Current Psychiatry

Workplace mobbing: Are they really out to get your patient?

Consider that coworkers' hostile behavior could be causing paranoid symptoms

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ALEX NABAUM FOR CURRENT PSYCHIATRY

James Randolph Hillard, MD
Professor
Department of psychiatry
Associate provost for human health affairs
Michigan State University
East Lansing, MI

Mr. G, age 46, works for a large federal government agency in a middle-management position. He presents seeking treatment for insomnia. He says, "I just need a sleeping pill. I haven't been able to sleep for the last 3 months because everybody at work is talking behind my back and spreading rumors about how I'm crazy. My boss is in on it, too. She is always trying to undermine me and makes a big deal out of every little mistake I make."

Mr. G is suspicious, asking questions about the confidentiality of medical records. His speech is rapid, and he is anxious but exhibits a full range of affect and no pressured speech or flight of ideas. Mr. G describes early, middle, and late insomnia, decreased energy and interest, and gaining 10 pounds over the past 3 months.

He admits owning a gun and having frequent thoughts of suicide and fantasies of killing his boss, although Mr. G repeatedly affirms he would never act on these thoughts. A week ago, his wife moved in with her parents because, he says, "she just couldn't stand to be around me any longer."

I consider involuntary hospitalization for Mr. G. Ultimately I contact his wife, who agrees to pick him up, stay with him overnight, and return with him the next morning. Because the only medication Mr. G is willing to consider is sleeping pills, I prescribe flurazepam, 30 mg qhs.

Mr. G was apparently paranoid, thinking of killing his boss, and had a gun. If his wife had not answered the phone and been willing to stay with him, he might have been involuntarily committed. As it was, further interviews with him revealed that Mr. G had been a tar-

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Workplace mobbing

Box

Workplace mobbing: How often does it occur?

In 1990 Leymann[3] estimated that 3.5% of the Swedish workforce had been victims of significant mobbing. Studies from various other European countries have estimated prevalence of mobbing at 4% to 15% of the total workforce.[10]

Studies from Europe have shown that all age groups can be affected, but that posttraumatic stress disorder among mobbing victims is more common in patients age >40. Both genders are equally at risk.[6]

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An uninformed mental health professional can unwittingly make a mobbing victim's situation much worse

get of workplace "mobbing," and that his insomnia and paranoia developed because of a deliberate campaign by coworkers.

This article discusses how to recognize symptoms of workplace mobbing, using Mr. G's experience to illustrate the dynamics of this group behavior. An informed mental health professional can be of enormous help to a mobbing victim, but an uninformed professional can unwittingly make the situation much worse.

What is 'mobbing'?

Initiated most often by a person in a position of power or influence, mobbing has been described as "a desperate urge to crush and eliminate the target…. As the campaign proceeds, a steadily larger range of hostile ploys and communications comes to be seen as legitimate."[1] This behavior pattern has been recognized in Europe since the 1980s but is not well recognized in the United States.

Davenport et al[2] brought the phenomenon and its consequences to the U.S. public's attention in 1999 with the publication of *Mobbing: emotional abuse in the American workplace.* Otherwise, little professional literature on workplace mobbing has been produced in the United States.

A PubMed search on the term "mobbing" limited to 1982 through October 2008 returned 95 listings, excluding those dealing purely with ethology, but only 1 report from the United States. Studies from outside the United States indicate that mobbing is relatively common (***Box***).

Mobbing, bullying, and harassment. The term "workplace mobbing" was coined by Leymann,[3] an occupational psychologist who investigated the psychology of workers who had suffered severe trauma. He observed that some of the most severe reactions were among workers who had been the target of "an impassioned collective campaign by coworkers to exclude, punish, or humiliate" them.

Many researchers use the term mobbing to describe a negative work environment created by several individuals working together.[1-3] However, some researchers such as Namie et al[4] use the term workplace bullying to describe the creation of a hostile work environment by either a single individual—usually a boss—or a number of individuals.

CASE CONTINUED

Why I first thought 'paranoia'

During our first interview, Mr. G said that 6 months before he sought treatment he had reported misuse of government property by his supervisor's boss. The case was investigated and dismissed. Mr. G's supervisor never confronted him about the complaint, but shortly afterwards Mr. G started to notice disturbing changes in the workplace.

His supervisor avoided Mr. G's phone calls and e-mails and stopped meeting with him. Instead, she met with Mr. G's subordinates. The subordinates started to ignore Mr. G's instructions and would roll their eyes or be inattentive when he spoke. Coworkers stopped talking when Mr. G approached, and he started receiving anonymous e-mails questioning his ability and sanity. He was reprimanded in writing for having made a $9 mathematical error in an expense reimbursement request.

Mr. G said when he approached his superior about the work environment, she stated that he was "just paranoid" and needed to see a psychiatrist.

When Mr. G's wife accompanies him to the second interview, she confirms his impressions of ostracism and gossip at work. She also relates her experiences with people from Mr. G's office who previously had been friendly but now were distant or hostile. Mr. G shows me copies of harassing work e-mails

and memos. I tell Mr. G I believe his story and diagnose him as suffering from posttraumatic stress disorder (PTSD). He begins supportive/cognitive therapy and continues flurazepam.

Mobbing syndrome

As it turns out, Mr. G was not paranoid; his coworkers really were trying to get him. Leymann[5] divided 45 types of mobbing behaviors into 5 categories. These were organized as attacks on:

- self-expression and ability to communicate (victim is silenced, given no opportunity to communicate, subject to verbal attacks)
- social relationships (colleagues do not talk to the victim, victim is physically isolated from others)
- reputation (victim is the target of gossip and ridicule)
- occupational situation (victim is given meaningless tasks or no work at all)
- physical health (victim is assigned dangerous tasks, threatened with bodily harm, or physically attacked).

Davenport et al[2] distilled this list into 10 key factors of the mobbing syndrome (***Table 1***); identified 5 phases in the mobbing process (***Table 2, page 48***); and defined 3 "degrees" of mobbing analogous to first-, second-, and third-degree burns (***Table 3, page 48***).

Mobbing risk factors. According to Leymann,[5] no specific personality factors predispose workers to being mobbed. Westhues[1] and others, however, identify a variety of social risk factors. These include any factors that make an individual different from other members of his or her work environment, such as:

- different ethnicity
- an "odd" personality
- high achievement.

Whistleblowers or union organizers also run a risk of stigmatization and mobbing. Organizations with unclear goals or extensive recent turnover in senior leadership can be conducive to mobbing. Three industries identified as at special risk for mobbing are academia, government, and religious organizations.[5]

Table 1

Mobbing syndrome: 10 factors

Assaults on dignity, integrity, credibility, and competence
Negative, humiliating, intimidating, abusive, malevolent, and controlling communication
Committed directly or indirectly in subtle or obvious ways
Perpetrated by ≥1 staff members*
Occurring in a continual, multiple, and systematic fashion over time
Portraying the victim as being at fault
Engineered to discredit, confuse, intimidate, isolate, and force the person into submission
Committed with the intent to force the person out
Representing the removal as the victim's choice
Unrecognized, misinterpreted, ignored, tolerated, encouraged, or even instigated by management

*Some researchers limit their definition of mobbing to acts committed by >1 person

Source: Adapted with permission from Davenport N, Schwartz RD, Elliott GP. Mobbing: emotional abuse in the American workplace. Ames, IA: Civil Society Publishing; 1999:41

Secondary morbidity. Victims of workplace mobbing frequently suffer from:

- adjustment disorders
- somatic symptoms (eg, headaches or irritable bowel syndrome)
- PTSD[6,7]
- major depression.[8]

In mobbing targets with PTSD, Leymann notes that the "mental effects were fully comparable with PTSD from war or prison camp experiences."[3] Some patients may develop alcoholism or other substance abuse disorders. Family relationships routinely suffer.[9] Some targets may even develop brief psychotic episodes, generally with paranoid symptoms.

Leymann[3] estimated that 15% of suicides in Sweden could be directly attributed to workplace mobbing. Although no other researcher has reported such a dramatic proportion, others have reported increased risk of suicidal behavior among mobbing victims.[10]

continued

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Factors that might increase one's risk of being mobbed include having a different ethnicity, an 'odd' personality, or high achievement

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Table 2

Phases of mobbing

Phases of mobbing
Conflict, often characterized by a 'critical incident'
Aggressive acts, such as those in ***Table 1, page 47***
Management involvement
Branding as difficult or mentally ill
Expulsion or resignation from the workplace

Source: Adapted with permission from Davenport N, Schwartz RD, Elliott GP. Mobbing: emotional abuse in the American workplace. Ames, IA: Civil Society Publishing; 1999:38

Table 3

Degrees of mobbing

Degrees of mobbing
First degree: Victim manages to resist, escapes at an early stage, or is fully rehabilitated in the original workplace or elsewhere
Second degree: Victim cannot resist or escape immediately and suffers temporary or prolonged mental and/or physical disability and has difficulty reentering the workforce
Third degree: Victim is unable to reenter the workforce and suffers serious, long-lasting mental or physical disability

Source: Adapted with permission from Davenport N, Schwartz RD, Elliott GP. Mobbing: emotional abuse in the American workplace. Ames, IA: Civil Society Publishing; 1999:39

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Major depressive disorder (often with suicide ideation) is frequently associated with being mobbed

CASE CONTINUED

Redirecting energy into a job search

As I met with Mr. G over the next 3 months, the pattern of malicious communication and actions continued at his office. For example, he received a written reprimand for being 10 minutes late after having overslept when starting flurazepam, which he continued to take for about 6 weeks without further tardiness. I encouraged Mr. G to withdraw energy from work by keeping a low profile and trying not to react to provocations. Instead, I counseled him to put energy into family activities and try to find a new job.

Within 3 months, Mr. G found a new position in the private sector at a similar salary, although with lower benefits. Six months later, he was still with his wife, had been promoted at his new job, lost the 10 pounds he gained, discontinued psychotherapy, and was sleeping well without medication. He reported that he still thinks "almost every day" about what happened in his previous job but keeps telling himself "everything did work out OK after all."

Mr. G experienced relatively mild, first-degree workplace mobbing, but it had a substantial effect on his quality of life and that of his wife for almost 1 year. If I had followed my first impulse and had Mr. G involuntarily hospitalized after our first interview, it would have confirmed rumors at his office and probably would have escalated the mobbing behavior.

Diagnostic recommendations

Consider the possibility that seemingly paranoid individuals could be the target of mobbing at work, and don't underestimate the psychological stress of being mobbed. Other forms of workplace harassment can be extremely stressful but do not have the "paranoidogenic" potential of mobbing. Patients may be so distressed that it is difficult to figure out what is going on in their work environment.

Ask patients to present physical evidence of conspiracy or harassment. Mobbing patients usually are willing to bring in large quantities of material. Keep in mind that when subjected to mobbing behavior over time, a person who is not initially paranoid is likely to develop some secondary suspiciousness and even frank paranoia.

Also consider the possibility of "pseudomobbing," in which an individual falsely believes he or she is a mobbing victim. Cases of pseudomobbing have been reported in European literature[11] and may represent a negative side effect of greater public awareness of the mobbing phenomenon (and of legal remedies to mobbing available in various European countries).

Mobbing is a serious stressor that can lead to psychiatric and medical morbidity and even suicide. Major depressive disorder—often with suicidal ideation—is frequently associated with being mobbed.[12]

A diagnosis of PTSD can be missed if the mobbing victim does not seem to have been subjected to a severe enough stress to meet PTSD criteria.

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Treatment recommendations

First, do no harm: Do not allow yourself to be used by the mob. This process can be direct—as in the Mr. G's case, where the patient was almost involuntarily committed—or subtle. For example, a person you know may describe the behavior of "someone at work," and you may be tempted to respond, "Well, I have not examined this person, but from what you say, it sounds like maybe…" You could then be quoted as a psychiatrist who agrees that the person is paranoid.

Giving your patient a name for what is happening to him or her may be the most therapeutic intervention. Generally, patients have not heard of mobbing. They typically are confused about what is happening and may blame themselves.

Treat the patient's family. Giving a patient's spouse or partner a name for what is happening is almost always helpful. One-third of mobbing victims suffer breakup of their marriages or relationships during the course of a mobbing, which can create a vicious cycle of stress, leading to isolation, leading to more stress.[3] Encourage the patient not to subject the spouse to repeated ruminations about insults at work.

Treat secondary symptoms of depression, anxiety, PTSD, or other sequelae with pharmacotherapy, psychotherapy, or a combination as appropriate. Refer patients with somatic symptoms to primary care if you feel that they need further evaluation.

Encourage your patient to visualize choices and ways to escape the situation. Frequently, patients will be locked into "fighting for justice" or putting up with the situation because they see no options.

Encourage your patient to withdraw energy from work and invest it in family, social life, or anything else. At the appropriate time, encourage him or her to grieve losses experienced as a result of the mobbing.

Related Resources

- Leymann H. The Mobbing Encyclopaedia. www.leymann.se.
- Westhues K. Workplace mobbing in academe. http://arts.uwaterloo.ca/~kwesthue/mobbing.htm.
- Namie R, Namie G. The Workplace Bullying Institute. www.bullyinginstitute.org.

Drug Brand Name

Flurazepam • Dalmane

Disclosure

Dr. Hillard reports no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

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Giving patients a name for what is happening to them may be the most therapeutic intervention

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Bottom Line

Consider the possibility that a seemingly paranoid patient is a victim of workplace mobbing. Mobbing victims are subject to severe stress and may develop adjustment disorders, depression, or posttraumatic stress disorder. Treat these disorders symptomatically, and encourage patients to withdraw energy from the workplace and invest it in family, job searching, or other activities.