

COPING AND HEALTH IN HARASSED TEACHERS

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ABSTRACT

The present study examined the relationship among bullying, coping strategies, and health in a sample of 255 Spanish teachers. They completed a set of questionnaires to evaluate: 1) *bullying* (with a bullying perceived questionnaire); 2) *health* (with General Health Questionnaire); and 3) *coping* strategies (with the Brief COPE). Results showed that teachers bullied by colleagues had a poorer health than those not bullied. The analysis established also the differences between targets and non-targets in coping strategies: It was observed that bullying targets use more non-functional coping strategies and fewer functional ones than non-targets. These results suggest that it is necessary eradicate bullying in order to improve workers' health and well-being. The victims also need to change their strategies to coping harassment. More investigations in these issues are needed, as they are essential to workplace health and well-being.

RESUMEN

En este estudio se examinó la relación entre el sentimiento de acoso psicológico en el trabajo, la salud y las estrategias de afrontamiento del estrés. Participaron 255 profesores no universitarios que completaron el Cuestionario de Acoso Psicológico Percibido, el Cuestionario de Salud General y el Brief Cope (Cope-28, en español). Los resultados hallaron que los profesores acosados por colegas tenían peor salud que los no acosados. Se encontraron también diferencias en el uso de estrategias de afrontamiento entre las víctimas y las no víctimas de acoso: las primeras utilizan más estrategias disfuncionales y menos estrategias funcionales. Estos resultados sugieren que es necesario erradicar el acoso en el entorno laboral con el fin de mejorar la salud y el bienestar. También las víctimas de acoso necesitan cambiar sus estrategias de afrontar el bullying. Son necesarias más investigaciones en el campo de la salud y el bienestar en el ámbito laboral.

Keywords: Bullying; Mobbing; Health; Coping with stress.

BULLYING AND HEALTH

Many studies suggest that workplace bullying is a grave problem for many people in Europe (Einarsen, Hoel, Zapf, & Cooper, 2003), as well as for many organizations. The concept of bullying at work refers to all situations where one person feels subject to negative treatment from others in the workplace, situations in which they are unable to defend against these actions (Einarsen, 2005). It causes them to feel excluded and actively rejected by their own social group, which, in addition, causes them to question their professional worth. Frequently it arises for arbitrary, inexplicable, and irrational reasons, and has nothing to do with the professionalism or personal worth of the victims. According to Leymann (1996a), the characteristics of bullying are psychological harassment and abusive behavior, or psychological violence, carried out systematically (once a week) for more than six months.

Workplace bullying is a deliberate, systematic, and persistent maltreatment inflicted to someone by one or more people in the workplace, with a dual objective: destroying him psychologically and socially, and forcing him to leave the organization (Moran, 2002). Workplace bullying can make different forms: one form is direct bullying which consists of aggressive acts that make it difficult for targets to do their work, or involving their personal life with rumors, defame, offending mockery, or sexual harassment. Indirect bullying may take the form of social isolation or withdrawal of necessary information (Hansen, Høgh, Persson, Karlson, Garde, & Ørbæk, 2006). The supervisors can also be involved in the harassment sometimes. The perpetrator can be a co-worker that, for any reason, is stronger than the target; but also, any subordinates, if they form a group, can bully a supervisor as well.

The prevalence of bullying shows large differences depending on the measure and the definition given to the participants, however most research find the prevalence mostly varies between 2% and 17%. In a survey, Einarsen et al. (2003) found that between 1% and 10% of workers are exposed to the acts that are considered harassment at work. Bullying is most frequent in workplaces with a negative and stressful environment (Einarsen, Raknes, & Matthiesen, 1994).

There is unanimous agreement that bullying affects to health (Hoel, Zapf, & Cooper, 2002). Most of bullying victims report somatic symptoms, like muscular aches, headaches, or joint pain, irritability, depression, insomnia, dysmenorrhea, lost of concentration. In addition, victims show high levels of burnout and could present post-traumatic stress symptoms (Leymann & Gustafsson, 1996). Leymann (1996b) found that bullying is contingent with health loss; at the beginning, physical illnesses and somatic symptoms can be detected. Furthermore bullying affects the victim's mental health (mental health is an essentially positive concept, including feelings of satisfaction and plenitude) causing higher levels of anxiety, insomnia, and depression. Bullying affects social well-being, seen as the capacity for high productivity, autonomy and decision-making also.

COPING

Lazarus (1993) defined coping as the cognitive and behavioral efforts developed for a person in order to manage specific external and/or internal demands appraised as situations exceeding their resources. He created a coping scale to measure different ways that people manage the problems with stress. Lazarus made a distinction between two general categories of coping: 1) problem-focused coping aimed at solving or doing something to alter the source of the stress; and 2) emotion-focused coping, pointed at reducing or managing the emotional distress that is associated with the situation. Lazarus argued that it is not viable to categorize coping strategies into "right" or "wrong" ways to deal with a stressful situation, although Park & Adler (2003) suggest that, some strategies do appear to be more adaptive than others are.

Both, problem solving and cognitive restructuring coping have been linked with physical health and general wellbeing (while avoidance coping is frequently associated with poorer adjustment and

more negative outcomes). Following Lazarus (1993) theory, Carver (1997) proposed a brief cope inventory, which has proven to be useful in health-related research. The Brief COPE evaluates fourteen coping styles that people typically use to coping problems with stress: active coping, planning, seeking social support for instrumental reasons, seeking emotional support, denial, acceptance of responsibility, positive reinterpretation and growth, religion, humor, self-distraction, self-blame, disconnecting, venting emotions, and substance use (Morán, 2010).

This study had two aims: to know the repercussions of bullying on general health, an specific (somatic symptoms, anxiety-insomnia, depression, and social dysfunction); and seeking differences on coping strategies among teachers bullied and teachers not bullied (targets and non-targets of workplace bullying).

METHODOLOGY

Participants and procedure

They were two 255 teachers, 92 were male (36%). Mean age was 38 years old ($SD = 10,09$), with a range which went from 21 to 65 years old They had been working for a mean of 13 years, with a maximum of 37 years, and a minimum of 1 year.

People trained in psychological assessing by survey applied the questionnaires to teachers of school, high school, and university.

Measures

The Bullying Perceived Questionnaire (Moran, Gonzalez, & Landero, 2009) measure with 15 items different acts and sentiments of bullying at work. Examples of the items are: 7: I feel that I cannot trust my colleagues; 9: It's difficult to feel sure about what you do, you can be attacked from any direction; 13: I feel that I'm being harassed in my workplace. Participants rated the frequency of bullying experience related to each element using a 5-point scale with verbal anchors: 1 = Never to 5 = always, with intermediate points. Level of reliability for this study was 0.92.

General Health Questionnaire (GHQ-28) (Goldberg & Williams, 1996, orig. 1988;) is a self-administered screening questionnaire for detecting common mental disorder in the general population. Items on the questionnaire asked respondents if they had recent (over the past few weeks) complaints, such as lost much sleep over worry. Each individual item was scored using a 1–4 point Likert scale. Test reliability is 0.82 for somatic symptoms, 0.90 for anxiety-insomnia, 0.76 for social dysfunction, 0.85 for depression, and 0.92 for the total questionnaire in this work.

Brief COPE (Carver, 1997) is a shortened form of the COPE inventory (Carver, Scheier, & Weintraub, 1989) and consists of 28 items to measure different behaviors and cognitive activities that people might to cope problems with stress. A Spanish form of Brief COPE was applied (Moran, Landero, & Gonzalez, 2010). In the current study, individuals were asked to rate each item on a 4-point scale (1: "I haven't been doing this at all; 4: "I've been doing this a lot") to indicate the degree to which they typically used each strategy to deal with workplace stress.

RESULTS

In Table 1 we can see descriptive statistics bullying perceived and health scales; also sowed Pearson inter-correlations between bullying perceived and health scales.

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Table 1. Descriptive statistics and Pearson correlations for the Bullying Perceived Questionnaire and the GHQ-28.

	Bullying	Somatic symptoms	Anxiety-insomnia	Social-dysfunction	Depression	General health
Mean	27.02	5.71	5.31	6.92	1.28	19.20
SD	10.10	3.97	4.23	2.59	2.41	11.03
α	.92	.82	.90	.76	.85	.92
r (Pearson)	1	.348	.472	.247	.310	.441
Bullying sig.		.000	.000	.000	.000	.000

Bullying perceived correlated positively to all the variables of health measured with the GHQ-28. The highest relation was for anxiety-insomnia ($r = .472$); general health (distress) had the next highest score ($r = .441$); also had positive correlation with somatic symptoms ($r = .348$), depression ($r = .310$), and social dysfunction ($r = .247$). The relationship of bullying to health appears clearly reflected in this result, so people feeling target of bullying have more health problems, physical, social, and psychological health, and therefore a lower general well being.

Differences between teachers bullied and not bullied in coping strategies

To know that the participants were distributed in three groups according the scores obtained on the Bullying Perceived Questionnaire. Group 1 (low perception of bullying) formed for 42 teachers, those who obtained scores less than 17 (minimum score was 15); this group was named “*non-targets*”. The group 2 (high perception of bullying) contained 30 teachers (30 represent the 12%) who scored higher than 40 (maximum score was 65); this group was named “*targets*”. Group 3 (medium perception of bullying) contained 183 teachers; the group 3 was not included in this analysis. This classification was carried out based on the statistics presented in many studies (see Einarsen et al., 2003), where it was shown that 1-10% of the workforce may be experiencing harassment in the workplace. As well, Malinauskiene (2004) find out in your study of bullying among teachers in Kaunas, that the 13.9 % of teachers is a target of bullying.

Table 2. T-test for Equality of Means between non-targets (N=42) and targets (N=30) in 14 scales of brief COPE (only showed in table coping strategies who are statistically differences).

Coping strategies	Bullying	Mean	<i>t</i>	Sig.
Planning	Non-targets	6.45	1.981	.050
	Targets	5.33		
Positive reframing	Non-targets	6.07	2.691	.009
	Targets	4.10		
Acceptance	Non-targets	5.19	2.497	.015
	Targets	4.00		
Denial	Non-targets	.76	-2.345	.022
	Targets	1.67		
Self-distraction	Non-targets	2.10	-2.676	.011
	Targets	3.35		
Venting	Non-targets	1.86	-2.215	.032
	Targets	2.96		

Result of the T-test for Equality of Means, in Table 2, show significant differences in coping strategies, such as planning: non-target teachers showing higher use of planning than target teachers do; non-targets used more positive reframing and acceptance of the problems. Targets teachers obtain higher scores for coping strategies such as self-distraction, venting, and denial. The results shown that teachers bullied used more non-functional coping strategies, on the other hand, teacher non bullied preferred functional strategies for cope their problems with stress.

DISCUSSION

The results of our study show that bullying has a significant relationship with worse health in all of scales: greater quantity of somatic symptoms, higher levels of anxiety and insomnia, high social dysfunction and higher levels of severe depression. The relationship between bullying and health has been investigated in numerous studies, such as that carried out by Hansen, Høgh, Perrson, Karlson, Garde & Ørbæk (2006), which showed that the employees sufferers harassment complained of more somatic symptoms, depression, anxiety, and negative affect than non-victims. These authors also found differences between victims and non-victims of harassment in the workplace in cortisol levels in their saliva. Björkqvist, Österman & Hjelt-Bäck (1994) found that nearly all victims of bullying interviewed complained of insomnia, nervous symptoms, melancholy, apathy, loss of concentration and socio-phobia. In a review, Einarsen & Mikkelsen (2004) found that the exposure to systematic bullying at work causes a host of negative effect in the targets.

Another objective was to found differences between teachers non-target and target in coping strategies. Results show that non-targets use more planning to cope problems with stress than bullying targets, and used more positive reframing, re-evaluating problems in terms of its positive side, leading to personal growth. They also had greater acceptance of personal responsibility in the problems. However, bullying targets make a greater use of non-functional coping strategies, such as self-distraction, which reduces the resources available to resolve the problem, or denial, which at the beginning minimizes the stress, but in a long term, the strategies to cope the problem are not developed, and venting emotions that has the same effect. The majority of laboratory studies (Carver, Scheier, & Weintraub, 1989) have therefore considered these strategies like dysfunctional. Mikkelsen (2004) find that the victims used a combination of strategies, being the most prevalent 1) initial attempts to control or suppress their negative feelings whilst trying to live up to the bully's demands; followed by 2) seeking support among colleagues and in some cases their superiors; 3) confronting the bully; and finally 4) taking a final sick-leave after which they left the company (the latter strategy were used by the majority of victims after they had sought assistance from their union). Pehkonen (2004) meet significant differences between the bullied and control group in coping: active coping, planning, turning to religion, venting of emotions, denial, and mental disengagement the bullied group scored significantly higher than the control group. The control group scored significantly higher than the bullied group in humor. There was no significant difference in the use of adaptive coping strategies between the bullied and control groups but significant differences were found for less-adaptive and mal-adaptive strategies with these strategies used more frequently by the bullied group.

The results of this study are not conclusive, further studies are needed to determinate why the victims fail to cope certain workplace situations such as psychological harassment. We are motivated to continue researching in this field, with the hope of shedding some more light on the reasons why victims do not defend themselves, or do not do so effectively.

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