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Bullying in Turkish white-collar workers

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Objectives To determine the prevalence of reported workplace bullying among a group of white-collar workers, to evaluate the association between reported bullying and its effect on health and to assess the effects of support at work for bullied workers.

Methods A cross-sectional questionnaire survey among full-time government employees in the health, education and security sectors. Bullying was assessed using a 20-item inventory. The potential effects of reported bullying were assessed using the Job Induced Stress Scale, the Hospital Anxiety and Depression Scale, Job Satisfaction Scale and the Propensity to Leave Scale.

Results The response rate was 79% (944/1200) and 877 questionnaires were analysed after exclusion of non-complete data. Of respondents, 55% (483) reported experiencing one or more types of bullying in the previous year and 47% (416) had witnessed the bullying of others. The bully was most likely to be a superior. Sixty per cent of victims had tried to take action against bullying, but most were dissatisfied with the outcome. There were significant differences in anxiety, depression, job-induced stress and support at work scores between those reporting bullying and those not reporting bullying at work. Those who reported bullying with low support at work had the poorest scores on the mental health scales.

Conclusions Bullying is a serious problem in this group of workers and may lead to health consequences. Feeling that the work environment is supportive appears to have a protective effect in terms of the health outcomes.

Key words Occupational mental health; public sector; self-reported; Turkey; workplace stress.

Introduction

Bullying in the workplace is now widely recognized since the work of Leymann in the 80s [1–3]. There is now extensive literature regarding this phenomenon [4] and the International Labor Office has considered bullying together along with other violent behaviours [5]. The prevalence of bullying in member countries of the European Union has been reported as 9% [6] and in the United States, it is estimated that one in five workers is affected by bullying [7]. A national Australian study reported that 35% of Australians had been verbally abused by a co-worker and 31% by a superior, at some time [8]. However, in developing countries bullying is less well recognized and previously in Turkey it has not been recognized as an occupational health issue. Because of methodological difficulties, there is no gold standard for the measurement of bullying behaviour and there is no standardized definition [1–4,9–11]. In general, bullying can be defined as situations in which individuals or groups of individuals are subject to one or more negative behaviours at work over an extended period of time. Rayner and Hoel [10] defined bullying behaviour into the following five categories: professional threat, personal threat, isolation, work overload and destabilization.

Our study is based on a descriptive and epidemiological approach [12]. We wanted to determine the prevalence of bullying, its effect on health and the effects of feeling supported at work among a group of full-time government employees.

Methods

We performed a cross-sectional questionnaire survey among full-time government employees in the three main public sectors: health, education and security. This study was approved by the Uludag University Ethical Committee (02.05.2004; # 2004-13), the Directorate of Health of Bursa (21.05.2004; # B104ISM416009-3564/9496), the Directorate of Education of Bursa (02.07.2004; # B0.08.4.MEM0.416.00.07-050/27579) and the Directorate of Security of Bursa (05.07.2004; B0.05.1.EGM0.4.16.00.71.02. 04/7/019746). Selected workplaces

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were drawn from the three municipal areas of the metropolitan city of Bursa. From a list of health, education and security workplaces in the public sector (private workplaces in health and education were excluded) we randomly selected 25 primary health care units and one public hospital, nine schools (two kindergartens, four primary schools, three high schools) and 13 police stations. During a period of 8 months, we visited each workplace, explained our purpose and invited personnel to join our study. Those who gave their verbal consent and were present on the day(s) of our visit were recruited as our study group. We then distributed printed questionnaires in closed envelopes and collected them back from the participants on a specific day.

Our main outcome measures were the following:

(i) A 20-item inventory of bullying developed by Quine [13].
(ii) A 7-item Job Induced Stress Scale developed by House and Rizzo [14].
(iii) A 14-item The Hospital Anxiety and Depression (HAD) Scale developed by Zigmond and Snaith [15] and translated by Aydemir *et al.* [16].
(iv) A 5-item Job Satisfaction Scale developed by Quinn and Staines [17].
(v) A 3-item Propensity to Leave Scale developed by Camman *et al.* [18].
(vi) An 8-item Support at Work Scale developed by Bosma *et al.* [19].

All these evaluation methods were translated into Turkish except the HAD Scale which had already been translated and validated. The other scales were first translated from the source language (English) into the target language (Turkish) and then translated back by a translator not involved in the original translation and the first and second translations were compared, discrepancies were identified and the problems about differently used words were solved. Approval for modifying the original bullying evaluation method was obtained from the author. Reliability analyses for these instruments were made using the Cronbach alpha coefficient and were as follows [Cronbach α (mean $\pm$ SD)]:

(i) Job Induced Stress Scale: 0.83 (20.6 $\pm$ 6.3).
(ii) Job Satisfaction Scale: 0.86 (10.4 $\pm$ 3.0).
(iii) Propensity to Leave Scale: 0.75 (10.8 $\pm$ 3.7).
(iv) HAD Scale: Anxiety: 0.81 (7.6 $\pm$ 3.7), Depression: 0.73 (6.6 $\pm$ 3.7).
(v) Support at Work Scale: 0.89 (23.8 $\pm$ 5.6).
(vi) A 20-item bullying inventory: 0.83 (39.3 $\pm$ 3.6).

The Cronbach alpha coefficients of all these scales were >0.70. Therefore, we accepted the translated versions of these scales as reliable and used them in statistical analyses. The cut-off points of the HAD Scale were 8 for depression and 11 for anxiety [16].

There were also questions in the survey regarding participants' age, gender, marital status, work sector, occupation, years working for the institution, having managerial responsibility, feelings and health complaints after exposure to bullying behaviour, type of bully, their perceptions about the causes for being bullied and their actions in response to this behaviour.

The term 'bullying' was explained at the beginning of the questionnaire. This explanation consisted of the definition of bullying, the five categories and the persistent and continuous character of this behaviour. It was also mentioned that exposure to such behaviour only once or twice could not be considered bullying. A trained staff member inputted the data to a computer and the quality and accuracy check of the data was made through 1/10 systematic sampling. Statistical analysis was performed using SPSS (Statistical Package for the Social Sciences) version 11.0. We used frequency distribution and binary logistic regression analysis.

Results

The response rate was 79% (944/1200). Sixty-seven of the returned questionnaires had missing data and were excluded from the analysis. The characteristics of the study group are shown in Table 1.

Table 1. Characteristics of the study group

		n	%
Age	19–30	271	31
	31–40	392	45
	41–50	190	22
	≥51	24	3
Gender	Male	404	46
	Female	473	54
Occupation	Nurse/midwife/ health technician	196	22
	Physician	254	29
	Teacher	223	25
	Police officer	179	20
	Secretarial/ administrative	25	3
Years with the institution	1–5	417	48
	6–10	218	25
	11–15	140	16
	16–20	69	8
	>20	33	4
Marital status	Single	178	20
	Married	667	76
	Divorced/widowed	32	4
Work sector	Education	230	26
	Health	462	53
	Security	185	21
Support at work	Poor	405	46
	Good	472	54
Managerial responsibility	Yes	133	15
	No	744	85

During the previous year, 55% of participants reported bullying and 47% had witnessed others being bullied. We found no significant relationship between reported bullying and age, gender, marital status and length of employment (Table 2).

The odds of having experienced bullying were increased by 60% among participants who had managerial responsibility compared with those without this responsibility. Seventy-five per cent of health personnel (except physicians), 64% of secretarial and administrative staff, 56% of police officers, 56% of physicians and 39% of teachers reported that they had been bullied at their workplaces within the last year.

The categories of reported bullying are shown in Table 3.

The most reported category was overwork, followed by destabilization, professional and personal threat. Isolation was rarely reported by any job types. The perpetrator was a superior in 44%, followed by someone of the same level (26%), someone senior (14%) and someone less senior (10%). In 37% of cases, the bully was male and in 25%, female; both sexes were involved in the remaining 38% of cases. Sixty-two per cent of male victims and 16% of female victims reported bullying by male perpetrators and 8% of male victims and 40% of female victims reported bullying by female perpetrators. In 50% of cases, the bully was the same sex as the victim and in 12% of cases it was someone of the opposite sex. In the remaining 38% of cases both sexes were involved as perpetrators. Of the 294 cases for which information was given about age, in 49% (144) the perpetrator was older than the victim, in 19% (55) both parties were of similar age and in 32% (95) the perpetrator was younger. Fifty-two per cent of the victims reported that the exposure to bullying affected their health and 36% were not sure about this. The most frequently reported effects were being anxious, tense and unwilling to do their jobs and ~4% reported taking time off work. The relationship

Table 2. Results of binary logistic regression analysis for reports of bullying in the last year

Variables	*P* value	Odds ratio (OR)	95% CI for OR	
			Lower	Upper
Gender[a]	0.68	1.08	0.76	1.54
Age[b]	0.780			
19–30	0.359	1.64	0.57	4.71
31–40	0.299	1.67	0.63	4.43
41–50	0.336	1.61	0.61	4.28
Marital status[c]	0.536			
Single	0.478	1.38	0.57	3.38
Married	0.863	1.08	0.47	2.45
Sector[d]	0.445			
Education	0.396	2.57	0.29	22.67
Health	0.203	2.99	0.55	16.11
Occupation[e]	**0.004**			
Nurse	0.550	0.69	0.21	2.31
Doctor	**0.035**	0.34	0.09	0.93
Teacher	**0.019**	0.30	0.04	1.22
Police	0.918	1.08	0.24	4.94
Managerial responsibility[f]	**0.030**	1.62	1.05	2.51
Working years[g]	0.533			
1–5	0.314	0.63	0.25	1.56
6–10	0.397	0.68	0.28	1.67
11–15	0.514	0.74	0.30	1.83
16–20	0.123	0.48	0.18	1.22
Anxiety[h]	**0.036**	1.74	1.04	2.91
Depression[i]	**0.005**	1.70	1.17	2.46
Support at work[j]	**0.000**	3.02	2.22	4.11
Stress	**0.001**	1.38	1.15	1.66
Job satisfaction	**0.000**	1.98	1.46	2.68
Propensity to leave	0.217	0.82	0.59	1.13

Values in bold are significant at $P < 0.05$.

All the variables which are shown in table: −2loglikelihood = 1006.491; $\chi^2(20) = 147.953$, $P = 0.000$. Hosmer-Lemeshow statistics = 7.711 with 8 d*f*, $P = 0.462$. [a]Female, [b]51+, [c]Divorced, [d]Security, [e]Secretary, [f]No., [g]20+, [h]Low, [i]Low, [j]Good.

Table 3. Type and category of reported bullying behaviour

n = 483	No. (%)
Threat to professional status	202 (42)[a]
Persistent attempts to belittle and undermine one's work	72 (15)
Persistent and unjustified criticism and monitoring of one's work	73 (15)
Persistent attempts to humiliate one in front of colleagues	24 (5)
Intimidatory use of discipline or competence procedures	150 (31)
Threat to personal standing	155 (32)[a]
Undermining one's personal integrity	82 (17)
Destructive innuendo and sarcasm	47 (10)
Verbal and non-verbal threats	42 (9)
Making inappropriate jokes	35 (7)
Persistent teasing	70 (15)
Physical violence	5 (1)
Violence to property	8 (2)
Isolation	96 (20)[a]
Withholding necessary information	45 (9)
Freezing out, ignoring or excluding	36 (8)
Unreasonable refusal of applications for leave, training or promotion	56 (12)
Overwork	338 (70)[a]
Undue pressure to produce work	81 (17)
Setting of impossible deadlines	322 (67)
Destabilization	267 (55)[a]
Shifting of goal posts without telling	137 (28)
Constant undervaluing of one's efforts	107 (22)
Persistent attempts to demoralize one	150 (31)
Removal of areas of responsibility without consultation	154 (32)

[a]Some participants reported more than one type of bullying behaviour in each category.

between bullying and anxiety, depression and stress were examined by binary logistic regression analysis. Employees reporting bullying had significantly higher anxiety, depression and job induced stress scores and were significantly more likely to report low job satisfaction. There was no difference in the reported propensity to leave the job. Of employees who reported bullying, 60% reported making some response to it when it occurred, but 23% were not satisfied with the outcome. The most frequently reported responses to bullying were talking to colleagues and friends (80%), ignoring the perpetrator (62%) and warning the perpetrator not to do this again (62%). Jealousy, having a different point of view and success at work were the most commonly reported reasons for being subjected to bullying.

Respondents who reported poor support at work reported bullying significantly more than those with good support. Mean depression and anxiety scores among employees reporting bullying with good support at work were lower than those with poor support. Among employees reporting bullying with poor support, stress levels were higher and job satisfaction levels were lower than those with good support. Figure 1 shows the main effects of having good or poor support at work for each outcome variable.

Discussion

Our study of governmental white-collar workers found that bullying was reported by over half of respondents and had been witnessed by almost half. The most frequent responses to bullying behaviour were ignoring the perpetrator or talking with friends and colleagues. About two-thirds of those reporting bullying had challenged the perpetrator but most were unhappy with the outcome. Workers who reported bullying had lower levels of job satisfaction, higher levels of job-induced stress and higher anxiety and depression scores than those who did not report bullying.

This was a cross-sectional study and recall and selection bias may occur in this type of study. It is also difficult to draw causal interferences from this type of

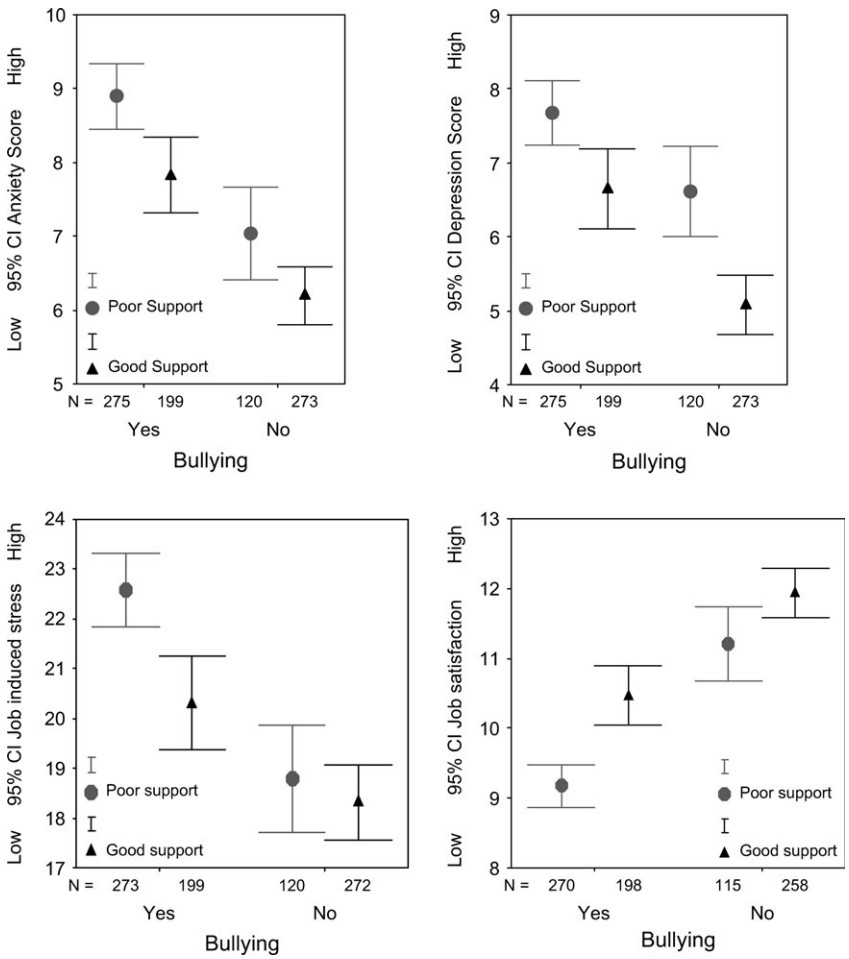

Figure 1. Main health outcomes, bullying and support at work. Anxiety and depression scores were calculated from the HAD Scale. Job induced stress score was obtained from the Job Induced Stress Scale by House and Rizzo [14]. Total scores were used. Job satisfaction score was obtained from Job Satisfaction Scale by Quinn and Staines [17]. Total scores were used. Support at work was measured by the Support at Work Scale by Bosma *et al.* [19]. Mean of total score was used. Scores <3 were accepted as poor support and scores ≥ 3 were accepted as good support.

study therefore relationships between reported bullying and health outcomes need to be considered carefully. Against this, however, we obtained a good response rate of >70%.

While there is little empirical evidence at present, our study suggests that bullying in the workplace does extend beyond the industrialized world. Like our study, research from Sweden and the United States found that age, gender or social class did not influence incidence of bullying or emotional abuse [3,20]. However, other studies have found sex and age to influence the incidence of bullying [6,21]. In terms of occupation and employment sector, Leymann [3] found that people working in educational settings to be most at risk, in Finland bullying was experienced most often in health care [6] and in Spain in public administration, education and health [22]. Being subjected to bullying has been found mostly among white-collar workers such as hospital staff, police officers and teachers and our results are similar to these studies [13,23–29]. Many studies have shown that the bully is often the victim's superior and while we found this in our study we also found a higher ratio of bullying between colleagues at the same level. Like our study, other studies have found the perpetrator likely to be male [30–32], older than the victim [13,32] and that males are rarely subjected to bullying by female workers [3,32]. Similar to our study, other studies have found unrealistic workload, destabilization and threats to professional status to be the most frequent categories of bullying [13,21,32,33].

In terms of the victim's response, we found that the most frequent responses were ignoring the bully or talking with friends and colleagues. Rayner [32] reported that 38% of victims did nothing, 45% responded to the perpetrator and 21% sought help from colleagues. Knorz and Zapf found that 66% of the victims talked with the perpetrator, 50% ignored the situation and 40% talked to colleagues [23]. A study in the United Kingdom showed that 95% of the workers were scared to report bullying [34] and bullying has been labelled the silent epidemic.

Studies about the reasons for being subjected to bullying behaviour have shown envy, success, good work performance and jealousy to be important factors [22,35] which is similar to our findings that jealousy, having a different point of view and success at work are the most important reasons.

Almost all studies on bullying have found a relationship between job satisfaction, job-induced stress and being subjected to this behaviour [31,35–38]. Like our study, it has also been shown that a supportive work environment can protect people from some of the harmful effects of bullying [1,3,7,9,13].

The implications of this study to clinicians and policymakers are that bullying and mental health issues related to work environment should not be ignored; clinicians should be aware of the physical and psychological symptoms and signs of bullying; policies and procedures that comprehensively address the issue of workplace bullying should be introduced to workplaces and social support services should be organized and maintained in every workplace to prevent or reduce the harmful effects of bullying.

This was the first study performed in Turkey about bullying. Our findings suggest that bullying is common and deserves further action. There are still some unanswered questions which need further research, for instance the extent of bullying among blue-collar workers, the economic cost of bullying in the workplace and more precise evidence for physical health consequences of bullying. We believe that these questions can be answered through well-organized cohort studies representative of the whole working population and carried out in a quantitative and qualitative manner.

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Conflicts of interest

None declared.

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