Review *Clin Ter 2023; 174 (1):93-96* *doi: 10.7417/CT.2023.2503*

Assessment of workplace bullying in Italy by INAIL: forensic and occupational medicine considerations

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Abstract

The Authors, after a broad examination of the operating methods of inail (National Institute for Accident Insurance at Work) for the correct assessment and indentification of workplace bullying, carried out a comparative evaluation on the various diagnostic tests in the forensic psychiatric field for this occupational problem. ***Clin Ter 2023; 174 (1):93-96 doi: 10.7417/CT.2023.2503***

Key words: *Workplace bullying, INAIL, Psychiatric tests*

Workplace bullying: an introduction

Workplace bullying is a series of aggressive and frequent behaviors towards an employee by the employer, superiors or colleagues.

Workplace bullying can be carried out directly by the employer ('bossing' or vertical descending bullying), by colleagues (horizontal bullying), by both (mixed bullying) or by subordinates towards the superior (vertical ascending bullying). A study conducted on Italian healthcare professionals shows that workplace bullying stands at 15.3%: workplace bullying emerges as even more acute among female healthcare workers (16.4%) and young workers (the most affected age group is that between 35 and 39 years). It can be seen that male gender is a protective factor related to bullying. Furthermore, there is a significant difference between regions: Northern ones (17.0%) have a greater presence of the phenomenon of bullying (1).

Risk Factors

The position taken by the INAIL on the subject of psychic pathologies determined by the organizational/environmental conditions of work finds its legal foundation in the Constitutional Court Sentence n. 179/1988 and in the Legislative Decree n. 38/2000 (art. 10, paragraph 4), according to which are occupational diseases, not only those listed in the appropriate tables of the law, but also all the others whose work cause is demonstrated.

According to an interpretation adhering to the evolution of the forms of organization of production processes and to the growing attention to safety and health profiles in the workplace, the notion of work cause allows us to include not only the harmfulness of the processes in which the cycle develops corporate production (whether tabulated or not) but also that attributable to the corporate organization of work activities (2, 3, 4).

Mental disorders can therefore be considered of occupational origin only if they are caused, or prevalently co-caused, by specific and particular conditions of the activity and organization of work.

It is believed that these conditions only occur in the presence of situations of inconsistency of choices in the organizational sphere, situations that can be defined with the expression "organizational constraint" (5, 6).

The most common situations of "organizational constraint" are shown below, in a list that has an essential indicative value for any similar situations.

List of "organizational constraints":

- Marginalization from work activity
- Emptying of tasks
- Failure to assign work tasks, with forced inactivity
- Failure to assign work tools
- Repeated unjustified transfers
- Prolonged attribution of disqualifying tasks with respect to the professional profile possessed
- Prolonged assignment of exorbitant or excessive tasks also in relation to possible psycho-physical handicap conditions
- Systematic and structural impediment to access to news

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ISSN 1972-6007

· Structural and systematic inadequacy of information concerning ordinary work activities
· Repeated exclusion of the worker from training, retraining and professional updating initiatives
· Exaggerated and excessive exercise of forms of control.

The protected risk can also include the so-called "strategic harassment" specifically related to work purposes. However, it is reiterated that the actions aimed at alienating or marginalizing the worker are of insurance relevance only if they materialize in one of the situations of "organizational constraint" referred to in the list above or in others similar to them.

Furthermore, organizational inconsistencies must have structural, lasting and objective characteristics and, as such, verifiable and documentable through equally objective checks and not susceptible to interpretative discretion (5, 6).

On the other hand, the following are excluded from the protected risk:
· organizational/managerial factors related to the normal performance of the employment relationship (new assignment, transfer, dismissal)
· the situations induced by the psychological-relational dynamics common to both work and life environments (interpersonal conflicts, relational difficulties or behaviors in any case attributable to purely subjective behaviors which, as such, inevitably lend themselves to interpretative discretions) (7, 8, 9).

Assessment of risk conditions

As with all other non-tabled illnesses, the policyholder is required to produce suitable documentation to support his/her request as regards both the risk and the illness.

The Institute, for its part, has the power-duty to verify the existence of the presuppositions of the alleged right, also through the participatory commitment in the reconstruction of the probative elements of the etiological nexus (9, 11).

The experience gained to date has shown that sufficient documentary evidence cannot always be produced by the insured, or acquired by the Institute (12, 13).

It is therefore necessary to carry out inspections to collect testimonial evidence from work colleagues, the employer, the company prevention and protection services manager and any person informed of the facts in order to:

acquire objective evidence of what was declared by the insured

integrate the evidence produced by the insured.

Further elements may be drawn from the eventual verification of the facts carried out in court or during inspection supervision by the Provincial Labor Directorate or the competent offices of the AA.SS.LL. (14, 15).

As with all other occupational diseases, the inspection investigation aimed at acquiring objective findings as well as any supplementary elements of what is alleged and produced by the insured must be activated upon request by the health function, which will also indicate the specific aspects to be investigated (16, 17, 18).

On the other hand, unlike other occupational diseases (for which inspections are only required if necessary), inspections must always be carried out for the pathologies in question. Exceptions are obviously the cases in which the health function, already at the end of the first preliminary phase, has reached the determination to define the case negatively due to the absence of the disease or due to the certainty of the exclusion of its professional origin (19, 20).

The diagnostic process of occupational disease from organizational constrictiveness

The diagnostic procedure to be followed for the purposes of a uniform medico-legal treatment of the cases reported to the Institute is described below (21).

• Previous and current work history
· Indicate the working sector, year of employment, qualification and duties performed.
· Describe the work situation believed to be the cause of the illness by identifying the specific conditions of organizational constraint.

Arrange, if not already in the documents, the necessary inspection investigations4 with the consequent acquisition of declarations from the employer, testimonies from work colleagues, any judicial documents, etc.

• Physiological history: report lifestyle habits (nutrition, smoking, alcohol, hobbies, educational qualification, etc.)
• Past pathological history:
· Report the diagnosis formulated in the 1st occupational disease medical certificate.
· Describe the course and symptoms of the mental disorder.
· Include, in the medical documentation of interest, the specialist certifications, the preventive and periodic health checks carried out in the company and any "previous INPS".
• Complete physical examination
• Neuropsychiatric investigations:
· Neuropsychiatric visit and report accompanied by any psychodiagnostic tests, if the neuropsychiatrist specialist is present on site.
· External specialist consultancy, in agreement with a neuropsychiatry specialist with proven experience or with a public facility, if the neuropsychiatrist specialist is not present on site.
• Psychodiagnostic tests:

The particularity of the subject leaves it up to the individual specialist, in relation to his or her professional experience, to choose which tests to administer, tests which supplement the objective psychic examination but cannot replace it. These tests, as a whole of the psychiatric video, assume undoubted importance due to their reproducibility and comparability over time and therefore for medico-legal purposes. We list below the most frequently used ones.

a) Personality questionnaires (MMPI and MMPI2, EWI, MPI, MCMI etc.)
b) Rating scales of psychiatric symptoms:
- for anxiety and depression, self- and external assessment (BDI, HAD scale, HAM-A, HAM and Zung depression

rating scale, MOOD scale);
- for aggression and anger (STAXI);
- for post-traumatic stress disorder (MSS-C);
- for amplification of somatic symptoms (MSPQ);

c) Projective tests (Rorschach, SIS, TAT, drawing reagents etc.)

• Medical-legal diagnosis:

· For the nosographic classification, refer exclusively to the following two conditions:
- chronic maladaptive syndrome (disorder);
- chronic post-traumatic stress syndrome (disorder).

The diagnosis commonly correlated to the risks in question is chronic adjustment disorder, with the various clinical manifestations (anxiety, depression, mixed reaction, alteration of conduct, emotional disturbances and somatoform disturbances). The evaluation of these manifestations will allow the classification in mild, moderate, severe (22, 23).

The diagnosis of post-traumatic stress syndrome (or disorder) can concern those cases for which the work event, assuming more extreme connotations, can be considered comparable to those mentioned in the international classifications of the ICD-10 and DSM-IV. These cases are defined as "extreme/exceptionally threatening or catastrophic" (in this regard it is worth remembering the possibility that cases configuring an "acute event" must find a natural place in the workplace accident) (24, 25).

· Exclude, for the purposes of differential diagnosis, the presence of:
- mental syndromes and disorders attributable to organ and/or systemic pathologies, drug abuse and the use of narcotic substances
- psychotic syndromes of a schizophrenic nature, bipolar affective syndrome, manic, severe personality disorders.

• Assessment of permanent biological damage

The table of impairments, relating to the assessment of biological damage in the INAIL5 context, provides for the presence of two items which both pertain only to post-traumatic stress disorder, moderate (item 180) and severe (item 181).

The evaluation range reported offers an adequate reference to allow, by analogy, the evaluation of the biological damage also from chronic adaptation disorder. The two impairments, even if they derive from a different harmful event, can in fact present prejudices of the psychic sphere that are partially superimposable and coincident.

The assessment of the damage will take into account the polymorphism and severity of the psychiatric and somatoform symptoms, according to the indications of the international classifications referred to above, as found in the individual case (26).

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