Mobbing: case record, gender differences, medico-legal issues

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Summary

Introduction: the “mobbing syndrome”, due to prolonged harassment at work, requires accurate diagnostic evaluation, both for clinical and medico-legal purposes.
Objectives: to evaluate with a multidisciplinary approach (occupational physician, psychologist, psychiatrist) the frequency and gender differences of psychiatric disorders due to mobbing in clinical practice.
Methods: between 2001 and 2011, we examined 474 outpatients (273 females, 201 males), aged between 21 and 61 years, for suspected psychopathological work-related problems. The diagnostic process included occupational health evaluation, psychological counseling, structured interview for DSM-IV (Diagnostic and Statistical Manual of Mental Disorders), personality test MMPI-2 (Minnesota Multiphasic Personality Inventory-2), psychiatric visit, laboratory and instrumental tests when indicated.
Results: a work-related psychiatric disorder was diagnosed in 152 subjects (32% of the whole case series): 37 cases (8%) were probably due to mobbing. The other patients presented work-unrelated psychiatric conditions (28% of cases) or no psychiatric disorders.

Discussion: using a rigorous diagnostic procedure, a psychopathological disorder due to mobbing is diagnosed in a limited number of patients, mostly women. Thus, caution should be adopted in labeling as “mobbing syndrome” clinical conditions that can show similar manifestations. Such conditions can easily generate conflict with employers, based on unfounded allegations, if superficially assessed. The study calls for adequate preventative measures, primarily aimed at protecting women’s work.

KEY WORDS: psychosocial factors, bullying, women (working), adjustment disorder.

Introduction

Mobbing (bullying, moral harassment, psychological violence) is one of the most formidable psychosocial risk factors found in the workplace. It is defined as “any improper conduct that takes place, in particular, through behavior, words, acts, gestures, or writing, which upsets the personality, dignity, physical or psychological integrity of a person, and alters and degrades the working environment” (1). To define a situation as mobbing, it is necessary that the harassing actions be repetitive (according to some Authors, at least once a week for at least six months) (2).

Depending on the relationships between victims (“mobbed”) and persecutors (“mobbers”), different forms of mobbing are defined: “vertical from above” (by employers or superiors), “vertical from below” (unusual, by a lower hierarchic position), “horizontal or among peers” (among workers with similar hierarchic level), “planned or strategic” (within a deliberate corporate strategy aimed at excluding one or more employees), “double mobbing” (in the workplace and family). The attack modalities may involve communication, reputation and/or performance. Other common forms of work-related stress should not be confused with mobbing: antagonism and competitiveness; disputes, character incompatibility, interpersonal conflicts; changes due to company needs; justified disciplinary actions (3-6).

As in all the situations of reiterated stress, mobbing can exhaust the capacities of individual adaptation,
and cause several psychopathological manifestations more or less severe, sometimes irreversible, with repercussions on the somatic sphere. Such a syndrome may include psychosomatic manifestations (insomnia, headache, cardiovascular and gastrointestinal disorders, immunodepression), emotional disturbances (anxiety, anger, crying fits, panic attacks, mood deflection, affective indifference, depersonalization), behavioral disorders (changes in appetite, drugs and substance abuse, self- or hetero-aggressiveness, apathy, changes in sexual behavior up to libido disappearance) (4-7).

The “mobbing syndrome” has not been clearly identified nosologically. Indeed, although several mobbing-related psychopathological conditions are described in scientific literature, both the ICD-10 (International Classification of Disease) and DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) identify only two stress-related conditions (not necessarily work-related): the Post-Traumatic Stress Disorder (PTSD), and the Adjustment Disorder (AD).

The problem of mobbing and resulting disease has complex medico-legal implications, in the penal, civil, and insurance contexts. During the last few years, the Italian Workers’ Compensation Authority (INAIL) recognized some cases, and included “mental and psychosomatic illnesses due to work organization dysfunctions (organizational coerciveness)” in the list II, group 7, of the new inventory of occupational diseases (Italian Ministry of Labour and Social Policy: Decree 27th April 2004). Thus, an accurate diagnostic procedure is essential not only for clinical (prognostic and therapeutic-rehabilitative) reasons, but also for the possible demonstration of the causal relation between harassment in the workplace and the suffered damage (8, 9).

The European Parliament Resolution of the 20th September 2001 identified women’s work as being a risk area. The EASHW (European Agency for Safety and Health at Work) has long stimulated each country to examine its critical issues regarding gender, health, and safety at work, in order to plan appropriate interventions. A document of the same agency emphasizes that, compared to men, research, prevention and awareness of working women’s risks are underestimated and neglected. In Italy, the article 28 of the Legislative Decree 81/2008 states that gender differences should be properly considered in the evaluation of occupational risks, including “those related to work stress”. Nevertheless, in scientific literature there are few studies on gender differences among victims of mobbing or other sources of work-related stress.

Objectives

The present study evaluates the frequency of mobbing syndrome and other non-mobbing-related psychiatric disorders, in patients with working discomfort, undergoing a multidisciplinary diagnostic procedure (occupational physician, psychologist, psychiatrist). The gender differences, and medico-legal implications, of the diagnosis are then analyzed.

Methods

From 2001 to 2011, 474 patients required a specialist visit at the Occupational Medicine Unit of our Institute for psychological health problems, related, in their opinion, to mobbing (or other forms of work discomfort) in the workplace. The sample consisted of 273 females (58%) and 201 males (42%), aged between 21 and 61 years (average: 41.8). Five subjects (1%) had attended primary school only, 166 secondary school (35%), 227 had a high school diploma (48%), and 76 were university graduated (16%). Three hundred and forty-three patients (72%) were employed in private companies, while the remaining 131 (28%) worked in public institutions. About 12% of the subjects were executives, 15% intermediate managers, 39% clerks, 22% workmen; the remaining 12% had other qualifications.

The diagnostic process, developed by our Unit over the years (10), begins with an evaluation by an occupational health specialist: for each patient a careful work history is collected, as well as family, social, physiological and pathological history; this step is followed by a careful physical examination, in order to identify possible diseases associated with the symptoms of the patient. It should be specified that the evaluations are mostly based on patient reports, in that our hospital unit cannot (by law) directly verify the existence of harassment in the workplace (a very difficult task, for which sufficiently validated methods are still lacking). Therefore, we formulated the mobbing syndrome diagnoses in probabilistic terms.

The diagnostic protocol then includes: psychological counseling, structured interview for DSM-IV: SCID (Structured Clinical Interview for DSM-IV) axis I and II, a complete personality test MMPI-2 (Minnesota Multiphasic Personality Inventory-2), psychiatric examination, and other laboratory and instrumental tests when indicated.

The structured interview is based on a specific protocol, and attributes specific symptoms, on which the examiner focuses, to the different disease conditions. By giving each patient a severity score, we obtain satisfactory results. For axis I, the process starts with patient’s history and leads to evaluate the presence of psychiatric disorders, such as anxiety and depression. The axis II consists of a self-report questionnaire followed by an interview regarding critical items of the questionnaire, to identify personality disorders and mental retardation.

The MMPI-2, i.e. the updated and standardized version of the MMPI test, is intended to assess the most important structural features of personality and emotional disorders. It includes 567 questions on different topics: general health, neurological conditions, cranial nerves, motility and coordination, sensitivity, vasomotor function, trophism, speech, secretory functions, cardiovascular, respiratory, gastrointestinal and genitourinary systems, habits, family and marital situation, professional activity, education, sexual, social and religious behavior, attitudes towards politics, law and order, morality, masculinity, femininity, presence of depression, manic, obsessive and compulsive disorders, presence of hallucinations, illusions, delusions, phobias, sexual sadistic and masochistic trends. The patient should respond to

Prevention & Research 2014; 3(2):74-78
items with “True” or “False”, but all omissions and items with dual response are considered “I don’t know”. The usefulness of information obtained through the MMPI-2 depends on the ability of the subject to understand instructions, carry out the required task, understand and interpret the content of the items, and record the answers correctly. To calculate the scores, a computer program and a manual scoring are available. The interpretation of results requires a high level of psychometric, clinical, and professional competence.

The ethical committee of our Institution approved the study protocol, according to the criteria of the Declaration of Helsinki.

Results

As shown in Figure 1, 16 (3%) of the examined patients did not complete the described diagnostic procedures. In 176 subjects (37%) no psychiatric diagnosis (according to the DSM IV criteria) was formulated, while finding altered dynamics in interpersonal relationship with colleagues and concurrent stressful conditions. In 130 patients (28%), we diagnosed a psychiatric disturbance not related to work (depressive and/or anxiety disorder, personality disorder like cluster A and B, dysthymia). Only 152 patients (32%) were affected by work-related psychiatric disorders: among these, 37 (8% of the total; 14 males, 23 females) were likely cases of mobbing, including 2 PTSDs (both females) and 35 ADs (14 males, 21 females). These cases were reported to the judicial and compensation authorities as probable occupational diseases. Other 105 subjects (40 males, 65 females) suffered from work-related anxiety with somatization. Finally, 10 patients (3 males, 7 females) presented AD not consequent to mobbing. The average age of the 152 patients with a work-related stress disorder was 40.8 years: 45.7 years for males, 39.5 for females, the latter representing a higher proportion (63%) than men (37%). The majority of the subjects had medium or high education; in particular, 23 patients had graduated from university (15%), 76 had a high school diploma (50%), the remaining 52 attended secondary school (34%), 1 primary school (1%). Regarding work task, 126 subjects (83%) worked in private companies, the remaining 26 (17%) in public administrations; tasks and skills were very different with a clear prevalence of office workers, in which interpersonal relationships and communication are inherently part of the work. The harassment’s length was variable, ranging from 6 months to 15 years.

Discussion

At the end of the diagnostic multidisciplinary procedure, the mobbing syndrome (PTSD or AD) was actually identified, with a reasonable degree of probability, in less than 10% of all patients. This proportion is lower than that described in other Italian case series (11, 12). The discrepancy could be due to different methods in the diagnostic approach or to pre-selection criteria of patients entering the outpatient service. In our series the subjects were referred by the family doctor, while in the study of Monaco et al. (12), for example, the 152 patients had been subject to a previous selection by a group of psychologists: in these subjects, the percentage of mobbing diagnoses was 49%.

A cautionary approach should be adopted in labeling as “mobbing syndrome” clinical conditions that can show similar manifestations; as regards this, the high proportion of psychiatric diseases unrelated to work (approximately one third) must be highlighted. As recently reported in literature (13), these conditions can easily generate litigation with employers, based on unfounded allegations, if superficially assessed. These disputes may lead to worsening of preexisting clinical conditions. Despite being limited by the lack of direct verification of what was reported by patients, our data confirm that a rational diagnostic approach (necessarily interdiscipli-
nary) to mobbing is crucial in order to correctly estimate the true prevalence of this phenomenon (often overestimated by mass-media), and to allow proper identification from a forensic and insurance point of view.

Among workers with work-related psychiatric disorders, we found a preponderance of females (63%). This gender difference remains in the small group of patients whose psychopathology (PTSD or AD) was mobbing-related: both cases of PTSD, and 21 (out of 35) of AD, were women.

The majority of women affected by psychiatric disorders related to occupational stress (including mobbing) was between 34 to 45 years: this can be explained by the increased family commitment in this age range, resulting in rise of stressful conditions and working difficulties (11, 14).

Previous investigations of moral violence and gender differences are not univocal. In prison officers, for example, there was no evidence of significant gender differences in the prevalence and modes of bullying practices; some specific types of actions, as the non-allocation of work tasks and exclusion from meetings, were instead found to be more frequent against men than women (15). Research on other professionals has come to similar conclusions, indicating that this kind of bullying is more common in male managerial roles (2).

In Turkey, a questionnaire dispensed to a large working population found that, in many and varied employment areas, men are at increased risk of physical aggression, while women are more exposed to verbal, psychological and sexual abuse (16).

According to our data, Bjorkqvist et al. reported that, among mobbing victims (within the university), about 2/3 are women (17). Also, bullying was more commonly reported by women than men (with double frequency) in a survey conducted among businessmen (18). This condition could result from increased exposure to negative actions, lower perceived ability to defend, or to a tendency to more easily define the proper experience as bullying.

The female gender is more frequently mobbed also in the series of Work Clinic of Milan, where a diagnostic protocol similar to ours was used (19).

When researching the perception of harassment, we found that women focus on comments regarding private life and rumors, while men are more involved in activities aimed to discredit the work. A possible correlation between different mobbing modalities and the victims’ gender has also been shown: among women, emotional mobbing is more frequent; among men the strategic kind (4). The bullying behavior against a woman begins, in most cases, when she has just returned from maternity leave and/or needs to frequently leave work to take care of her family. In such cases, it happens that, after making her feel guilty about the (real or alleged) inconvenience related to her absence, the worker is isolated. The hostility to female workers who are entitled to special contractual benefits, such as particular schedules, maternity and expectancies, triggers the bullying phenomenon. Moreover, women more easily report work problems, unlike men who, according to old stereotypes, provide for the family with their work, thus achieving a full satisfac-

tion. Probably because of these reasons, men are more reluctant to disclose problems related to the working environment.

The reasons why women are more targeted by psychological harassment, in our and other case series, may be various, e.g. a more passive attitude (more easily attacked) and rare managerial positions: bullying is mainly exercised by superiors towards subordinates.

The present study highlights the need for preventative interventions. Mobbing and work-related stress prevention begins with proper risk assessment (as required by the article 28 of the Legislative Decree 81/2008), and must involve workers and professionals institutionally appointed to protect their health: employers, prevention technicians, corporate physicians, unions. Ethical behavior should primarily be promoted, to spread trust, tolerance and respect in the workplace (5). The containment of moral violence is based on the possibility of starting a cultural change in interpersonal relationships, values and attitudes (in particular to women).

Acknowledgments

We thank Christine Broughton for linguistic revision, and Paola Baiardi (Biostatistician) for helpful discussion.

References


