instance, bullying victims may feel anxious and their confidence may suffer. Other groups who may feel discomfort are former victims of bullying and observers of bullying”.

“Clearly, there must be ways to protect these groups of employees. For instance, victims or observers of bullying should feel free to withdraw from the study at any time. They should also feel free to contact the researchers and express their concerns or distress at any stage of the study”.

“It should be the researchers’ duty to listen to vulnerable participants, offer them support and help them to get professional help and advice (e.g. from confidential counsellors)”.

10. Description of study materials

Information provided:

A detailed description of study questionnaires and other study materials

See Ch's 6 & 7 in the thesis (description of study method)

See also copies of questionnaires and covering letters in appendices (III – VI)

Other information provided:

Names of parties responsible for the data:

Brynja Bragadóttir (MSc) and Prof. Lyn Quine

Planned safety measures (protection of confidentiality):

“The potential participants will be provided with pre-paid envelopes, directed to the researcher. In the covering letter (attached to the questionnaire), they will be encouraged to use these envelopes when returning their questionnaires. In addition, they will be requested to return the questionnaires to locked mail boxes, located in the hospital's central areas”.

“Through the above measures, confidentiality of survey data should be warranted. The importance of confidentiality will also be explained to the hospital authorities. Namely, that only the researcher will have access to the questionnaire data”.

11. Scientific value of the study

The value of the study extensively described (see part of the text below).

“There is a great need for longitudinal studies, focusing on the relationship between bullying and health outcomes. So far, the relationship between bullying and health outcomes has been tested cross-sectionally. The results from cross-sectional studies can be complex to interpret, since the direction of causality is not known. Other designs, such as longitudinal research designs enable the researcher to infer more about causal relationships...”

“Also, the issue of bullying at work has hardly been studied in Icelandic workplaces and this project can be

seen as a good starting point. Undoubtedly, it is important for Icelandic people to know how prevalent the problem is in Icelandic workplaces”.

12. Research background (literature review)

See Ch's 1, 2 & 3 in the thesis.

13. Method of data collection

See Ch. 6: Description of study method.

14. Analytical methods (e.g. methods of statistical analyses)

See Ch's 6 & 7 (results sections).

15. Study period

Period of data collection: Six to eight months.
Total study period: 12 months approximately.

16. Presentation and/or utilisation of results

Information regarding presentation of results:

“Results of the study will be presented in a local report, i.e. a report written and designed for local managers and hospital staff”.

“The whole study will also be presented in an impending PhD thesis, focusing on bullying at work. In addition, it may possibly be reported in an academic journal”.

Information regarding utilisation of results:

“Expectantly, the hospital authorities will utilise the results to increase peoples' awareness of bullying at work and to express the view that bullying and mistreatment is unacceptable”.

“The results should also encourage management to look for potential risk factors (e.g. factors related to work culture and climate) and to develop procedures to deal with the problem”.

17. Transportation of research material (e.g. transportation of material between countries)

Information provided:

“Questionnaires will be transported (in cardboard boxes) by air mail from Iceland to England (University of Kent at Canterbury)”.

See Ch. 6 (description of study method).

18. Protection of research material

Information provided:

“The data will be numerically coded and entered into a computer program (SPSS for Windows). The data set will be kept in the computer for 1 or 2 years. Only the researcher will have access to the data set”.

19. Other use of materials (apart from the use already described in the form)

A section not regarded relevant to the project

20. Protection of participants' health and well-being

Information provided:

“Potential participants have a free choice to participate or not. They can also withdraw at any stage of the study. In addition, they can send queries to the researcher and ask for help and advice”

See also section 9 (“other ethical issues”)

21. Financial rewards (e.g. rewards for participating in the study)

A section not relevant to the project

22. Other applications related to the project

Application sent to the hospital authorities: A formal request to conduct a survey study among the hospital staff.

23. List of accompanying documents

Documents provided:

CV of principal researcher, copies of questionnaires and covering letters.

About the National Bioethics Committee (NBC)

The NBC is located in Reykjavik, the capital city of Iceland. The institution has the role to critically assess applications for research projects involving human participants. In particular, the committee has the role to ensure that participants' health and well-being is protected. Examples are clinical trials and studies focusing on health-related issues (e.g. studies based on survey data or medical records).

The assessment of applications pertains to the scientific and ethical issues concerning the proposed research project, as stated in the Acts on the Rights of Patients (regulation no. 74/1997): ...

An evaluation of the research made by the scientific ethics committee or an ethics committee...must have revealed that scientific and ethical views do not oppose its implementation.

...and also to the Regulation on Scientific Research in the Health Sector (regulation no. 552/1999):

It is prohibited to conduct scientific research on humans without prior approval of the ethics committee or the National Bioethics committee.

In addition to the evaluation of applications for scientific research projects, the NBC has a supervisory role, defined by law, with regards to research projects the Committee has previously approved. Such supervision pertains to for instance complaints and comments that the committee receives from participants in the projects.

According to the Regulation on Scientific Research in the Health sector (no. 552/1999), the supervisory role of the NBC is defined as follows:

The NBC shall monitor the progress of scientific studies which it has approved. The committee may require the researcher to submit progress reports and results. The NBC may revoke its permit for the study, should the committee believe that implementation of the study is not consistent with the protocol and data submitted by the researcher, and that the study no longer meets the committee's scientific or ethical standards.

According to the above description, the NBC plays a crucial role in ensuring that Icelandic research projects are acceptable in two respects. Namely, in terms of scientific prestige and ethical matters.

The ethical clearance process

The ethical clearance process lasted for 5 months and involved four consecutive stages (see stages below).

1. The application for ethical approval was sent to the NBC in December 2001 (see description of application form above).
2. In February 2001, the author received a written reply from the Committee. In this letter, the project was seen to generally meet the Committee's scientific and ethical standards.

Yet, it was the Committee's view that more information was needed in terms of selection of participants. In particular, they requested more information about the researcher's intended access to employee files.

They also requested more detailed information in the study's covering letters. Specifically, they requested more information about how potential participants were selected for the study.

Hence, at this stage, the NBC was not ready to grant full approval of the project.

3. In order to meet the above requests, the author spent the next two months (March/April) to find the best way to create the study sample (e.g. the selection of names from an exhaustive list of employees).

During this period, the author was in regular contact with the hospital's personnel department. The managers of this department showed great interest in the project and showed no objection to the researcher's access to employee files.

In May 2001 the NBC were informed (through writing) about this outcome. The Committee was also informed about steps taken to revise the study's covering letters.

In particular, they were told that in new versions of the letters, it was stated that potential participants were randomly selected from a list of all hospital employees.

4. Ten days later, the author received a second reply from the Committee. This time, the NBC had no particular queries about the project and the author's replies to previous queries (see above) were found to be satisfactory. The content of the letter was as follows:

The National Bioethics Committee thanks you for your reply, dated May 20th 2001, regarding the stipulations set for the approval of the...research project in the Committee's letter of February 1st 2001. Your reply has been reviewed and discussed by the National Bioethics Committee and was found to be satisfactory.

The project is hereby granted the full approval of the National Bioethics Committee.

Thus, the ethical clearance process was completed in May 2001.

