Bullying, workers’ health, and labour instability

Violence and bullying in the workplace seem to be an increasing phenomenon in Europe, even though self-reported bullying shows wide variations across nations. Bullying in the workplace is certainly not a recent phenomenon and is probably inherent to many human relations and organisations. However, its rising importance could be related to the global deterioration of working conditions. ‘‘Thus the European Parliament,’’ besides an increasing number of countries has legislated to cut down on and prevent these occurrences.’’

Notwithstanding the importance of these legal measures, we are faced with crucial problems. At the working population level, the crux of the matter is that we are facing two unresolved questions: how can we measure bullying behaviours and its deleterious effects on the victims? What are the dimensions of interest? Which methods can measure bullying behaviours and its deleterious effects on the victims?

Bullying is one of the negative environmental characteristics in the workplace that can have an impact on the worker’s health; we measured it through a self-administered postal questionnaire submitted to all workers in two enterprises (one stable and one unstable). Work instability is understood as enterprise instability—that is, recent or future merger, downsizing, or restructuring. The two workplaces are from the tertiary sector (service industry). The asset of such design survey is the possibility to study bullying on large samples and to go beyond individual case report, which is often the case in this subject matter. Another advantage is the longitudinal protocol, which permits more interpretations than cross sectional designs.

Identical questionnaires were sent to all workers twice: in 2000 and in 2001. Global participation (completed questionnaires) was 95% (518 participants), and 86% (492 workers) participated to the two measures. With the longitudinal protocol, which permits more interpretations than cross sectional designs, we found significant relations between bullying and of health outcomes—subjective health status, depression, anxiety, somatisation, neurosis, or chronic fatigue. Bullied workers being always at higher risk of the mentioned health problems than non-bullied ones. No noticeable differences could be observed in terms of gender, nationality, education, professional qualification, or health related behaviours (smoking, alcohol consumption, and alcohol dependence).

Further researches are crucial to explore and validate the methodological aspects of bullying measurement as well as the influences of bullying on different health outcomes by way of well conducted prospective epidemiological studies. It is also too early to evaluate the effects of the new regulation on the prevention of bullying. Even concluded and prevention could be sought in a more global, organisational, and economic environment to prevent this from happening, and not at the individual level solely, even if victims must be helped and supported. Unstable, fragile workplaces—nowadays such a common reality for so many workers—deserve special attention.

Key points

- Bullying in the workplace seems to be an increasing phenomenon in Belgium
- In this survey bullying is a significant independent predictor of sick leave
- More research is needed to validate instruments that measure bullying
- Research is needed to evaluate the effects of the new legislation
- More should be done at the workplace level to prevent it

"social isolation", "destabilisation". As Hirigoyen states, bullying can be behaviours, words, acts, gestures, writings that can affect the personality, the dignity, or physical or psychological integrity."

We conducted a longitudinal survey in Belgium (two measures, one year interval) on psychosocial factors at work and their influence on the worker’s health. With the working hypothesis that bullying, as other stressors, could have a negative impact on health. A second hypothesis was that in an unstable work environment, besides being exposed to higher stress, bullying could be an additional stressor.

The objective was double: to assess the bullying prevalence—including its comparison in different work environments—and to study its eventual negative effects on the victims.

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Identical questionnaires were sent to all workers twice: in 2000 and in 2001. Global participation (completed questionnaires) was about 40%, and 1030 workers (two thirds women) participated to the two measures; 549 in the stable enterprise, 481 in the unstable one. Participants were representative of the total workforce population for the available criteria: age, sex, department/service. Two assumptions were kept: dimensions of Quine’s instrument were used to measure bullying at work: namely isolation and destabilisation. The upper quartile of a score based on all those seven items defined arbitrarily the category of ‘‘presently bullied’’. Self-reported repeated absenteeism was used as health indicator, defined as at least three sick leaves between the two measures.

In the unstable work environment, there is a significant increase in the proportion of bullied workers between the two measures (from 27% to 33%, p<0.05, McNemar test for paired samples). The two most often cited items of bullying are a constant under-valuation of my efforts and ‘‘withholding necessary information’’.

Repeated absenteeism remains stable in the two firms, but its prevalence is higher in the unstable firm, for the two measures (around 11% in the stable, 16% in the unstable one). Cross sectional data (at the first measure and at the second one) show very important relations between bullying and different health outcomes: subjective health status, depression, anxiety, somatisation, neurosis, or chronic fatigue. Bullied workers
Tackling health inequalities since the Acheson Inquiry


A decade ago, the then British government shunned the very mention of the phrase “health inequalities”. Its successor, by contrast, began by commissioning the Acheson Inquiry (1998) and has since introduced a large number of policy initiatives across a number of government departments to reduce health inequalities. This useful book reviews in detail how three areas of policy highlighted by Acheson have been implemented so far (tax and benefit reform, performance management, and transport).

It is a short book that nevertheless touches on some large themes. To take one example: it is easier for governments to target identifiable deprived neighbourhoods than to target deprived people, many of whom live in affluent or middle income areas. The book acknowledges that such an approach to health inequalities is likely to fail in the long run (and that governments are more concerned with the short run).

Similarly, the authors show how the government’s approach seems to be based on economics rather than social justice: poor health is a poor use of human resources, and policies focus on employment and the future workforce (children) rather than, say, the quality of life of older people. The authors might have been more explicit about the government’s failure to promote policies such as progressive taxation and improving public transport.

The book will not cheer those who wish to see government policies evidence based. Robust evidence for the effectiveness of many of the policies is missing (an absence somewhat glossed over in the Acheson report), while the sheer number of initiatives means that the effectiveness of any one of them will be impossible to evaluate. It will not be possible to assess whether the policies as an aggregate have reduced health inequalities for some years to come. Inevitably, therefore, this book’s early intelligence is both very welcome and rather tantalising.

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An authors’ error occurred in this paper by Dr Sundquist and others (2004; 58: 71–7).

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