

Workplace Bullying in Nurses

LYN QUINE

University of Kent at Canterbury, UK

LYN QUINE is Reader in Health Psychology at the Centre for Research in Health Behaviour, Department of Psychology, University of Kent at Canterbury. Her research interests include occupational health, stress moderators and mediators, and the application of social cognition models to health-related behaviour.

ACKNOWLEDGEMENTS: The author would like to thank all the NHS staff who participated in this study.

COMPETING INTERESTS: None declared.

ADDRESS. Correspondence should be directed to:

LYN QUINE, Centre for Research in Health Behaviour, Department of Psychology, University of Kent at Canterbury, Canterbury CT2 7NP, UK. [Tel. +44 1227 823078; Fax +44 1227 827032; email: L.Quine@ukc.ac.uk]

Journal of Health Psychology
Copyright © 2001 SAGE Publications
London, Thousand Oaks and New Delhi,
[1359-1053(200101)6:1]
Vol 6(1) 73-84; 015313

Abstract

The article reports a study of workplace bullying in community nurses in an NHS trust. The aims were to determine the prevalence of bullying, to examine the association between bullying and occupational health outcomes, and to investigate whether support at work could moderate the effects of bullying. Forty-four percent of nurses reported experiencing one or more types of bullying in the previous 12 months, compared to 35 percent of other staff. Fifty percent of nurses had witnessed the bullying of others. Nurses who had been bullied reported significantly lower levels of job satisfaction and significantly higher levels of anxiety, depression and propensity to leave. They were also more critical of aspects of the organizational climate of the trust. Support at work was able to protect nurses from some of the damaging effects of bullying.

Keywords

nurses, stress moderators, support at work, workplace bullying

WORKPLACE bullying refers to a process in which the victim is subjected to a series of systematic stigmatizing attacks from a fellow worker or workers which encroach on his or her civil rights. With a few exceptions (e.g. Brodsky, 1976) it was not recognized as an issue of scientific interest until the mid-1980s. Systematic research began in Scandinavia (Bjorkqvist, Osterman, & Hjelt-Back, 1994; Leymann, 1990; Leymann & Gustavsson, 1984) and there is now high public awareness, government-funded research and established anti-bullying legislation. In the UK, although trades unions have recognized workplace bullying as an important issue for about five years, and a number of reports have described the misery, psychological distress and physical illness suffered by victims of bullying (MSF, 1995; NASUWT, 1995, 1996; UNISON, 1997), it has only recently become a subject of academic study. In June 1997, for example, the *Journal of Community and Applied Social Psychology* devoted a special issue to the subject of 'Bullying in Adult Life' which contained several articles on workplace bullying (Adams, 1997; Crawford, 1997; Rayner, 1997; Rayner & Hoel, 1997).

In the school-based literature, bullying is defined as a subset of aggressive behaviours involving three criteria: it is intentional harming or aggressive behaviour; it involves an imbalance of power between the victim and the bully; and it is carried out repeatedly and over time (Olweus, 1999). Three main types of bullying are identified: direct physical, verbal and indirect. Research into workplace bullying presents the researcher with significantly more difficulties, for there is no clear consensus on what constitutes adult bullying, whether it refers to a range of possible behaviours or can be expressed in a single definition. Though physical bullying is rarely reported (Einarsen, Raknes, & Matthiesen, 1994), the workplace presents opportunities for a wider range of intimidating behaviours. Rayner and Hoel (1997, p. 183) suggest that five categories of bullying behaviour are to be found. These are: *threat to professional status* (e.g. belittling opinion, public professional humiliation, accusation of lack of effort); *threat to personal standing* (e.g. gossiping about you, name-calling, insults, teasing); *isolation* (e.g. preventing access to opportunities such as leave or training, physical or social isolation, with-

holding of information); *overwork* (e.g. undue pressure to produce work, impossible deadlines, unnecessary disruptions); and *destabilization* (e.g. failure to give credit when due, meaningless tasks, removal of responsibility, shifting of goal-posts, repeated reminders of error, setting up to fail).

Definitions of workplace bullying generally share three common elements. First, bullying is defined in terms of its *impact on the recipient*. Bullying exists when an individual is subjected to a range of intimidating behaviours which make him or her *feel* bullied or harassed. Thus it is subject to variations in personal perceptions, which present further methodological problems for the researcher. Second, most definitions suggest that there must be a *negative effect on the victim* (Lockhart, 1997; Lyons, Tivey, & Ball, 1995; Randall, 1997; Rayner & Hoel, 1997). See, for example, Lyons, Tivey and Ball's definition:

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*. (Lyons et al., 1995, p. 3) (emphasis added)

Third, the bullying behaviour must be *persistent*. In Sweden, for example, an incidence of about one occurrence a week for the past six months is adopted (Vartia, 1996). As in school bullying, some definitions include an intention on the part of the bully to cause harm (ACAS, 1999), while others, influenced by case law definitions in the related areas of racial and sexual harassment, deliberately exclude it (see Leymann, 1996; Lyons et al., 1995).

The literature reflects three main approaches to workplace bullying. The first has been qualitative and individualistic, identifying a role for the individual either in terms of vulnerability to bullying or a propensity to bully (Brodsky, 1976; Crawford, 1997; Field, 1996; Lockhart, 1997; Randall, 1997). Primarily dependent on anecdotal evidence and illustrated by case histories, these writers elucidate the processes by which people become bullies or victims and the dynamics of bully-victim relationships. The second approach has been descriptive and epidemiological and is usually based on self-report

elicited by structured interviews or postal questionnaires (Bjorkqvist et al., 1994; Einarsen & Skogstad, 1996; Leymann & Thallgren, 1989; Rayner, 1997). These studies document the prevalence of workplace bullying, age and sex differences, the types of bullying experienced, who is told, what action is taken, and so on. The third approach, epitomized by the Scandinavian research, is influenced by theories and constructs in organizational psychology and has focused on the interaction between the individual and the organization and the way aspects of the organizational structure and climate of the workplace may affect both the interpretation of behaviour as bullying and its acceptance (Einarsen et al., 1994; Einarsen & Skogstad, 1996; Vartia, 1996; Zapf, Knorz, & Kulla, 1996). Relationships have been demonstrated between high rates of workplace bullying and male-dominated organizations, leadership style, low job control, role conflict, lack of participation in decision-making processes, and lack of support from senior staff. These aspects of the organizational climate are seen as encouraging the development of a bullying culture.

It has been suggested in the literature on occupational stress (Payne, 1979) that having a supportive work environment can act as a coping strategy, helping to moderate the effects of work stressors such as bullying and protecting the individual from the harmful effects of stress. This is consistent with the idea that some of the functions of social support are related to appraisal (information relevant to self-evaluation) and emotional concern (House, 1981). Our study, which reports on bullying among nurses in an NHS community trust, investigated whether support at work could perform this moderating role. The objectives of the study were: (1) to assess the prevalence of workplace bullying in nurses and to examine the differences in rates between them and other staff; (2) to examine the relationships between bullying and occupational health; and (3) to investigate whether job control and support at work can protect staff from the adverse effects of bullying.

The study

In 1996 a community NHS trust in the south-east of England commissioned an examination of the prevalence of workplace bullying as part of a

larger survey of working life. The trust provides a range of mental health, learning disability, primary care, and child health services comprising residential care facilities, multidisciplinary community and day service teams, health promotion, health visiting, school and community nursing services, occupational therapy, physiotherapy, speech and language therapy, and child and family psychiatry services. Results for all staff are reported in the *British Medical Journal* (Quine, 1999). This study concentrates on the 396 qualified nurses in the trust, and examines differences in the prevalence of bullying between them and other staff.

Participants and procedure

A questionnaire entitled 'Working Life Survey' was sent out to all 1580 trust employees, together with a covering letter explaining the purpose of the research and a prepaid envelope. The questionnaire was anonymous to encourage participation, but we asked participants to post back a prepaid postcard which they had signed at the same time as they returned their questionnaires. This enabled us to send reminders to staff who had not returned questionnaires. Reminders were sent after three weeks, followed by a second questionnaire after a further three weeks, and then a final reminder. After this the data were entered onto computer and analysed using SPSS for Unix.

The questionnaire

The questionnaire contained four sections. Section 1 collected profile information about the participant's job, qualifications, professional group, hours worked, and supervisory responsibilities. Section 2 contained measures of the occupational health outcomes: job satisfaction (Quinn & Staines, 1979), propensity to leave (Cammann, Fichmann, Jenkins, & Klesh, 1979) and anxiety and depression (Zigmond & Snaith, 1983). A scale measuring support at work adapted from Payne (1979) was also included. The Job Satisfaction Scale uses five items to tap a worker's general affective reaction to the job (Quinn & Staines, 1979). Propensity to leave was measured by the subscale of the Michigan Organizational Assessment Questionnaire (Cammann et al., 1979). It provides a three-item index of employees' intention to leave their job. The Hospital Anxiety and Depression Scale is a

14-item measure, seven items of which measure anxiety and seven of which measure depression (Zigmond & Snaith, 1983). Cut-off points are provided to give the best separation between non-cases (0–7), doubtful cases (8–10) and cases (11+) of clinical anxiety and depression. The scale can be used as a continuous score to measure severity. Care was taken when it was produced to separate out the concept of emotional and somatic illness, so the scores are reported not to be affected by the presence of bodily illness.

Support at work was measured by a scale adapted from Payne's (1979) work, in which the author defines support as 'the degree to which the work environment makes available resources (physical, intellectual, technical, financial and social) relevant to the demands made upon the system/person/group' (Payne, 1979, p. 86). Staff were asked to rate on a 5-point scale a number of resources in the work environment, including feedback and support from colleagues and managers, access to community resources, level of workplace morale, positive working practices, work environment, etc. All the scales have been used widely in the literature and are reported to have satisfactory reliability and validity.

The third section of the questionnaire contained questions about the staff's perceptions of the organizational climate of the trust and their experience of workplace bullying, and examined the consequences of bullying. We tried to avoid some of the methodological problems inherent in some previous research by enquiring about the experience of bullying behaviours rather than bullying itself, which is more likely to be subject to variations in personal perceptions. Twenty types of bullying behaviour were culled from the literature (Adams, 1992; Bassman, 1992), representing each of the categories provided in Rayner and Hoel's (1997) work. Staff were asked to indicate whether they had been persistently subjected to any of these behaviours in the workplace in the last 12 months. Since the commissioning trust was concerned to establish the prevalence of each type of bullying behaviour since trust status had been granted, we used a time period of 12 months and a simple yes/no response so that we could report the results as percentages. Section 4 of the questionnaire asked for sociodemographic information—age,

gender, educational level, etc—and contained questions concerning smoking, drinking and exercise habits.

Results

A total of 1100 completed questionnaires was returned, representing a response rate of 70 percent. Seventy-three percent ($n = 778$) of participants held professional qualifications: 36 percent of the sample ($n = 396$) were qualified nurses from a range of disciplines, for example registered general nurses, registered mental health nurses, registered learning disabilities nurses and health visitors; 12 percent ($n = 132$) had secretarial or administrative qualifications; 10 percent ($n = 111$) had qualifications in the therapies (occupational, speech and language, chiropody, physiotherapy); 5 percent ($n = 49$) had medical degrees; 1 percent ($n = 11$) had qualifications in clinical psychology; and 9 percent ($n = 101$) had a range of qualifications in other areas such as social work, residential care or health promotion. Twenty-seven percent of staff ($n = 300$) were unqualified. These staff comprised unqualified residential care staff, porters and catering, cleaning and maintenance staff. Table 1 shows the profile of the participants, including the distribution by age, gender and hours worked. Note that participant numbers do not always add up to 1100 because questions

Table 1. Profile of participants

	%	<i>n</i>
Occupational group		
Nurses	36	396
Therapists	10	111
Administrative staff	12	132
Doctors	5	49
Clinical psychologists	1	11
Other professionals	9	101
Unqualified staff	27	300
Total	100	1100
Gender		
Male	16	176
Female	84	915
Total	100	1091
Hours		
Full time	51	560
Part time	49	537
Total	100	1097

were occasionally omitted by error. Checks made with the personnel department indicated that the sample accurately reflected the profile of the trust in terms of age, gender and occupational groups, and there was no indication that non-responders differed from responders in any significant way.

Scale reliability

Scales were constructed of all the main measures and their reliability was investigated using Cronbach's alpha (see Table 2). Satisfactory alphas were found for all scales.

Prevalence of bullying

Qualified nurses were more likely to have been subjected to bullying than other staff in general. Overall, significantly more nurses (44 percent, $n = 174$) reported experiencing one or more types of bullying in the previous 12 months, compared with other staff (35 percent, $n = 247$, $\chi^2 = 8.4$, d.f. = 1, $p < .01$). Nurses also reported experiencing significantly more types of bullying than other staff (nurses' $M = 2.2$, $SD = 3.8$; other staff $M = 1.5$, $SD = 2.9$, $t = 3.5$, $p < .001$). Table 3 shows the percentage of nurses and other staff experiencing each category and type of bullying behaviour. Thirty-three percent of nurses had experienced destabilizing behaviours, compared to 23 percent of other staff. Twenty-seven percent had experienced behaviours designed to isolate, compared with 21 percent of other staff. Twenty-two percent had experienced threats to personal standing, compared with 18 percent of other staff. Nineteen percent of nurses had experienced threats to professional status, compared to 16 percent of other staff and 19 percent had experienced pressure to overwork, compared to 13 percent of other staff. There was no statistically significant difference between nurses and other staff in the category 'Threat to professional status', though one item, 'Persistent

attempts to belittle and undermine your work', showed a significant difference. Nor was there a statistical difference in the category 'Threat to personal standing' between nurses and other staff, though three individual items showed statistically significant differences. However, for the categories 'Isolation', 'Overwork', and 'Destabilization' there were significant differences between nurses and other staff. A higher proportion of nurses experienced bullying from these categories than other staff did.

Nurses were also more likely than other staff to have witnessed the bullying of others. Fifty percent of nurses ($n = 198$) reported witnessing other people being bullied in the previous 12 months, compared to 36 percent ($n = 250$) of other staff ($\chi^2 = 13.4$, d.f. = 1, $p < .001$).

Characteristics of the victims of bullying

Among nurses there were no differences by age or gender in reports of bullying. However, nurses who worked full time were more likely to be bullied than those who worked part time (65 percent, ($n = 113$) as against 35 percent ($n = 61$), $\chi^2 = 9.1$, d.f. = 1, $p < .01$). Of nurses who had experienced bullying, 69 percent ($n = 63$) had tried to take action about the bullying when it occurred. Strategies included ignoring the bully (48 percent, $n = 34$), talking to friends and colleagues (86 percent, $n = 61$), reporting it to personnel or to a line manager (59 percent, $n = 41$), making a formal complaint (6 percent, $n = 4$), or confronting the bully themselves (37 percent, $n = 26$), but only 22 percent ($n = 15$) were satisfied with the outcome. Only 7 percent ($n = 5$) had used the staff stress counselling service, which was comparatively new.

Twenty-six percent ($n = 45$) of nurses who had experienced bullying reported that their health had been affected, and 18 percent ($n = 26$) were unsure. Eight percent ($n = 13$) had taken time off

Table 2. Mean, standard deviation and reliability of scales

	Items	α	M	SD	n
Job satisfaction	5	0.84	12.5	2.7	1064
Propensity to leave	3	0.71	7.6	2.8	1083
Anxiety	7	0.85	6.8	4.0	1079
Depression	7	0.81	3.9	3.3	1078
Support at work	17	0.91	54.7	12.7	1093
Bullying scale	20	0.81	3.1	3.3	1093

Table 3. Differences between nurses and other staff for each type and category of bullying

	Nurses		Other staff		χ^2	
	%	n = 396	%	n = 704		
Threat to professional status [†]	19	(76)	16	(109)	2.5	NS
1. Persistent attempts to belittle and undermine your work	15	(57)	10	(67)	6.0	**
2. Persistent unjustified criticism and monitoring of your work	11	(41)	10	(68)	0.2	NS
3. Persistent attempts to humiliate you in front of colleagues	10	(37)	8	(53)	1.2	NS
4. Intimidatory use of discipline/competence procedures	7	(26)	4	(31)	2.5	NS
Threat to personal standing [†]	22	(88)	18	(129)	2.4	NS
5. Undermining your personal integrity	14	(53)	9	(61)	6.1	**
6. Destructive innuendo and sarcasm	14	(54)	10	(69)	3.8	*
7. Verbal and non-verbal threats	7	(26)	5	(37)	0.8	NS
8. Making inappropriate jokes about you	6	(25)	3	(24)	5.1	*
9. Persistent teasing	4	(15)	2	(17)	1.7	NS
10. Physical violence	2	(7)	2	(11)	0.1	NS
11. Violence to property	1	(4)	2	(12)	0.8	NS
Isolation [†]	27	(107)	21	(148)	5.1	*
12. Withholding necessary information from you	20	(78)	14	(100)	5.8	**
13. Freezing out/ignoring/excluding	15	(58)	12	(85)	1.5	NS
14. Unreasonable refusal of applications for leave, training or promotion	12	(47)	5	(31)	21.7	***
Overwork [†]	19	(74)	13	(92)	6.2	**
15. Undue pressure to produce work	17	(66)	11	(73)	9.2	**
16. Setting of impossible deadlines	10	(39)	7	(50)	2.5	NS
Destabilization [†]	33	(132)	23	(162)	13.8	***
17. Shifting goalposts without telling you	27	(105)	14	(99)	26.1	***
18. Constant undervaluing of your efforts	14	(56)	10	(70)	4.5	*
19. Persistent attempts to demoralize you	13	(49)	9	(65)	2.7	NS
20. Removal of areas of responsibility without consultation	10	(40)	6	(44)	5.4	*

[†] Denotes experience of one or more behaviours in each category

NS: not significant, * $p < .05$, ** $p < .01$, *** $p < .001$

work because of bullying. A wide range of symptoms of malaise were described, including feeling unwanted or devalued (71 percent, $n = 70$), thinking about leaving the job (76 percent, $n = 60$), feeling miserable and depressed (87 percent, $n = 69$), feeling as if they did not want to go to work (82 percent, $n = 65$), feeling easily upset (73 percent, $n = 58$), having difficulty sleeping (70 percent, $n = 55$), feeling worthless (60 percent, $n = 47$), feeling constantly keyed up and jittery (54 percent, $n = 43$), and feeling anxious most of the time (51 percent, $n = 40$). Forty-three percent ($n = 20$) of smokers who had experienced bullying reported an increase in their smoking in the previous year, and 43 percent ($n = 39$) of drinkers reported an increase in their drinking habits. Eighty-three percent ($n = 143$) of nurses who had been bullied reported an increase in stress levels.

Characteristics of the bully

Those nurses who reported bullying were asked to describe a recent incident (in the last three months) and a number of questions were asked about it. Twenty-five percent of nurses ($n = 96$) described a recent incident. They reported that when an incident occurred, the bully was most likely to be a senior manager or line manager (59 percent, $n = 77$), though in 38 percent of cases ($n = 36$) it was someone of the same level of seniority, and in 3 percent of cases ($n = 3$) it was someone less senior than the victim. In 26 percent of cases the bully was male, in 66 percent of cases female, and in 8 percent of cases the victim was bullied by a person of each gender. The bully was frequently older than the victim (44 percent of cases, $n = 39$), though in 31 percent of cases ($n = 27$) both parties were of

similar age, and in 25 percent of cases ($n = 22$) the bully was younger than the victim.

Relationship between bullying and perceptions of the organizational climate

Nurses who reported one or more types of bullying were more likely than other nurses to be critical of aspects of the organizational climate of the trust. They reported higher workloads ($M = 3.2$, $SD = 1.0$ as against $M = 2.8$, $SD = 0.9$, $t[1, 383] = 4.3$, $p < .001$), greater role ambiguity ($M = 2.5$, $SD = 1.2$ as against $M = 1.9$, $SD = 0.9$, $t[1, 387] = 6.4$, $p < .001$), less participation in decision making ($M = 2.9$, $SD = 1.2$ as against $M = 1.9$, $SD = 0.9$, $t[1, 389] = 7.8$, $p < .001$) and lower job control ($M = 16.5$, $SD = 4.3$ as against $M = 19.5$, $SD = 2.5$, $t[1, 377] = 8.2$, $p < .001$) than did other nurses.

Relationships with occupational health outcomes

Relationships between bullying and occupational health outcomes were examined by t -test or chi-squared test where appropriate. Nurses who had experienced one or more types of bullying in the last year reported significantly lower levels of job satisfaction at the time of response than nurses who were not bullied ($M = 10.1$, $SD = 2.8$ as against $M = 11.9$, $SD = 2.2$, $t[1, 386] = 7.2$, $p < .001$). Additionally they had higher scores on the Propensity to Leave Scale, showing that they were more likely to contemplate leaving than nurses who were not bullied ($M = 8.5$, $SD = 2.9$ as against $M = 7.3$, $SD = 2.6$, $t[1, 396] = 4.3$, $p < .001$). They were significantly more likely to suffer clinical levels of anxiety (34 percent, $n = 59$ as against 11 percent, $n = 24$, $d.f. = 1$, $\chi^2 = 31.4$, $p < .001$) and depression (8 percent, $n = 14$ as against 1 percent, $n = 3$, $d.f. = 1$, $\chi^2 = 10.6$, $p < .001$) as measured by the cut-off point of the Hospital Anxiety and Depression Scale. They took significantly more days off

work for sickness absence than nurses who were not bullied ($M = 18.0$, $SD = 50.1$ as against $M = 5.3$, $SD = 16.4$, $t[1, 378] = 3.4$, $p < .001$).

Correlations between occupational health outcomes and categories of bullying

Correlations between the five categories of bullying and occupational health outcomes conducted for nurses only are presented in Table 4. Each of the categories of bullying was significantly positively correlated with anxiety, depression and propensity to leave, and negatively correlated with job satisfaction. The categories of bullying that proved to have the highest correlations with occupational health outcomes for nurses were pressure to overwork and destabilization.

Support at work as a buffer against bullying

As we suggested earlier, it has been hypothesized that having a supportive work environment may moderate the effects of work stressors such as bullying, buffering the individual from their harmful consequences. According to Baron and Kenny (1986), a moderator is 'a variable that partitions a focal independent variable into subgroups that establish its domains of maximal effectiveness in regard to a given dependent variable'. The moderator effect is typically shown as an interaction term in analysis of variance, in this case high/low bullying by good/poor support.

To test whether support at work could moderate the effects of bullying for nurses, four two-way analyses of variance were conducted. The dependent variables were job satisfaction, propensity to leave, anxiety and depression. The independent variables were scores on the support at work scale, which was split at the median to give two groups, nurses with poor support (49 percent, $n = 193$) and nurses with

Table 4. Correlations between occupational health outcomes and categories of bullying

	<i>Job satisfaction</i>	<i>Anxiety</i>	<i>Depression</i>	<i>Propensity to leave</i>
Threat to professional status	-0.27***	0.25***	0.21***	0.21***
Threat to personal standing	-0.20***	0.26***	0.25***	0.11*
Overwork	-0.30***	0.41***	0.37***	0.17***
Isolation	-0.26***	0.23***	0.25***	0.21***
Destabilization	-0.39***	0.31***	0.33***	0.26***

* $p < .05$, *** $p < .001$

good support (51 percent, $n = 200$), and scores on the bullying variable, which was divided into reported bullying (44 percent, $n = 174$) and no reported bullying (56 percent, $n = 222$). Figure 1 and Table 5 show that there were main effects of bullying and support on all outcome variables and interaction (modifying) effects for three out of four outcome variables.

Discussion

Almost one in two nurses reported experiencing one or more types of bullying, compared with one in three other staff in the trust. This compares with about one in five found in a recent UNISON survey of union members (UNISON, 1997) and one in three in a Royal College of Nursing Survey (Alderman, 1997), though such comparisons should be treated with caution because of differences in definition and timeline. A higher proportion of nurses than other staff reported 13 of the 20 bullying behaviours. The behaviours reported most frequently were shifting the goalposts, withholding necessary information, undue pressure to produce work, freezing out, ignoring or excluding, and persistent attempts to belittle or undermine the person's work. Nurses were also more likely to have witnessed the bullying of others.

A quarter of nurses who had been bullied reported that their health had been affected, and 8 percent had taken time off work because of it. A wide range of illness symptoms was reported, from feeling miserable and depressed, and feeling unwanted or devalued, to having difficulty sleeping. Nearly 70 percent of those bullied had tried to take action to stop the bullying, but only 22 percent were satisfied with the outcome. The most likely bully was a manager who was older than the victim. Nurses who had been bullied had less positive perceptions of the organizational climate than other nurses. They were more likely to report having higher work-

loads, greater role ambiguity, less participation in decision-making processes and lower job control than other nurses.

Nurses who had experienced bullying reported lower levels of job satisfaction and were more likely to report wanting to leave. They were more likely to be clinically anxious and depressed. These findings are consistent with those of research from Norway and Finland. In the Norwegian study, Einarsen and Raknes (1991) found that employees who had been bullied were especially affected by depression, while in the Finnish study (Bjorkqvist et al., 1994) bullied employees showed significantly more symptoms of anxiety and depression. In a cross-sectional study, the causal definition of variables cannot be properly determined. Three possible explanations may be advanced to account for the associations between bullying and negative outcomes. The first is that being bullied does indeed lead to psychological ill-health, reduced job satisfaction and a desire to leave the job. The second is that being depressed or anxious may place a person at risk of bullying by people who single out the weaker ones to victimize. Anxiety or depression may also weaken an individual's ability to cope with stressors such as bullying. The third explanation is that certain staff may be more likely to perceive themselves as (or report being) bullied than others and to report lower levels of job satisfaction and higher levels of depression, anxiety and propensity to leave. These might be people who are more pessimistic in outlook or have a tendency to experience negative emotional states.

Recently attention has turned to the role of negative affectivity in understanding relations between self-reports of stressors and strains (Watson & Pennebaker, 1989; Watson, Pennebaker, & Folger, 1987). Watson and Clark (1984), for example, have argued that a number of commonly used instruments such as the Taylor Manifest Anxiety Scale (Taylor, 1953)

Table 5. Results of two-way analysis of variance

<i>Outcome</i>	<i>Main effect of bullying</i>	<i>Main effect of support</i>	<i>Interaction effect</i>
Job satisfaction	$F(1, 389) = 22.3 ***$	$F(1, 389) = 50.8 ***$	$F(1, 389) = 4.1 **$
Anxiety	$F(1, 384) = 25.0 ***$	$F(1, 384) = 18.6 ***$	$F(1, 384) = 0.1 NS$
Depression	$F(1, 383) = 25.3 ***$	$F(1, 383) = 31.1 ***$	$F(1, 383) = 4.9 *$
Propensity to leave	$F(1, 389) = 8.1 **$	$F(1, 389) = 24.0 ***$	$F(1, 389) = 4.3 *$

NS: not significant, * $p < .05$, ** $p < .01$, *** $p < .001$

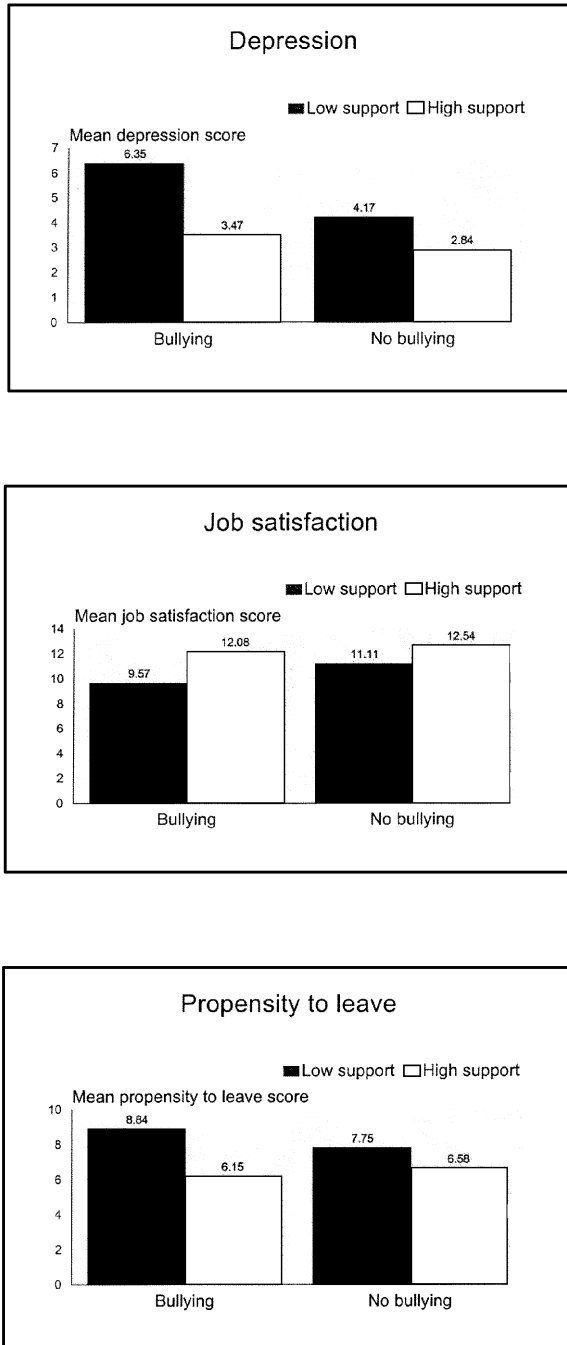


Figure 1. Results of the analysis of variance.

and the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) purporting to measure trait anxiety and depression can be considered as alternative measures of a more global trait, which they named negative affectivity. The authors define negative affectivity as a stable and pervasive individual difference characterized by a tendency to experience aversive emotional states. They conclude that 'high negative affectivity individuals are more likely to report distress, discomfort, and dissatisfaction over time and regardless of the situation, even in the absence of any overt or objective sources of stress' (Watson & Clark, 1984, p. 483). High levels of negative affectivity are associated with a type of cognitive bias through which people approach or interpret their life experiences. This cognitive style may influence how people experience and evaluate their job.

A number of investigators have shown that negative affectivity does inflate correlations between stressors and work-related variables. Inflated correlations have been found for job satisfaction (Levin & Stokes, 1989), somatic complaints and symptoms of depression (Burke, Brief, & George, 1993, though see also Chen and Spector, 1991, who found that negative affectivity accounts for a large proportion of shared variance between stressors and physical symptoms, but not for much of the variance shared by stressors and affective strains such as job satisfaction and feelings of stress). Longitudinal data and a conceptually developed scale of negative affectivity such as that produced by Stokes and Levin (1990) are required to try to disentangle these effects, for the issue is complex. However, to suggest that victims of bullying are simply those who view the world through gloomier spectacles introduces a fundamental problem, since it denies the existence of bullying and precludes any discussion of the health consequences that bullying may have for the victim. In our study, 50 percent of nurses had witnessed the bullying of others, including many who did not report being bullied themselves. This suggests that bullying is not simply in the eye of the beholder. The role of negative affectivity may be partially to inflate the correlations between bullying and adverse health outcomes rather than to explain them. This issue requires further research in which the effects of negative affectivity are partialled out.

In addition, bullying seems to occur significantly more frequently among some occupational groups, which together with the findings on organizational climate suggests a role for organizational factors. Much of the Scandinavian research addresses this topic (Einarsen & Skogstad, 1996; Vartia, 1996; Zapf et al., 1996), but as yet it has not been investigated in the UK.

The results of the two-way analysis of variance support the hypothesis that a supportive work environment is able to act as a moderator, protecting individuals from some of the harmful effects of bullying. Nurses who reported being bullied but had good support at work had significantly lower scores on the propensity to leave and depression scales and higher scores for job satisfaction than those who reported being bullied but had poor support. Cohen and Hoberman (1983) suggest that support may function as a buffer against stress by meeting coping requirements related to the appraisal and self-esteem that are elicited when individuals experience stressful events. Other factors such as high levels of job control and personal dispositions such as hardiness, optimism or self-efficacy may also be able to protect people against bullying. These deserve research attention.

Bullying at work is acknowledged as a workplace risk by the Health and Safety Executive in their guide *Stress at Work* (Health and Safety Executive, 1995). The guide reminds employers that there is a duty under the Management of Health and Safety at Work Regulations (MHSW, 1992) to assess the nature and scale of risks to health in the workplace and base their control measures on it. The guide advises that employers should have effective systems for dealing with interpersonal conflict, bullying and racial and sexual harassment, including agreed grievance procedures and proper investigation of complaints. The provision and enactment of policies and procedures against bullying will benefit employees and employers alike: reduced stress results in better health, reduced sickness absence, increased performance and output, better relationships with clients and colleagues, lower staff absence and turnover and less likelihood of litigation from workers who believe their health has been damaged. Travers and Cooper (1993), for example, have estimated that between 30 and 55 percent of all work-related

stress is caused by workplace bullying and that 40 million working days a year are lost because of it.

The results of this study indicate that in combination with developing anti-bullying policies and formal and informal grievance procedures, taking steps to provide a positive work environment with appropriate attention to staff support structures may be an effective way of protecting people's health and welfare in the workplace.

References

- ACAS. (1999). *Bullying and harassment at work: A guide for employees*. London: ACAS.
- Adams, A. (1992). *Bullying at work: How to confront and overcome it*. London: Virago.
- Adams, A. (1997). Bullying at work. *Journal of Community and Applied Social Psychology*, 7, 177-180.
- Alderman, C. (1997). Bullying in the workplace. *Nursing Standard*, 11(35), 22-26.
- Baron, R. M., & Kenny, D. A. (1986). The moderator-mediator variable distinction in social psychological research: conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology*, 51, 1173-1182.
- Bassman, E. (1992). *Abuse in the workplace*. New York: Quorum.
- Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, 4, 461-571.
- Bjorkqvist, K., Osterman, K., & Hjelt-Back, M. (1994). Aggression among university employees. *Aggressive Behaviour*, 20, 173-184.
- Brodsky, C. M. (1976). *The harassed worker*. Toronto: Lexington.
- Burke, M. J., Brief, A. P., & George, J. M. (1993). The role of negative affect in understanding relations between self-reports of stressors and strains: A comment on the applied psychology literature. *Journal of Applied Psychology*, 78(3), 402-412.
- Cammann, C., Fichmann, M., Jenkins, D., & Klesh, J. (1979). The Michigan Organizational Assessment Questionnaire (Unpublished manuscript). Ann Arbor, MI: University of Michigan.
- Chen, P. Y., & Spector, P. E. (1991). Negative affectivity as the underlying cause of correlations between stressors and strains. *Journal of Applied Psychology*, 76, 398-407.
- Cohen, S., & Hoberman, H. M. (1983). Positive events and social support as buffers of life change stress. *Journal of Applied Social Psychology*, 13(2), 99-125.
- Crawford, I. (1997). Bullying at work: a psychoanalytic perspective. *Journal of Community and Applied Social Psychology*, 7, 219-225.
- Einarsen, S., & Raknes, B. I. (1991). *Mobbing in worklife: A study of the prevalence and health effects of mobbing in Norwegian workplaces*. Bergen: Forskningscenter for arbeidsmiljø (FAHS), University of Bergen.
- Einarsen, S., Raknes, B. I., & Matthiesen, S. B. (1994). Bullying and its relationship to work and environment quality: An exploratory study. *European Work and Organizational Psychologist*, 4, 381-401.
- Einarsen, S., & Skogstad, A. (1996). Bullying at work: Epidemiological findings in public and private organizations. *European Journal of Work and Organizational Psychology*, 5(2), 185-201.
- Field, T. (1996). *Bully in sight: How to predict, resist, challenge and combat workplace bullying*. Wantage: Success Unlimited.
- Health and Safety Executive. (1995). *Stress at work: A guide for employees*. London: HMSO.
- House, J. S. (1981). *Work stress and social support*. Reading, MA: Addison-Wesley.
- Levin, I., & Stokes, J. P. (1989). Dispositional approach to job satisfaction: Role of negative affectivity. *Journal of Applied Psychology*, 74, 752-758.
- Leymann, H. (1990). Mobbing and psychological terror at workplaces. *Violence and Victims*, 5(2), 119-126.
- Leymann, H. (1996). The content and development of mobbing at work. *European Journal of Work and Organizational Psychology*, 5(2), 165-184.
- Leymann, H., & Gustavsson, B. (1984). *Psychological violence at workplaces: Two exploratory studies*. Stockholm: Arbetsarkivstyrelsen.
- Leymann, H., & Thallgren, U. (1989). An investigation into the frequency of bullying in SSAB, with a new questionnaire. *Arbete, Manniska, Mjilo*, 1, 3-12.
- Lockhart, K. (1997). Experience from a staff support service. *Journal of Community and Applied Social Psychology*, 7, 193-198.
- Lyons, R., Tivey, H., & Ball, C. (1995). *Bullying at work: How to tackle it. A guide for MSF representatives and members*. London: MSF.
- MHSW (1992). Management of Health and Safety at Work Regulations 1992 Approved Code of Practice L21. London: Health and Safety Executive Books.
- MSF. (1995). *How big is the problem of bullying at work? Report of a survey of MSF workplace representatives on their experiences and impressions of bullying at work*. London: MSF.
- NASUWT. (1995). *Workplace bullying: Report of NASUWT survey of members 1995*. Birmingham: NASUWT.
- NASUWT. (1996). *No place to hide: Confronting workplace bullies*. Birmingham: NASUWT.
- Olweus, D. (1999). Bullying in Sweden. In P. K. Smith, Y. Morita, J. Junger-Tas, D. Olweus, R. Catalano, & P. Slee (Eds.), *The nature of school bullying* (p. 11). London: Routledge.
- Payne, R. (1979). Demands, supports, constraints and

- psychological health. In C. Mackay, & T. Cox (Eds.), *Response to stress: Occupational aspects*, 85–105. London: IPC Business Press.
- Quine, L. (1999). Workplace bullying in NHS community trust: Staff questionnaire survey. *British Medical Journal*, *318*, 228–232.
- Quinn, R. P., & Staines, G. L. (1979). *The 1977 Quality of Employment Survey*. Ann Arbor, MI: Institute for Social Research, University of Michigan.
- Randall, P. (1997). *Adult bullying: Perpetrators and victims*. London: Routledge.
- Rayner, C. (1997). The incidence of workplace bullying. *Journal of Community and Applied Social Psychology*, *7*, 199–208.
- Rayner, C., & Hoel, H. (1997). A summary review of literature relating to workplace bullying. *Journal of Community and Applied Social Psychology*, *7*, 181–191.
- Stokes, J. P., & Levin, I. M. (1990). The development and validation of a measure of negative affectivity. *Journal of Social Behavior and Personality*, *5*(2), 173–186.
- Taylor, J. A. (1953). A personality scale of manifest anxiety. *Journal of Abnormal Social Psychology*, *48*, 285–290.
- Travers, C., & Cooper, C. (1993). Occupational stress among UK teachers. *Work and Stress*, *7*, 203–219.
- UNISON. (1997). *Bullying at work: Bullying survey report*. London: UNISON.
- Vartia, M. (1996). The sources of bullying: Psychological work environment and organizational climate. *European Journal of Work and Organizational Psychology*, *5*(2), 203–214.
- Watson, D., & Clark, L. A. (1984). Negative affectivity: The disposition to experience aversive emotional states. *Psychological Bulletin*, *96*, 465–490.
- Watson, D., & Pennebaker, J. W. (1989). Health complaints, stress and distress: exploring the central role of negative affectivity. *Psychological Review*, *96*, 234–254.
- Watson, D., Pennebaker, J. W., & Folger, R. (1987). Beyond negative affectivity: Measuring stress and satisfaction in the workplace. In J. M. Ivancevitch & D. C. Ganster (Eds.), *Job stress: From theory to suggestion* (pp. 141–157). New York: Haworth Press.
- Zapf, D., Knorz, C., & Kulla, M. (1996). On the relationship between mobbing factors and job content, social work environment and health outcomes. *European Journal of Work and Organizational Psychology*, *5*(2), 215–237.
- Zigmond, A. S., & Snaith, R. P. (1983). The Hospital Anxiety and Depression Scale. *Acta Psychiatrica Scandinavica*, *67*, 361–370.