



Izvirni znanstveni članek / Original article

WORKPLACE MOBBING: A CASE STUDY REPORT

RAZŠIRJENOST TRPINČENJA NA DELOVNEM MESTU: ŠTUDIJA PRIMERA

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Key words: workplace mobbing, physicians, nurses, Leymann Inventory of Psychological Terrorization Questionnaire, victim, perpetrator

ABSTRACT

Introduction: Mobbing in the workplace is defined as any systematic maltreatment of employees against a colleague (horizontal mobbing), a subordinate (downward mobbing) or a superior (upward mobbing). Employees in health care sector are often faced with mobbing due to unclearly defined tasks and expectations and the extant health care vertical hierarchical organizational structure. The aim of research is to establish the prevalence and nature of mobbing events among physicians and nurses, addressing the extent to which demographic issues are pertinent to the workplace mobbing.

Methods: Translated and adopted the *Leymann Inventory of Psychological Terrorization* questionnaire was used, including questions about the respondents' demographics, psychosomatic implications of mobbing, sick leave, length of work experience, and educational status of perpetrators. Of the 200 questionnaires distributed, 161 were returned (response rate = 80.5 %). Participating in the study were 84 (52.2 %) physicians (every second) and 77 (47.8 %) nurses (every eighth) who had been employed in the Celje General Hospital for more than six months, representing a systematic sample. The participation was voluntary and anonymity assured.

Results: The incidence of exposure to mobbing among physicians and nurses was high (60.1 %) but comparable to the results of other studies. A higher percentage of nurses (71.4 %) as compared to physicians (51.2 %) were exposed to mobbing ($p = 0,009$). In both cases, the perpetrators were mainly superiors and most frequent mobbing behavior towards victims was prohibiting of communication.

Discussion and conclusions: As a result of mobbing, the victims from both healthcare groups developed different psychological and physical health problems. Hospital executives should therefore adopt zero-tolerance policy towards workplace mobbing, take effective preventive measures to eliminate mobbing behaviour and apply appropriate sanctions to perpetrators.

Ključne besede: trpinčenje na delovnem mestu, zdravniki, medicinske sestre, LIPT-vprašalnik, žrtev, povzročitelj

IZVLEČEK

Izhodišča: Trpinčenje na delovnem mestu je sistematično slabo ravnanje s podrejenimi, sodelavci ali nadrejenimi, s katerim se zaposleni v zdravstvenem sektorju pogosto srečujejo. Delovne naloge in pričakovanja niso vedno jasno opredeljeni, k pojavu trpinčenja pa prispeva tudi hierarhična struktura. Namen raziskave je ugotoviti pojavnost in značilnosti trpinčenja na delovnem mestu med zdravniki in medicinskimi sestrami.

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Članek v slovenščini in prevod v angleščini / Article in Slovenian and translation in English
Prispelo / Received: 14. 12. 2011; Sprejeto / Accepted: 23. 3. 2012

Metode: Uporabljen je bil preveden in prirejen vprašalnik *Leymann Inventory of Psychological Terrorization*, skupaj z vprašanji o izbranih simptomih in podatkih o spolu, starosti, delovni dobi, bolniškem staležu izpostavljenih trpinčenju na delovnem mestu in izobrazbenem statusu povzročiteljev. Od 200 razdeljenih vprašalnikov je bilo vrnjenih 161 (80,5% odziv). Sodelovalo je 84 (52,2 %) sistematično izbranih zdravnikov (vsak drugi) in 77 (47,8 %) medicinskih sester (vsaka osma), ki so bili v Splošni bolnišnici Celje zaposleni več kot šest mesecev. Sodelovanje je bilo prostovoljno in anonimno.

Rezultati: Izpostavljenost trpinčenju na delovnem mestu med zdravniki in medicinskimi sestrami je bila visoka (60,1 %), vendar primerljiva z drugimi študijami. Medicinske sestre so bile dejanjem trpinčenja na delovnem mestu izpostavljene v večjem deležu (71,4 %) kot zdravniki (51,2 %, $p=0,009$). V obeh primerih so bili povzročitelji večinoma nadrejeni, prevladovalo je onemogočanje komunikacije.

Diskusija in zaključki: Zaradi trpinčenja na delovnem mestu so se zdravniki in medicinske sestre soočali s psihičnimi in telesnimi težavami, zato bi bili potrebni tudi organizacijski ukrepi, ki bi takšno vedenje preprečevali oziroma sankcionirali.

Introduction

Though the English word *mob* denotes a crowd, often in a destructive or hostile mood, several European languages have adopted *mobbing* as a loanword to describe all forms of disruptive behaviour in working life, including that by single persons. (In the English language, the term *bullying* is sometimes used as an alternative to *mobbing*, with similar or slightly different connotations). Konrad Lorenz, an Austrian ethnologist, first used the term to describe the anti-predator behaviour of birds, attributing it to instincts rooted in the Darwinian struggle to survive. In his view, we humans are subject to similar innate impulses but capable of bringing them under rational control (Selič, 2009).

In the 1980s, the Swedish psychiatrist Heinz Leymann (1996; 1990) observed similar behaviour in a workplace. According to Leymann, the *workplace mobbing* (WPM) involves hostile and unethical communication which is directed in a systematic manner by one or more individuals, mainly toward one individual, who, due to mobbing, is pushed into a helpless and defenseless position and held there by means of continuing mobbing activities. These actions occur on a very frequent basis (statistical definition: at least once a week) and over a long period of time (statistical definition: at least six months' duration). Because of the high frequency and long duration of hostile behavior, this maltreatment results in considerable mental, psychosomatic and social misery. The author developed a typology of 45 mobbing activities which could be subdivided into five groups or topics, depending on the effects they have on the victim:

- Effects on the victim's possibilities to communicate adequately;
- Effects on the victim's possibilities to maintain social contacts;
- Effects on the victim's possibilities to maintain his/her personal reputation;
- Effects on the victim's occupational situation;
- Effects on the victim's physical health (Leymann, 1996; 1990).

The results of numerous studies indicate that WPM takes place in organisations which allow or even

reward such a behaviour and promote authoritarian management style (Urdih Lazar, 2006; Vartia, 2001).

WPM can seriously impact both psychological and physical individual's health as well as behavioral health issues. The sequelae of WPM include increased depression/self-blame, anxiety disorders, sleep and digestive disturbances, irritability, hypertension, headache, abdominal pains, arthralgia, myodynia, cardiovascular diseases, eating disorders and increased suicidal tendencies. Leymann observed also that mobbing may result in symptoms mirroring post-traumatic stress disorder. The symptomatology manifested as anxiety and depression evolves only after a certain latent phase (Sperry, Duffy, 2009; Pompili et al., 2008; Koić, 2006; Moayed et al., 2006; Leymann, 1996; 1990). In addition, the observations of victims of WPM have shown other grave effects such as social isolation, family tension and stress, financial problems due to a disease and absence from work, invalidity and voluntary or involuntary resignation or dismissal. (Cvetko, 2006). WPM can affect also the victim's co-workers who may experience guilt by not helping the victimised, fearing that they themselves may become the target (Selič, 2009).

Aim

The purpose of the present study was to explore the prevalence and forms of WPM among the physicians and nurses employed in one of the general hospitals in Slovenia. Several socio-demographic and work situation factors were examined in order to identify and compare the phenomenon in the two groups of healthcare providers. The study aims to establish to what extent the demographic issues are pertinent to the WPM in health care sector. It examines a correlation between the aspects of age, gender, educational level, length of work experience, work absenteeism of the victims and WPM prevalence.

Methods

Subjects

Using a systematic sampling technique, every second

physician and every eighth nurse, employed in one of the general hospitals in Slovenia in March 2011, participated in the study. Of the 200 questionnaires distributed, 161 were completed and returned (response rate = 80.5 %). The participation was voluntary and anonymity assured.

The sample consisted of 84 (30.7 %) out of 274 physicians and 77 (9.6 %) out of 802 nurses employed in the public hospital at the time the study was conducted. As for gender aspect, 44 physicians were female (52.4 %) and 40 male (47.6 %). The cohort of nurses consisted of 55 female (71.4 %) and 22 male (28.6 %) subjects. The mean age of physicians was 38 years (37.89 ± 9.65 years), the youngest was 26 years old and the oldest 58 years. The mean age of nurses was approximately 36 years (35.82 ± 8.32 years), the youngest was 21-year old and the oldest 54 years. The demographic data are presented in Table 1. The study was approved by the National Medical Ethics Committee of the Republic of Slovenia on February 21, 2011, decree number 138/02/11.

Description of the research instrument

Translated and adopted *Leymann Inventory of Psychological Terrorization* (LIPT) was used to establish the prevalence of WPM. The questionnaire consists of 45 questions subdivided into five groups/topics (A – E), which present specific forms of workplace mobbing (Leymann, Gustafsson, 1996). Ten questions from the group A refer to the victims' possibilities to communicate adequately, five questions from the group B concern the victims' possibilities to maintain social contacts, 14 questions from the group C inquire about the victims' possibilities to maintain their personal reputation, seven questions from the group D address the victim's occupational situation and the last seven questions from the group E target the victim's physical health (Leymann, Gustafsson, 1996).

The first part of the questionnaire inquired about the participants' socio-demographic characteristics and employment. Participants were asked to provide data on their gender, age, marital status and number of years of work experience, frequency of sick-leave and their cognisance of the workplace mobbing. This part of the questionnaire was answered by all the participants. The second section of the questionnaire was designed to measure the perceived exposure to mobbing and victimisation at work. It was answered only by those participants who had been subjected to any form of mobbing at work. It included questions about the victims' actions taken, the perpetrators' educational level and the effects of mobbing on the victim's health. The statistical definition of workplace mobbing included exposure to workplace psychosocial stressors at least once a week over a period of at least six months' duration.

The reliability test for the entire model confirmed that the variables included in the questionnaire were selected appropriately (Cronbach $\alpha = 0.780$). The internal consistencies of the dimensions, reported as Cronbach's alpha coefficients, were 0.607 for group D - the victim's occupational situation and Cronbach $\alpha > 0.6$ for other groups.

Data collection and analysis

In agreement with the hospital executives, every second physician and every eighth nurse from the alphabetical list of employees was invited to participate in the study. 200 questionnaires were distributed and 161 completed questionnaires were returned and placed in the box provided.

Statistical analysis of the data collected was carried out using IBM SPSS Statistics version 19.0. Descriptive statistics of nominal and ordinal variables are presented as frequencies and percentages. The variables where the respondents filled in the information on their age, work experience expressed in months and the change of workplace were subdivided into structural classes.

In the category of WPM behaviours, the positive values were added up and a new variable mobbing was introduced as a result of the analysis of count data. When analysing the behaviours to which respondents were subjected, all positive answers of each participant were summed up from the groups A – E. Those respondents who had been subjected to any form of mobbing only once or never (values 1 or 2) were eliminated. Pearson's chi-squared test (χ^2) was used to evaluate statistically significant differences and/or the relationship between independent variables and the dependent variable mobbing. The significance level was $p \leq 0,05$.

Results

Demographic characteristics and prevalence of WPM

The results of the analysis revealed a significant effect for work experience, age and sick leave (Table 1). With regard to number of years of work experience, statistically significant differences were established in the group of nurses as for work experience but only in the category of up to two years ($\chi^2 = 8.194$, $p = 0.017$). Statistically significant differences were identified also in victimisation of physicians in age groups from 31 to 45 years and 46 years and more ($\chi^2 = 8.249$, $p = 0.016$) and in the variable of sick leave (never and twice) ($\chi^2 = 9.182$, $p = 0.027$).

Table 1. Prevalence of WPM against nurses and physicians according to selected socio-demographic characteristics

	Nurses				Physicians			TOTAL n (%)	
	TDM yes	TDM no	p	Total	TDM yes	TDM no	p		
Gender	n=55 (%)	n=22 (%)		n=77 (%)	n=43 (%)	n=41 (%)		n=84 (%)	n=161 (%)
Male	16 (29.1)	6 (27.3)	0.873	22 (28.6)	22 (51.2)	18 (43.9)	0.505	40 (47.6)	62 (38.5)
Female	39 (70.9)	16 (72.7)		55 (71.4)	21 (48.8)	23 (56.1)		44 (52.4)	99 (61.5)
Age	n=55 (%)	n=22 (%)		n=77 (%)	n=43 (%)	n=41 (%)		n=84 (%)	n=161 (%)
18 – 30 years	13 (23.6)	6 (27.3)	0.732	19 (24.7)	11 (25.6)	10 (24.4)	0.016	21 (25)	40 (24.8)
31 – 45 years	35 (63.6)	12 (54.5)		47 (61)	28 (65.1)	17 (41.5)		45 (53.6)	92 (57.1)
46 years and more	7 (12.7)	4 (18.2)		11 (14.3)	4 (9.3)	14 (34.1)		18 (21.4)	29 (18)
Marital status	n=55 (%)	n=22 (%)		n=77 (%)	n=43 (%)	n=41 (%)		n=84 (%)	n=161 (%)
Single	8 (14.5)	5 (22.7)	0.217	13 (16.9)	10 (23.3)	5 (12.2)	0.052	15 (17.9)	28 (17.4)
Married	26 (47.3)	11 (50)		37 (48.1)	18 (41.9)	23 (56.1)		41 (48.8)	78 (48.4)
Divorced	5 (9.1)	4 (18.2)		9 (11.7)	0 (0)	4 (9.8)		4 (4.8)	13 (8.1)
Unmarried partnership	16 (29.1)	2 (9.1)		18 (23.4)	15 (34.9)	9 (22)		24 (28.6)	42 (26.1)
Work experience	n=55 (%)	n=22 (%)		n=77 (%)	n=43 (%)	n=41 (%)		n=84 (%)	n=161 (%)
Up to 2 years	1 (1.8)	4 (18.2)	0.017	5 (6.5)	7 (16.3)	6 (14.6)	0.198	13 (15.5)	40 (24.8)
Up to 10 years	13 (23.6)	2 (9.1)		15 (19.5)	21 (48.8)	13 (31.7)		34 (40.5)	92 (57.1)
10 years and more	41 (74.5)	16 (72.7)		57 (74)	15 (34.9)	22 (53.7)		37 (44)	29 (18)
Change of work place during last six months	n=55 (%)	n=22 (%)		n=77 (%)	n=43 (%)	n=41 (%)		n=84 (%)	n=161 (%)
Never	45 (81.8)	21 (95.5)	0.122	66 (85.7)	26 (60.5)	25 (61)	0.774	51 (60.7)	117 (72.7)
1 - 3 times	10 (18.2)	1 (4.5)		11 (14.3)	12 (27.9)	13 (31.7)		25 (29.8)	36 (22.4)
More than 4 times	0 (0.0)	0 (0.0)		0 (0)	5 (11.6)	3 (7.3)		8 (9.5)	8 (5)
Sick-leave during last year	n=55 (%)	n=22 (%)		n=77 (%)	n=43 (%)	n=41 (%)		n=84 (%)	n=161 (%)
Never	20 (36.4)	8 (36.4)	0.536	28 (36.4)	20 (46.5)	29 (70.7)	0.027	49 (58.3)	77 (47.8)
Once	26 (47.3)	13 (59.1)		39 (50.6)	16 (37.2)	12 (29.3)		28 (33.3)	67 (41.6)
Twice	8 (14.5)	1 (4.5)		9 (11.7)	5 (11.6)	0 (0.0)		5 (6)	14 (8.7)
Three times and more	1 (1.8)	0 (0.0)		1 (1.3)	2 (4.7)	0 (0.0)		2 (2.4)	3 (1.9)

Legend: p > 0.05; n – number of respondents

The analysis shows also that most of the physicians (n=59, 70.2 %) and nurses (n=65, 84.4 %) are familiar with the term and definition of *mobbing* or *workplace mobbing*. The term is more often used among nurses (p = 0.033, $\chi^2 = 4.562$). Altogether, 64 (76.2 %) physicians and 49 (63.6 %) nurses share the belief that their work is honoured and respected (p > 0.05).

Characteristics of WPM

51.2 % of the physicians and even a greater percentage of nurses 71.4 % (p = 0.009, $\chi^2 = 6.908$) from the sample had been subjected to workplace mobbing. At the time of the study, the majority of physicians (61 %) were no longer exposed to WPM and 70.7 % of the subjects had not reported mobbing occurrences to their superiors. By

contrast, 58.2 % of nurses were still victimized even though 56.4 % of the subjects ($p > 0.05$) had notified their organizational superiors of mobbing occurrences.

Compared to physicians, nurses were exposed to WPB to a far larger extent in the realm of communication and self-expression ($p = 0.003$), social contacts in workplace ($p = 0.047$) and personal dignity ($p = 0.000$) (Table 2).

Table 2. *Workplace mobbing behaviours affecting nurses and physicians*

WPM behaviours	Frequency and percentage of exposure to WPM		p	χ^2
	Nurses	Physicians		
Topic A – Events that affect the victim's possibilities of adequate communication and self-expression	52 (67.5 %)	37 (44.0 %)	0.003	8.963
Topic B – Events that affect the victim's possibilities to maintain social contacts	23 (29.9 %)	14 (16.7 %)	0.047	3.957
Topic C – Events that affect the victim's possibilities to maintain his/her personal reputation	38 (49.4 %)	16 (19.0 %)	0.000	16.550
Topic D – Events that affect the victim's occupational situation	24 (31.2 %)	26 (31.0 %)	0.976	0.001
Topic E – Events that affect the victim's physical health	6 (7.8 %)	8 (9.5 %)	0.697	0.015

Legend: $p > 0.05$; χ^2 – chi square

Physicians were exposed to WPM perpetrated mainly by their co-workers with higher (39.5 %) or equal educational status (34.9 %), of whom 87.8 % were physicians and 12.2 % nurses. In the group of nurses similar results were obtained. The perpetrators of WPM usually possessed higher educational qualification than the victims (69.1 %). The offenders in the latter case were nurses (54.5 %) and physicians. In both groups of respondents the mobbing events were witnessed by other people (in case of physicians in 69.8 % and nurses in 69.8 %), ($p > 0.05$). The majority of the respondents suffered from at least one psychological

problem ensuing WPM (65.1 % of physicians and 85.5 % of nurses). The chi-square test ($p = 0.018$, $\chi^2 = 5.558$) revealed statistically significant difference between the physicians and nurses in respect to psychological symptomatology. The symptoms were more frequently manifested in nurses than in physicians (Table 3) and included fatigue and apathy ($p = 0.007$), general loss of motivation and feelings of discontent ($p \leq 0.01$), ($p = 0.014$), depressive moods, such as deep sadness, weeping, despair, despondency ($p = 0.014$) and indecisiveness ($p = 0.003$).

Table 3. *Psychological symptoms related to WPM in nurses and physicians*

Psychological impacts of WPM	Prevalence of symptoms in percentages		
	Physicians	Nurses	p
Irritability, increased sensitivity	44.2 %	55.6 %	0.266
Fatigue and apathy	20.9 %	47.3 %	0.007
Sleeping disorders (insomnia or somnolence)	18.6 %	20.4 %	0.828
Anxiety, undefined fears	11.6 %	22.2 %	0.173
Restlessness or slowness and inactivity	9.3 %	5.5 %	0.463
General loss of motivation and feelings of discontent	7.0 %	38.2 %	0.000
Memory and concentration disturbances	7.0 %	14.5 %	0.239
Depressive moods (sadness, weeping, despair, despondency)	4.7 %	22.2 %	0.014
Undefined physical pains (headaches, muscle and joint pains)	4.7 %	1.8 %	0.419
Social isolation, public avoidance behaviour	2.3 %	5.5 %	0.437
Eating disorders with weight loss or weight gain	0.0 %	1.9 %	0.370
Indecisiveness	0.0 %	18.2 %	0.003
Sexual disturbances	0.0 %	1.8 %	0.374

Legend: $p > 0.05$

Table 4. *Somatic symptoms related to WPM in nurses and physicians*

Somatic symptoms related to WPM	Prevalence of symptoms in percentages		
	Physicians	Nurses	p
Functional gastrointestinal disorders	14 %	12.7 %	0.859
Palpitations	9.3 %	7.3 %	0.716
Hypertension	9.3 %	0.0 %	0.021
Aggravation of potential skin diseases (more common recidivism)	2.3 %	7.3 %	0.269
Aggravation of potential allergic diseases (more common recidivism)	0.0 %	7.3 %	0.071
Excessive sweating	0.0 %	12.7 %	0.015

Legend: $p > 0.05$

30.2 % of physicians and 40.0 % of nurses suffered from at least one physical health problem related to WPM. As regards the impact of WPM on physical health of the respondents no statistically significant differences were established ($p = 0.317$, $\chi^2 = 1.003$) (Table 4). A larger percentage of physicians (9.3 %) suffered from hypertension than nurses ($p = 0.021$). More often than among physicians, excessive sweating was reported among nurses (12.7 %, $p = 0.015$).

Discussion

51.2 % of physicians and 71.4 % of nurses included in the study had experienced WPM. Most of the WPM perpetrators who targeted nurses had higher qualifications than their victims. On average, the victims of WPM needed sick leave more often than the group of subjects who had not experienced WPM.

Little data is available about the prevalence of WPM among Slovenian physicians. In 2009, most medical residents (70.2 %) reported experience of WPM during their residence training (Selič, Jakopin, 2010). A study conducted among physicians in Bosnia and Herzegovina working in the public sector in 2004 and 2005 also revealed a high share of WPM, as over 76 % of physicians reported of one or more occurrences of the WPM they had been subjected to (Pranjić et al., 2006). The share among public sector physicians is lower by half in England and among younger doctors in Great Britain (Resch, Schubinski, 1996). In Finland, only 5 % of hospital staff reported experience of WPM (Pranjić et al., 2006).

There is very little data about the prevalence of WPM among nurses in Slovenia; however, numerous foreign studies reveal a higher share of WPM among healthcare professionals, where nurses are in the greatest danger (Yildirim, 2009; Dilek, Aytolan, 2008; Ozturk et al., 2008; Yildirim, Yildirim, 2007). This can also be partly explained by the two-tier hierarchy in hospitals: one of physicians, and the other of nurses. Each has its

own leadership who issue orders – nurses often do not even know who their direct superior is.

Although the number of male employees in nursing care is growing, it remains a predominantly female profession. Women are more often mobbed, and when women are violent, the violence tends to be psychological rather than physical (Yildirim, 2009). Yildirim and Yildirim (2007) conducted several studies among nurses in Turkey with only female respondents (until May 2007 it was illegal for men to perform this job). In a study in 2006 conducted among nurses in public and private hospitals as many as 86.5 % of nurses reported experience of WPM, with the share being statistically significantly higher among respondents working in private hospitals (Yildirim, Yildirim, 2007). In Portugal, 51 % of employees in the healthcare sector encountered verbal violence, while 60 % were subject to psychological violence; in Australia in 2004, 50 % of nurses had experienced WPM in the 12 months prior to the study (Dilek, Aytolan, 2008; Yildirim, Yildirim, 2007).

In Slovenia, the first national study of WPM - conducted in 2008 by the Clinical Institute of Occupational, Traffic and Sports Medicine - showed that 10.4 % of respondents had experienced WPM in the six months prior to the study (Urdih Lazar, 2006). The experience of physicians and nurses in the present study is higher (Table 1). In both groups, the most common WPM acts influenced the self-expression and manner of communication of the persons who experienced WPM (Table 2). The answers of physicians in this study match the results of the study conducted among residents in Slovenia, where the most common form of WPM was withholding of important information, followed by verbal attacks related to work assignments, assigning new work tasks which were not within the victim's competence and spreading rumours (Selič, Jakopin, 2010). The most prevalent acts of WPM among physicians in Bosnia and Herzegovina were those related to work assignments (criticism, disregard

for work), withholding significant information and being ignored by colleagues (Pranjić et al., 2006). WPM studies among nurses display similar results; the most common are attacks on the victim's ability to communicate – withholding significant information, avoiding and ignoring colleagues, shouting at victims, disrespectful communication, mocking (Yildirim, 2009; Dilek, Aytolan, 2008; Yildirim, Yildirim, 2007).

WPM perpetrators among physicians had an educational level higher or equal to that of the victims; almost 90 % were physicians. In the nurses' group, WPM perpetrators had higher qualifications than the nurses in question in almost 70 % of cases; over half of the cases was accounted for by nurses, while in other cases the perpetrators were physicians, which corresponds to the findings of Selič and Jakopin (2010), and Pranjić et al (2006). In the study of medical residents in Slovenia, 76 % of perpetrators had a higher educational level than the victims, which means the former were mostly superiors (Selič, Jakopin, 2010); in the study conducted in Bosnia and Herzegovina, over 80 % of WPM perpetrators were superior to victims (Pranjić et al., 2006). Similarly, WPM studies among nurses show that WPS perpetrators are most often superiors; colleagues accounted for a third of cases, while WPM was very rarely committed by subordinates (Yildirim, 2009 ; Yildirim, Yildirim, 2007).

It is interesting that at the time of the study, 61 % of physicians were no longer exposed to WPM, although they had not informed any of their superiors. Failing to inform superiors is understandable, as superiors are usually the perpetrators of WPM. In contrast, an almost equal share (58 %) of nurses was still experiencing WPM during the study, despite having reported it to superiors in over half the cases (56.4 %). These data also point to a lack of understanding and ineffectiveness on the part of superiors when resolving WPM issues.

Numerous studies have focused on researching the effects of WPM on health. It has been established that WPM is a powerful stressor, which can cause serious psychological or psychosomatic problems, the most common of which include depression, post-traumatic stress syndrome and generalised anxiety disorder, with also increased suicidal tendencies. All this affects family and social relationships, workforce productivity, and leads to more frequent sick leave, and eventual resignation or dismissal (Sperry, Duffy, 2009; Pompili et al., 2008; Koić, 2006; Moayed et al., 2006; Leymann, 1996; 1990).

At least one psychological problem occurred among over 65 % of physicians and over 80 % of nurses in the present study due to exposure to WPM. More often than among physicians, fatigue, despondency, lack of motivation and a feeling of discontent, depression and indecisiveness were reported among nurses (Table 3), while physical health was less frequently affected (Table 4).

Similar results are reported in the study of residents, where anxiety, irritability and fatigue were reported in over half the cases, while among physical symptoms, the most common were functional digestive disorder (Selič, Jakopin, 2010). In the study of exposure to WPM among physicians in Bosnia and Herzegovina, the most common problems include fatigue, headache, loss of motivation and self-confidence, feelings of anger and insomnia (Pranjić et al., 2006). The Turkish study also revealed that WPM most frequently led to psychological issues – fatigue, irritability and headache among 65 % of respondents, while over half reported eating disorders and gastrointestinal disturbances (Yildirim, Yildirim, 2007).

In the nurses group, there are statistically significant differences between those who have experienced WPM and those who have not experienced it only in persons with less than two years of work experience (Table 1). A study of Turkish nurses does not point to a statistically significant correlation between WPM and age, education and years of employment; while the correlation with sick leave was not investigated into (Yildirim, Yildirim, 2007). Among physicians, statistically significant differences between WPM victims and others were revealed in the age distribution and sick leave (Table 1). The results of a study conducted among residents and physicians in Bosnia and Herzegovina also show that physicians reporting mobbing took sick leave more often (Selič, Jakopin, 2010; Pranjić et al., 2006).

Advantages and limitations of the study

The present study shows the prevalence of WPM in one of the Slovenian general hospitals. One of the significant results of the study is that it has raised awareness of the existence and incidence of WPM among employees, which could assist hospital management in approaching the issue of WPM systematically.

Conclusion

A comparison between physicians and nurses reveals that nurses are more burdened by incidents which could be defined as WPM, and that this issue is resolved less successfully in this group. Physicians and nurses were relatively aware of the phenomenon of WPM, but additional information on the issue would be beneficial for all staff. The prevalence of WPM should be studied at the primary, secondary and tertiary levels of healthcare and systemic measures should be taken based on valid and reliable findings.

Preventive measures would have to be taken to resolve the issue of WPM effectively; these are essential for timely ascertaining the state of an organisation and improving the working environment; they reduce the likelihood of social alienation and the disruption

of communication with victims. As management sometimes find it difficult to distinguish between WPM and everyday conflict, it would be reasonable to implement special measures against WPM and carry out activities to improve the psycho-social working environment and strengthen inter-personal skills.

Considering the substantial prevalence of WPM and because those who experience it usually turn for help to their primary care physicians, particularly due to sick leave, primary care physicians should be systematically informed about WPM.

Slovensko / Slovenian

Uvod

Izraz trpinčenje na delovnem mestu (TDM) izvira iz angleškega glagola to mob, ki v slovenskem prevodu pomeni »planiti na, napasti, lotiti se koga«. Predstavil ga je avstrijski etnolog Lorenz, ki je z besedo mobbing opisoval napad skupine majhnih živali na večjo žival (Selič, 2009). Leymann (1996; 1990) je podobno obnašanje opazoval v delovnem okolju in pred dobrimi tridesetimi leti opredelil TDM kot sovražno in neetično komunikacijo enega ali več posameznikov, sistematično in najpogosteje usmerjeno proti drugemu, ki ostaja nemočen in brez zaščite. Zaradi pogostosti (najmanj enkrat na teden) in dolgotrajnosti (vsaj šest mesecev) sovražnega obnašanja se trpinčenje odraža v znatnih duševnih, psihosomatskih in socialnih problemih. Avtor je opredelil 45 različnih tipičnih načinov vedenja, značilnih za psihično nasilje, in jih razvrstil v pet skupin:

- vedenje in ravnanje, ki vpliva na samoizražanje in na način komunikacije osebe, izpostavljene TDM;
- vedenje in ravnanje, ki omejuje in preprečuje socialne stike osebe, izpostavljene TDM;
- vedenje in ravnanje, ki napada osebni ugled žrtve;
- vedenje in ravnanje, ki predstavlja napad na kakovost poklicnega dela ter
- vedenje in ravnanje, ki pomeni neposreden napad na zdravje osebe, izpostavljene TDM (Leymann, 1996; 1990).

Rezultati številnih raziskav kažejo, da se TDM dogaja v organizacijah, ki dopuščajo ali celo nagrajujejo takšno vedenje ter spodbujajo avtoritativni način vodenja (Urdih Lazar, 2006; Vartia, 2001).

TDM žrtvam povzroči hude zdravstvene težave, psihične in vedenjske kot tudi telesne (npr. depresijo in anksiozne motnje, nespečnost, razdražljivost, visok krvni tlak, glavobol, bolečine v trebuhu, sklepah in mišicah, srčno-žilne bolezni, motnje hranjenja), poveča se nevarnost samomorilnega vedenja; kot zapoznili odgovor na stresni dogodek ali zelo obremenilne okoliščine se lahko razvije tudi posttravmatska

Acknowledgement

The authors would like to thank the physicians and nurses who participated in the study.

The study was partially conducted within the framework of the P3-0339 Research Programme, which is financed by the Slovenian Research Agency.

stresna motnja, znaki se pokažejo po določeni časovni latenci in imajo v veliki meri značaj tesnobe in depresije (Sperry, Duffy, 2009; Pompili et al., 2008; Koić, 2006; Moayed et al., 2006; Leymann, 1996; 1990). Posledice TDM niso samo zdravstvene, lahko se pojavi socialna osamitev, težave v družini ter predvsem finančne težave kot posledica odsotnosti z delovnega mesta zaradi bolezni, bega v invalidnost ali odpovedi pogodbe o zaposlitvi (Cvetko, 2006). TDM vpliva tudi na sodelavce žrtve, ki lahko občutijo krivdo, ker žrtvi ne morejo ali si ne upajo pomagati zaradi strahu pred posledicami, mnogi se bojijo, da bi tudi sami postali žrtve TDM (Selič, 2009).

Namen

Namen študije je bil ugotoviti pojavnost TDM med zdravniki in medicinskimi sestrami, zaposlenimi v eni od slovenskih splošnih bolnišnic, primerjati obe preiskovani skupini ter opredeliti odnos med dejavniki, kot so starost, spol, izobrazba, delovna doba in pogostost bolniškega staleža žrtev, ter pojavnostjo TDM.

Metode

Vzorec

V študijo so bili s sistematičnim vzorčenjem vključeni zdravniki (vsak drugi) in medicinske sestre (vsaka osma), ki so bili marca 2011 zaposleni v eni od slovenskih splošnih bolnišnic več kot šest mesecev. Od 200 razdeljenih vprašalnikov je bilo vrnjenih 161, odziv je bil 80,5 %. Sodelovanje je bilo prostovoljno in anonimno. Sodelovalo je 84 (od 274) zdravnikov in 77 (od 802) medicinskih sester. Vzorec zdravnikov predstavlja 30,7 % vseh zdravnikov, vzorec medicinskih sester pa 9,6 % medicinskih sester, zaposlenih v javnem zavodu v času izvedbe študije. Med zdravniki je bilo 44 žensk (52,4 %) in 40 moških (47,6 %), med medicinskimi sestrami je bila večina žensk – 55 (71,4 %), moških je bilo 22 (28,6 %). Povprečna starost v skupini

zdravnikov je bila 38 let ($37,89 \pm 9,65$ let), najmlajši je bil star 26, najstarejši pa 58 let. Povprečna starost medicinskih sester je bila okoli 36 let ($35,82 \pm 8,32$ let), najmlajša je bila stara 21, najstarejša pa 54 let (Razpredelnica 1). Raziskavo je odobrila Komisija Republike Slovenije za medicinsko etiko 21. 2. 2011, z odločbo št. 138/02/11.

Merski instrument

Za ugotavljanje TDM je bil uporabljen prevedeni in prirejeni vprašalnik *Leymann Inventory of Psychological Terrorization* (LIPT), ki obsega 45 vprašanj, razdeljenih po sklopih (A–E), ki predstavljajo posamezne oblike TDM. Sklop A zajema 10 vprašanj, ki se nanašajo na možnost sporazumevanja prizadetega, sledi pet vprašanj v zvezi z možnostjo ohranjanja družabnih stikov na delovnem mestu, sklop C s pomočjo 14 vprašanj odkriva napade na osebni ugled, v sklop D je zajetih sedem vprašanj o onemogočanju kakovosti dela, medtem ko se sklop E s sedmimi vprašanji nanaša na ogrožanja telesnega zdravja (Leymann, Gustafsson, 1996).

Na prvi del vprašalnika so odgovarjali vsi sodelujoči in je poleg vprašanj o oblikah TDM vseboval tudi vprašanja o spolu, starosti, zakonskem stanu, delovni dobi, bolniškem staležu in seznanjenosti s TDM. Drugi del vprašalnika, ki so ga izpolnjevali samo tisti sodelujoči, ki so bili izpostavljeni kateremu od dejanj TDM, je vseboval vprašanja o ukrepih žrtev, izobrazbenem statusu povzročitelja ter morebitnih zdravstvenih posledicah TDM pri žrtvah. Kot TDM je štela izpostavljenost najmanj enemu izmed naštetih dejanj vsaj enkrat tedensko v obdobju vsaj šest mesecev.

Test zanesljivosti za celoten model je pokazal, da so bile spremenljivke, s katerimi so bili izmerjeni sklopi vprašalnika LIPT, dobro izbrane (Cronbach $\alpha = 0,780$). Test zanesljivosti za vsak posamezen sklop kaže, da vprašanja sprejemljivo merijo sklop D o onemogočanju kakovosti dela (Cronbach $\alpha = 0,607$), medtem ko se je izkazalo, da ostali sklopi notranjo konsistentnost merijo slabše (Cronbach $\alpha > 0,6$).

Obdelava podatkov

V dogovoru z vodstvom bolnišnice sta bila marca 2011 vsak drugi zdravnik in vsaka osma medicinska sestra z abecednega seznama zaposlenih povabljeni k sodelovanju. Razdeljenih je bilo 200 vprašalnikov. Izpolnjene vprašalnike so sodelujoči vrnili v za to pripravljeno škatlo.

Za analizo podatkov je bil uporabljen programski paket IBM SPSS verzija 19.0. Opisne statistike nominalnih in ordinalnih spremenljivk so prikazane kot frekvence in odstotki. Spremenljivke, kjer so anketiranci sami vpisovali svojo starost, delovno dobo v mesecih in število zamenjanih oddelkov/delovnih

mest, so bile razdeljene v strukturne razrede. Pri indikatorjih TDM so bile seštete pozitivne vrednosti ter oblikovana nova spremenljivka mobbing kot rezultat analize count, s katero smo prešteli, kolikokrat se pri vsaki osebi pojavi odgovor DA pri dejanjih TDM od sklopa A do E. Izločili smo tiste osebe, ki so bile izpostavljene vsaj enemu od dejanj TDM (vrednost 1), in one, ki niso bile izpostavljene nobenemu dejanju TDM (vrednost 2). S testom hi-kvadrat (χ^2) so bile preverjene statistično značilne razlike oziroma odnos med neodvisnimi spremenljivkami in odvisno spremenljivko mobbing. Meja statistične pomembnosti je bila $p \leq 0,05$.

Rezultati

Demografske značilnosti in razširjenost TDM

Pri medicinskih sestrah so se statistično značilne razlike med izpostavljenimi TDM in tistimi, ki niso bile izpostavljene TDM (Razpredelnica 1), pokazale le glede na delovno dobo ($\chi^2 = 8,194$, $p = 0,017$), in sicer pri osebah, ki so imele do dve leti delovne dobe. Pri zdravnikih so se statistično značilne razlike glede na izpostavljenost TDM pokazale v starosti ($\chi^2 = 8,249$, $p = 0,016$) in bolniškem staležu ($\chi^2 = 9,182$, $p = 0,027$), in sicer v starostni kategoriji od 31 do 45 let ter od 46 let in več, pri bolniškem staležu pa v kategorijah *nikoli in dvakrat* (Razpredelnica 1).

Analize tudi kažejo, da se je večina zdravnikov, 59 (70,2 %), in medicinskih sester, 65 (84,4%), z izrazom mobbing ali TDM v preteklosti že srečala, medicinske sestre v večji meri ($p = 0,033$, $\chi^2 = 4,562$). Na splošno se je večina zdravnikov, 64 (76,2 %), in medicinskih sester, 49 (63,6%), počutila spoštovana pri opravljanju svojega dela ($p > 0,05$).

Značilnosti TDM

Med zdravniki jih je imelo izkušnjo s TDM 51,2 %, med medicinskimi sestrami pa 71,4 % ($p = 0,009$, $\chi^2 = 6,908$).

Večina zdravnikov (61 %) TDM v času izvedbe študije ni bila več izpostavljena; 70,7 % zdravnikov ni nikogar od nadrejenih obvestilo o dogajanju. Pri medicinskih sestrah je bil rezultat obraten: 58,2 % jih je bilo še vedno izpostavljenih TDM, kljub temu da so o tem v 56,4 % obvestile nadrejene ($p > 0,05$).

Medicinske sestre so bile v večji meri kot zdravniki izpostavljene dejanjem TDM, ki vplivajo na komunikacijo in samoizražanje ($p = 0,003$), na socialne stike na delovnem mestu ($p = 0,047$), in dejanjem, kjer je napaden njihov osebni ugled ($p = 0,000$) (Razpredelnica 2).

Razpredelnica 1: Pogostost TDM med medicinskimi sestrami in zdravniki glede na izbrane socio-demografske značilnosti

	Medicinske sestre				Zdravniki				Vsi SKUPAJ n (%)
	TDM da	TDM ne	p	Skupaj	TDM da	TDM ne	p	Skupaj	
Spol	n=55 (%)	n=22 (%)		n=77 (%)	n=43 (%)	n=41 (%)		n=84 (%)	n=161 (%)
moški	16 (29,1)	6 (27,3)	0,873	22 (28,6)	22 (51,2)	18 (43,9)	0,505	40 (47,6)	62 (38,5)
ženske	39 (70,9)	16 (72,7)		55 (71,4)	21 (48,8)	23 (56,1)		44 (52,4)	99 (61,5)
Starost	n=55 (%)	n=22 (%)		n=77 (%)	n=43 (%)	n=41 (%)		n=84 (%)	n=161 (%)
18–30 let	13 (23,6)	6 (27,3)	0,732	19 (24,7)	11 (25,6)	10 (24,4)	0,016	21 (25)	40 (24,8)
31–45 let	35 (63,6)	12 (54,5)		47 (61)	28 (65,1)	17 (41,5)		45 (53,6)	92 (57,1)
46 let in več	7 (12,7)	4 (18,2)		11 (14,3)	4 (9,3)	14 (34,1)		18 (21,4)	29 (18)
Zakonski stan	n=55 (%)	n=22 (%)		n=77 (%)	n=43 (%)	n=41 (%)		n=84 (%)	n=161 (%)
samski	8 (14,5)	5 (22,7)	0,217	13 (16,9)	10 (23,3)	5 (12,2)	0,052	15 (17,9)	28 (17,4)
poročen	26 (47,3)	11 (50)		37 (48,1)	18 (41,9)	23 (56,1)		41 (48,8)	78 (48,4)
razvezan	5 (9,1)	4 (18,2)		9 (11,7)	0 (0)	4 (9,8)		4 (4,8)	13 (8,1)
izvenzakonska skupnost	16 (29,1)	2 (9,1)		18 (23,4)	15 (34,9)	9 (22)		24 (28,6)	42 (26,1)
Delovna doba	n=55 (%)	n=22 (%)		n=77 (%)	n=43 (%)	n=41 (%)		n=84 (%)	n=161 (%)
do 2 leti	1 (1,8)	4 (18,2)	0,017	5 (6,5)	7 (16,3)	6 (14,6)	0,198	13 (15,5)	40 (24,8)
do 10 let	13 (23,6)	2 (9,1)		15 (19,5)	21 (48,8)	13 (31,7)		34 (40,5)	92 (57,1)
10 let in več	41 (74,5)	16 (72,7)		57 (74)	15 (34,9)	22 (53,7)		37 (44)	29 (18)
Menjava del. mesta v zadnjih 6 mesecih	n=55 (%)	n=22 (%)		n=77 (%)	n=43 (%)	n=41 (%)		n=84 (%)	n=161 (%)
nikoli	45 (81,8)	21 (95,5)	0,122	66 (85,7)	26 (60,5)	25 (61)	0,774	51 (60,7)	117 (72,7)
1-3-krat	10 (18,2)	1 (4,5)		11 (14,3)	12 (27,9)	13 (31,7)		25 (29,8)	36 (22,4)
več kot 4-krat	0 (0,0)	0 (0,0)		0 (0,0)	5 (11,6)	3 (7,3)		8 (9,5)	8 (5)
Bolniški stalež v zadnjem letu	n=55 (%)	n=22 (%)		n=77 (%)	n=43 (%)	n=41 (%)		n=84 (%)	n=161 (%)
nikoli	20 (36,4)	8 (36,4)	0,536	28 (36,4)	20 (46,5)	29 (70,7)	0,027	49 (58,3)	77 (47,8)
1-krat	26 (47,3)	13 (59,1)		39 (50,6)	16 (37,2)	12 (29,3)		28 (33,3)	67 (41,6)
2-krat	8 (14,5)	1 (4,5)		9 (11,7)	5 (11,6)	0 (0)		5 (6)	14 (8,7)
3- in večkrat	1 (1,8)	0 (0)		1 (1,3)	2 (4,7)	0 (0)		2 (2,4)	3 (1,9)

Legenda: p > 0,05; n – število anketirancev

Nad zdravniki so TDM večinoma izvajale osebe z višjim (39,5 %) ali enakim (34,9 %) izobrazbenim statusom. V 87,8 % so bili to zdravniki, v 12,2 % pa medicinske sestre. Tudi v skupini medicinskih sester so imeli povzročitelji TDM v veliki večini višjo stopnjo izobrazbe (69,1 %); večinoma so bile to medicinske sestre (54,5 %), v ostalih primerih pa zdravniki. Tako pri zdravnikih (69,8 %) kot tudi pri medicinskih sestrah (54,5 %) so bili ob dogodkih TDM prisotni še drugi ljudje (p > 0,05).

Vsaj ena psihična težava se je zaradi izpostavljenosti

TDM pojavila pri 65,1 % zdravnikov in pri 85,5 % medicinskih sester. Test hi kvadrat (p = 0,018, $\chi^2 = 5,558$) je pokazal statistično značilne razlike med zdravniki in medicinskimi sestrami glede prisotnosti psihičnih simptomov. Med medicinskimi sestrami so se v večji meri kot pri zdravnikih pojavljali utrujenost in brezvoljnost (p = 0,007), izguba veselja do vseh stvari in občutki nezadovoljstva (p ≤ 0,01), depresivno razpoloženje – žalost, jokavost, potrtnost, nerazpoloženost (p = 0,014) in neodločenost (p = 0,003) (Razpredelnica 3).

Razpredelnica 2: Prikaz dejanj TDM, ki so jim bili izpostavljeni medicinske sestre in zdravniki

Vedenja TDM	Frekvenca in odstotek izpostavljenosti TDM		p	χ^2
	Medicinske sestre	Zdravniki		
Sklop A – Dejanja, ki vplivajo na komunikacijo in samoizražanje	52 (67,5 %)	37 (44 %)	0,003	8,963
Sklop B – Dejanja, ki vplivajo na socialne stike na delovnem mestu	23 (29,9 %)	14 (16,7 %)	0,047	3,957
Sklop C - Napaden osebni ugled	38 (49,4 %)	16 (19 %)	0,000	16,550
Sklop D – Onemogočeno kakovostno delo	24 (31,2 %)	26 (31 %)	0,976	0,001
Sklop E – Ogroženo telesno zdravje	6 (7,8 %)	8 (9,5 %)	0,697	0,015

Legenda: $p > 0,05$, χ^2 - hi kvadrat

Razpredelnica 3: Pogostost pojavljanja psihičnih težav, povezanih s TDM, pri zdravnikih in medicinskih sestrah

Psihične težave, povezane s TDM	Odstotek pojava simptoma		p
	Zdravniki	Medicinske sestre	
razdražljivost, preobčutljivost	44,2 %	55,6 %	0,266
utrujenost in brezvoljnost	20,9 %	47,3 %	0,007
motnje spanja - nespečnost ali čezmerna zaspanost	18,6 %	20,4 %	0,828
tesnoba, nedoločen strah	11,6 %	22,2 %	0,173
nemir ali upočasnjenost in neaktivnost	9,3 %	5,5 %	0,463
izguba veselja do vseh stvari in občutki nezadovoljstva	7,0 %	38,2 %	0,000
motnje spomina in koncentracije	7,0 %	14,5 %	0,239
depresivno razpoloženje - žalost, jokavost, potrtnost, nerazpoloženost	4,7 %	22,2 %	0,014
nedoločene telesne bolečine - glavoboli, bolečine v mišicah, sklepah	4,7 %	1,8 %	0,419
umik iz družbe in izogibanje stikom z drugimi ljudmi	2,3 %	5,5 %	0,437
motnje apetita s povečanjem ali izgubo telesne teže	0,0 %	1,9 %	0,370
neodločenost	0,0 %	18,2 %	0,003
moteno spolno življenje	0,0 %	1,8 %	0,374

Legenda: $p > 0,05$

Razpredelnica 4: Pogostost pojavljanja telesnih simptomov, povezanih s TDM, pri zdravnikih in medicinskih sestrah

Telesni simptomi, povezani s TDM	Odstotek pojava simptoma		p
	Zdravniki	Medicinske sestre	
funkcionalne prebavne motnje	14,0 %	12,7 %	0,859
palpitacije	9,3 %	7,3 %	0,716
zvišan krvni tlak	9,3 %	0,0 %	0,021
slabšanje (pogostejši recidivi) morebitnih kožnih bolezni	2,3 %	7,3 %	0,269
slabšanje (pogostejši recidivi) morebitnih alergičnih bolezni	0,0 %	7,3 %	0,071
čezmerno znojenje	0,0 %	12,7 %	0,015

Legenda: $p > 0,05$

Vsaj en telesni simptom zaradi izpostavljenosti TDM se je pri zdravnikih pojavil v 30,2 % in pri medicinskih sestrah v 40,0 %; med primerjalnima skupinama ni bilo statistično značilnih razlik ($p = 0,317$, $\chi^2 = 1,003$). Med zdravniki je bilo več takih z zvišanim krvnim tlakom (9,3 %) kot med medicinskimi sestrami ($p = 0,021$), slednje pa so v večji meri poročale o čezmernem znojenju (12,7 %, $p = 0,015$) (Razpredelnica 4).

Diskusija

Izpostavljenost TDM je bila med zdravniki 51,2 % in med medicinskimi sestrami 71,4 %. Večina povzročiteljev TDM nad medicinskimi sestrami je imela višjo izobrazbo kot žrtev. Žrtve TDM so v povprečju v zadnjem letu večkrat potrebovale bolniški stalež kot skupina preiskovancev, ki ni bila izpostavljena TDM.

O razširjenosti TDM med slovenskimi zdravniki ni dostopnih veliko podatkov. Leta 2009 je večina specializantov medicine (70,2 %) poročala o izpostavljenosti TDM v času opravljanja specializacije (Selič, Jakopin, 2010). Raziskava med zdravniki Bosne in Hercegovine, zaposlenimi v javnem sektorju v letih 2004 in 2005, je prav tako pokazala na velik delež TDM, saj je več kot 76 % zdravnikov poročalo o enem ali več dejanjih TDM, ki so jim bili sami izpostavljeni (Pranjić et al., 2006). Za polovico manjši je bil delež med zdravniki javnega sektorja v Angliji ter med mlajšimi zdravniki v Veliki Britaniji (Resch, Schubinski, 1996). Na Finskem pa je le 5 % zaposlenih v bolnišnici poročalo o izpostavljenosti TDM (Pranjić et al., 2006).

O TDM med medicinskimi sestrami je v Sloveniji zelo malo dostopnih podatkov, številne tuje raziskave pa kažejo večji delež TDM med zdravstvenimi delavci, med katerimi so najbolj ogrožene medicinske sestre (Yildirim, 2009; Dilek, Aytolan, 2008; Ozturk et al., 2008; Yildirim, Yildirim, 2007). To lahko med drugim pojasnimo tudi z vsaj dvema hierarhijama v bolnišnici: eno predstavljajo zdravniki, drugo pa medicinske sestre; vsaka hierarhija ima svoje vodstvo, ki deli ukaze in medicinske sestre velikokrat niti ne vedo, kdo je njihov neposredni nadrejeni, ki mu odgovarjajo.

Čeprav število moških med zaposlenimi v zdravstveni negi narašča, je to še vedno pretežno ženski poklic; ženske so pogosteje trpinčene, kadar pa so nasilne, je to v večji meri na psihični, in ne na telesni ravni (Yildirim, 2009). Yildirim in Yildirim (2007) sta v Turčiji med medicinskimi sestrami opravila več raziskav, v katerih so sodelovale samo ženske, saj do maja 2007 v Turčiji moški niso smeli legalno opravljati tega poklica. V študiji iz leta 2006, izvedeni med medicinskimi sestrami v javnih in zasebnih bolnišnicah, je kar 86,5 % medicinskih sester poročalo o izpostavljenosti TDM, delež je bil statistično značilno višji med anketirankami v zasebnih bolnišnicah (Yildirim, Yildirim, 2007). Na

Portugalskem se je 51 % delavcev v zdravstvenem sektorju srečalo z verbalnim nasiljem, 60 % jih je bilo izpostavljenih psihološkemu nasilju; v Avstraliji je bilo leta 2004 zadnjih 12 mesecev pred študijo TDM izpostavljenih 50 % medicinskih sester (Dilek, Aytolan, 2008; Yildirim, Yildirim, 2007).

V Sloveniji je prva nacionalna raziskava o TDM potekala leta 2008, izvajal jo je Klinični inštitut za medicino dela, prometa in športa. Rezultati so pokazali, da je bilo 10,4 % vprašanih v zadnjih šestih mesecih pred raziskavo izpostavljenih TDM (Urdih Lazar, 2006). Izpostavljenost zdravnikov in medicinskih sester v predstavljeni raziskavi je večja (Razpredelnica 1). Najpogostejša dejanja TDM so bila v obeh preiskovanih skupinah dejanja, ki vplivajo na samoizražanje in način komunikacije osebe, izpostavljene TDM (Razpredelnica 2). Predstavljeni odgovori zdravnikov se ujemajo z rezultati raziskave med slovenskimi specializanti, pri katerih je bila najpogostejša oblika TDM zamolčanje pomembnih informacij, sledili so verbalni napadi v zvezi z delovnimi zadolžitvami, dodeljevanje delovnih opravil, ki niso ustrezala njihovim kompetencam, in širjenje govoric (Selič, Jakopin, 2010). Tudi med zdravniki v Bosni in Hercegovini so med najpogostejšimi dejanji verbalni napadi v zvezi z delovnimi zadolžitvami (kritiziranje, omalovaževanje dela), zamolčanje pomembnih informacij ter ignoriranje s strani sodelavcev (Pranjić et al., 2006). Raziskave TDM med medicinskimi sestrami kažejo podobne rezultate; najpogostejši so napadi na možnost komunikacije žrtev - prikrivanje pomembnih informacij, izogibanje in ignoriranje s strani sodelavcev, kričanje na žrtve, nespoštljiva komunikacija, zasmehovanje (Yildirim, 2009; Dilek, Aytolan, 2008; Yildirim, Yildirim, 2007).

Povzročitelji TDM nad zdravniki so imeli višji ali enak izobrazbeni status kot žrtve, v skoraj 90 % so bili to zdravniki. V skupini medicinskih sester so imeli povzročitelji TDM v skoraj 70 % višjo izobrazbo kot medicinske sestre; v dobri polovici primerov so bile to medicinske sestre, v ostalih primerih pa zdravniki, kar se ujema z izsledki Selič in Jakopin (2010) ter Pranjić in sodelavci (2006). V raziskavi med specializanti medicine v Sloveniji je imelo 76 % povzročiteljev višji izobrazbeni status, torej so bili to večinoma nadrejeni (Selič, Jakopin, 2010), v študiji iz Bosne in Hercegovine pa je bilo med povzročitelji TDM nadrejenih več kot 80 % (Pranjić et al., 2006). Podobno tudi študije TDM med medicinskimi sestrami kažejo, da so bili povzročitelji TDM najpogosteje nadrejeni, v tretjini primerov sodelavci, zelo redko pa podrejeni (Yildirim, 2009; Yildirim, Yildirim, 2007).

Zanimiva je ugotovitev, da 61 % zdravnikov v času izpolnjevanja vprašalnika ni bila več izpostavljena TDM, kljub temu o dogajanju praviloma niso obvestili nikogar od nadrejenih. Neobveščanje nadrejenih je razumljivo, saj so nadrejeni večinoma povzročitelji

TDM. Nasprotno je bil skoraj enak delež (58 %) medicinskih sester v času izvedbe študije še vedno izpostavljen TDM, kljub temu da so o navedenem obnašanju v več kot polovici primerov obvestile nadrejene (56,4 %). Ta podatek kaže med drugim tudi na nerazumevanje in neučinkovitost nadrejenih pri reševanju problematike TDM.

Z raziskavami posledic TDM za zdravje so se ukvarjali številni avtorji, ki ugotavljajo, da je TDM močan stresor in lahko povzroči resne psihične in psihosomatske težave, med katerimi so najpogostejše depresija, posttravmatska stresna motnja in generalizirana anksiozna motnja, poveča se tudi nevarnost samomora. Vse naštetu vpliva tudi na družinske in socialne odnose, delovno storilnost, pogostejše bolniške staleže in lahko vodi do prekinitve delovnega razmerja (Sperry, Duffy, 2009; Pompili et al., 2008; Koić, 2006; Moayed et al., 2006; Leymann, 1996; 1990).

Vsaj ena psihična težava se je zaradi izpostavljenosti TDM pojavila pri več kot 65 % zdravnikov v predstavljeni študiji in pri več kot 80 % medicinskih sester. Med medicinskimi sestrami so se v večji meri kot med zdravniki pojavljali utrujenost, brezvoljnost, izguba veselja in občutki nezadovoljstva, depresivno razpoloženje in neodločenost (Razpredelnica 3), medtem ko so se telesne težave pojavljale redkeje (Razpredelnica 4).

Podobne rezultate navajajo tudi v raziskavi med specializanti, kjer so izstopale tesnoba, razdražljivost in utrujenost v več kot polovici primerov, med telesnimi simptomi pa so bile najpogostejše funkcionalne prebavne motnje (Selič, Jakopin, 2010). V raziskavi o izpostavljenosti TDM med zdravniki v Bosni in Hercegovini so bile najpogostejše težave utrujenost, glavobol, izguba motivacije in zaupanja vase, občutki jeze ter nespečnost (Pranjić et al., 2006). Tudi rezultati raziskave v Turčiji so pokazali, da je TDM povzročalo pretežno psihične posledice – utrujenost in razdražljivost ter glavobole pri več kot 65% anketiranih, več kot polovica pa jih je poročala o motnjah apetita in prebavnih težavah (Yildirim, Yildirim, 2007).

V skupini medicinskih sester so se statistično značilne razlike med izpostavljenimi TDM in tistimi, ki TDM niso doživele, kazale le glede na delovno dobo, in sicer pri osebah, ki so imele do dve leti delovne dobe (Razpredelnica 1). Raziskava med turškimi medicinskimi sestrami ne kaže statistično značilne razlike med TDM in starostjo, izobrazbo in delovno dobo; povezava z bolniško odsotnostjo pa ni bila preverjena (Yildirim, Yildirim, 2007).

Pri zdravnikih so se statistično značilne razlike med žrtvami TDM in ostalimi pokazale v starosti in bolniškem staležu (Razpredelnica 1). Tudi rezultati med specializanti in zdravniki v Bosni in Hercegovini kažejo, da so bili zdravniki, ki so poročali o trpinčenju, večkrat v bolniškem staležu (Selič, Jakopin, 2010; Pranjić et al., 2006).

Prednosti in omejitve raziskave

Predstavljena študija je pokazala razširjenost TDM v eni od slovenskih splošnih bolnišnic. Pomembna posledica raziskave je ozaveščanje zaposlenih o pojavu in dejanjih TDM, kar bi lahko pomagalo vodstvu bolnišnice pri sistemskem reševanju te problematike.

Zaključek

Primerjava med zdravniki in medicinskimi sestrami je pokazala pomembno večjo obremenjenost medicinskih sester z ravnanji, ki jih je moč opredeliti kot TDM, ter slabše reševanje tovrstne problematike pri tej poklicni skupini. Zdravniki in medicinske sestre so bili sorazmerno dobro seznanjeni s pojavom TDM, vendar bi bilo dodatno seznanjanje dobrodošlo za vse zaposlene. Razširjenost TDM bi kazalo raziskati tako na primarni kot sekundarni in terciarni ravni zdravstvene oskrbe, na podlagi veljavnih in zanesljivih ugotovitev pa sprejeti potrebne sistemske ukrepe.

Za učinkovito reševanje problema TDM bi bili potrebni preventivni ukrepi, ki so ključni za pravočasno ugotavljanje stanja organizacije in izboljšanje delovnega okolja ter zmanjšujejo možnost za socialno osamitev ali onemogočanje komunikacije pri žrtvah. Ker vodje včasih težko razlikujejo med TDM in vsakdanjimi konflikti, bi bilo smiselno izvajati tako posebne ukrepe proti TDM, kot tudi dejavnosti, usmerjene v izboljšave psihosocialnega delovnega okolja in krepitev veščin v medosebnih odnosih.

Glede na precejšnjo razširjenost TDM in ker izpostavljeni TDM največkrat iščejo pomoč pri družinskem zdravniku, predvsem zaradi bolniškega staleža, bi bilo treba s to problematiko sistematično seznanjati tudi zdravnike družinske medicine.

Zahvala

Avtorice se zahvaljujejo zdravnikom in medicinskim sestram, ki so sodelovali v raziskavi. Študija je bila deloma izvedena v okviru Raziskovalnega programa P3-0339, ki ga financira Agencija za raziskovalno dejavnost Republike Slovenije.

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Citirajte kot / Cite as:

Selič P, Nassib A, Makivić I. Razširjenost trpinčenja na delovnem mestu: študija primera. *Obzor Zdrav Neg.* 2012;46(2):113–26.