Taking a Health Promotion Approach
to the Problem of Bullying

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ABSTRACT

Health promotion is an emerging, multidisciplinary, endeavour that has much to offer the study of bullying. The negative health impacts of bullying are well documented, and indicate that having been bullied is associated with poor outcomes in both physical and mental health for both school children and adults. Governments, organizations and communities can improve health and prevent ill-health. Health Promotion advocates a 'settings approach' which is underpinned by the premise that the way in which a setting effects health is a function of the general conditions of that setting, rather than the provision of specific health care services within in it. Theoretical approaches to the understanding of bullying have consistently drawn attention to the interaction of individual and organisational factors, and to the importance of contextual factors, in particular power relations. Successful interventions, particularly in the school setting, are consistent with the settings approach, for example the whole-school approach, which has been implemented and evaluated in a series of studies. It results in a marked reduction in the number of bully/victim problems, in anti-social behaviour generally, and an improvement in student satisfaction with school life. The case is strong for taking a settings approach to dealing with bullying. This requires a recognition that the health of individuals within organisations such as schools and workplaces, is effected by the whole organisation and way it conducts itself, and will only be effectively resolved by addressing the difficulties, although experienced at an individual level, through organisational policies and practices. *Keywords*: bullying, workplace, health promotion, settings approach.

RESUMEN

La promoción de la salud es un esfuerzo emergente, multidisciplinario, que tiene mucho que ofrecer el estudio del *bullying*. Están bien documentados los impactos negativos del bullying sobre la salud, e indican que el acoso está asociado a resultados pobres en la salud física y mental en niños escolarizados y adultos. Ambientes cómo los gobiernos, las organizaciones y las comunidades pueden mejorar la salud y prevenir la enfermedad. La promoción de la salud supone un "acercamiento ambiental" que es sostenido por la premisa de que la manera por la cual el ambiente afecta a la salud es una función de las condiciones generales de ese ambiente, en vez de la provisión específica de cuidados de salud dentro de él. Los acercamientos teóricos a la comprensión del bullying han llamado constantemente la atención sobre la interacción de factores individuales y organizacionales, y a la importancia de factores del ambiente, en relaciones particulares de sinergia. Las intervenciones exitosas, particularmente en el ajuste de la escuela, son consistentes con un acercamiento ambiente, por ejemplo el acercamiento a la escuela-completa, que se ha

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puesto en marcha y evaluado en una serie de estudios. Los resultados muestran una reducción marcada en el número de los problemas de acoso/víctima, del comportamiento antisocial en general, y una mejora en la satisfacción del estudiante con la vida escolar. La situación es grave como para tener en cuenta un acercamiento ambiental al *bullying*, que requiere un reconocimiento de que la salud de los individuos, dentro de organizaciones como escuelas y ámbitos de trabajo, aunque sea experimentada a un nivel individual, sea asumida por la organización, conducida de una manera global con políticas y prácticas de organización que afronten las dificultades.
Palabras clave: acoso, lugar de trabajo, promoción de la salud, aproximación ambiental.

Health promotion is an emerging, multidisciplinary, endeavour that has much to offer the study of bullying, both school and workplace. Health promotion offers a particular approach to the improvement of health, the efficacy of which is increasingly clear from evidence-based research studies.

The negative health impacts of bullying are well documented. In short, bullying is bad for your health. There is ample evidence that the experience of having been bullied is associated with poor outcomes in both physical and mental health for both school going children and adults.

Bullying is the assertion of interpersonal power through aggression (Pepler & Craig, 2000), and is defined as negative physical or verbal actions that have hostile intent, cause distress to victims, are repeated and involve a power differential between bullies and their victims (Olweus, 1991; Pepler & Craig, 1995). Estimates of the prevalence of school bullying suggest about 9% of students to be victims or targets of bullying at school (Olweus, 2003). Victims of bullying experience a range of problems, such as depression and anxiety; and in extreme cases, suicide (Olweus, 1991; Craig, 1994). In addition, those who have experienced being bullied are more likely to report poor self-concepts, become under-achievers, and leave home (Olweus, 1994). Being bullied is also associated with poor friendship making and loneliness (Nansel *et al.* 2001), as well as psychosomatic symptoms (Due *et al.,* 2005) and higher levels of substance use (Mazur & Malkowska, 2003; Molcho *et al.*, 2004).

Those who both bully others and are victims of bullying represent a marginalised minority, estimated at around 6% of children in Europe and North America (Nansel *et al.,* 2004). Bully-victims may commence by being bullied and cope by being aggressors as well; they are likely to have been involved in bullying behaviour over a longer time period than either bullies or victims (Kumpulained *et al.,* 1999) and have been found to exhibit the disadvantages of both bullies and victims (Nansel *et al.,* 2004). Bully-victims tend to be more generalist in their bullying, experiencing and perpetrating multiple forms of bullying (Craig *et al*., in press). Bully-victims are least likely to report high self-rated health (Schnor *et al.,* 2006) or psychosocial adjustment (Olweus, 1991; 1994). Being a bully-victim has also been associated with weapon carrying (Nansel *et al.,* 2004), smoking and alcohol consumption (Nansel *et al.,* 2004, 2001), and for

boys, with overweight and obesity.

Studies on a diverse range of adult populations conducted since the mid 1970s converge on a prevalence rate of between 8 and 10% of working adults experiencing occasional bullying and 1 to 4% experiencing severe bullying in the workplace. Studies also expose the extent of poor health outcomes in persons who have been bullied in the workplace. Studies include both self-selected samples and random samples in which associations between exposure to aggressive, derogatory or bullying behaviour and self-reported indicators of health were measured. In such studies chronic fatigue, sleep difficulties, somatic problems, irritability, anxiety, depression and lowered self-esteem have all been reported (Einarsen & Mikkelsen, 2003; Rayner *et al.,* 2006). Suicidal intent and self-hatred have also been reported (Thylefors, 1987, cited in Einarsen and Mikkelsen, 2003) although it should be noted a person rarely commits suicide for one reason (Rayner *et al.,* 2006). Overall, mental health outcomes appear to show stronger associations with bullying experiences than physical, to whatever extent the two are, indeed, separate. There is evidence too, that those who have experienced bullying long-term display a constellation of symptoms that closely resembles PTSD (Einarsen & Mikkelsen, 2003).

Few studies have attempted to explore cause-and-effect relationships. Those that have, indicate that bullying does actually cause poorer health. For example a longitudinal study of Finnish hospital employees in which those reporting bullying at work, subsequently displayed significantly increased sickness absence compared to non-victims and compared to their own sickness absence rates in the year prior to reporting bullying (Einarsen & Mikkelsen, 2003).

Those who have been bullied very clearly attribute their health difficulties to the experience of being bullying, and although this does not constitute unquestionable evidence, Einarsen, in reviewing the evidence concludes that despite scarcity of empirical evidence that the causal link between bullying and negative health seems plausible (Einarsen & Mikkelsen, 2003).

HEALTH PROMOTION

Health Promotion is defined by the World Health Organisation as: "…the process of helping people to increase control over, and improve their health" (WHO, 1986). This definition was produced at a landmark WHO conference at Ottawa in 1986, which articulated the key concepts and principles of health promotion.

While the endeavor of Health promotion was formally defined in 1986, it has been evolving for many years previous. Broadly speaking, since the 1970s there have been changes in the way we define health, and in our understanding of the factors that influence health. It is increasingly acknowledged, for example that multiple factors influence health, and in particular there has been a move away from a focus on simply persuading individuals to change their lifestyle and behaviours, to exploring the influence of broader factors such as social networks, organizations and socio economic status.

Acknowledgment of the multiple influences on health has, in turn, led to changes in the way in which we try to improve health. At Ottawa, a framework or a blueprint

for action was articulated, which outlined how governments, organizations and communities could improve health and prevent ill-health.

The Framework for Action for Health Promotion includes the following five action areas:

1. Build healthy public policy. This means developing legislation, and policy such as social and fiscal policy to improve health. It can include national policy such as health and safety legislation, or work life balance policy (e.g. child care and statutory leave arrangement), or organisational policy

2. Create supportive environments. This refers to developing living and working conditions that promote health, (sometimes called Healthy settings) and ensuring the conditions in which we live and work are conducive to health, and facilitate it rather than compromise it. In a school this would include having resources available for non-curricular activities, or access to school counsellors. In the workplace this could include occupational health service access, progressive supportive management and a culture that supports workers to make healthy choices.

3. Strengthen community action. This refers to community participation, action and development, encouraging communities (for example geographical, work or school) to be involved in and take ownership of their health actions

4. Develop personal skills. This refers to helping people to reduce health harming behaviours and increase one that enhance health. For bullying this might include anger management or communication skills.

5. Reorient health services. Developing services to include preventative and promotive aspects as well as clinical and curative.

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THE SETTING APPROACH

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Of these 'creating supportive environments' has most relevance for addressing bullying, both in schools and workplaces. In its seminal documents, (specifically those emerging from the 3rd international conference on Health Promotion at Sundsvall, in Sweden in 1991) the World Health Organisation drew particular attention to the importance of the 'setting' as a focus for health promotion. Based on the premise 'health is created and lived by people within the settings of their everyday life; where they learn, work, play and love' (WHO, 1992) the settings approach found expression.

A setting is a place where people come together to undertake daily activities or perform specific tasks (not necessarily related to health) A settings has structures, policies, and institutional values. In a setting, environmental, organisational and personal factors interact to affect health and well-being. The way in which a setting effects health is a function of the general conditions of that setting, rather than the provision of specific health care services within in it (e.g. school nurse, occupational health doctor).

The settings approach involves more than just delivering health education in a convenient setting -the concept of *context* is very important. It includes how the setting is organised, managed, resourced and how resources are managed within it. It includes physical, social and psychological, economic and political aspects of the setting or environment. In this way health and conversely ill-health is 'created' by the setting

itself and the way it goes about its business. Therefore the improvement of health within that setting will require identification of underlying norms, roles and cultures and may involve re-shaping environments building partnerships, bringing about sustainable change, and developing empowerment and ownership of change throughout the setting (Nutbeam, 1998). A priority objective then is to promote health through the application of whole system thinking, and in particular organisational development.

It is within the settings approach we can see expression of the key precept within health promotion that organisational systems -and systems within which organisations are embedded- are critical determinants of health. Further, it reflects health promotion's ecological perspective -that an *'individual cannot be treated in isolation from the larger social unit or system in which they operate… Health is product of the interdependence between the individual and the sub-systems of the ecosystem'* (Green *et al.,* 2000). The ecological approach shifts emphasis away from individuals to focus on communities, organisations and populations, and towards a concern with how to develop environments that support health.

The settings approach is consistent with systems theory, viewed here as dynamic and complex, with inputs, processes and outputs, and which are characterised by integration, interconnectedness and interdependencies between different elements. Each setting is part of a greater whole -an 'open system' in synergistic exchange with the wider environment and thus with other settings (Dooris, 2006). In the case of the school this includes, pupils, teachers, parents, school boards, regional or national educational structures. In the case of the workplace it includes, workers, families, owners/managers, occupational or professional groups, trade unions, industrial networks, multinationals or public sector managers, and in both cases, ultimately, government.

In the settings approach there is a shift of emphasis to health creation, rather than merely health protection, particularly significant in the context of the workplace, which historically has had health matters addressed by occupational health services which have been protection/prevention focused. This shift in emphasis allows us explore how settings can create health, contribute to health, promote our health rather than simply ensure we don't experience poor health within them. In schools and workplaces this would be exploring how social interactions and relationships can improve mental health and well-being.

The implications of taking an ecological approach, as outlined by Green *et al.* (2000) and Dooris (2006) are as follows. Interventions which target one sub-system may have unintended effects on others. For example an intervention the aims to help workers identify bullying behaviour in the workplace and report it, may create havoc with line managers who have not been resourced to deal with 'bullies', nor have the backing of management to use punitive action.

While organisations can influence the health of those who attend them or work within them, individuals can also influence their environments. Health promotion typically focuses on empowering individuals to increase control over their health through effecting change within these environments. Green *et al.* (2000) refer to this as reciprocal determinism.

Providing evidence that the settings approach works presents a number of challenges

to researchers. If, as it is intended, health is integrated into the everyday work of the organisations, it, to all intents and purposes, becomes difficult to identify and therefore to measure (Dooris, 2006).

The complex interdependencies of the sub-systems and systems in a setting mean that interventions, to be maximally effective must address several levels within the setting. The above concerns notwithstanding, there is indeed evidence that the most effective health promotion interventions are those, which occur at a number of levels. For example, high risk behaviours in out-of-school young people are most effectively reduced by interventions that not only target behaviour change, but also facilitate access to counselling, life skills training and peer support (Jackson *et al.,* 2005).

THE CASE FOR TAKING A HEALTH PROMOTION APPROACH

The case for applying a health promotion approach is strong in relation to bullying, both school and workplace. Why is this?

Theoretical approaches to the understanding of bullying have consistently drawn attention to the interaction of individual and organisational factors, and to the importance of contextual factors, in particular power relations. Successful interventions are consistent with the settings approach.

School Bullying

Definitions of bullying frequently refer to power struggles. For example Pepler and Craig describe Bullying as the assertion of interpersonal power through aggression and Olweus (1994) defines it as negative physical or verbal actions that have hostile intent, cause distress to victims, are repeated and involve a power differential between bullies and their victims. Further it is asserted with repeated bullying, the power relationships between bullies and victims become consolidated: bullies increase and victims lose their power. In such relationships young people who are being bullied become increasingly powerless to defend themselves.

It is grounded in this understanding of school bullying that the whole-school approach to bullying has evolved. The whole-school approach is associated with the work of Olweus and associates at in the Bergen School, University of Bergen. The Olweus Bullying Prevention programme addresses both individual and organisational determinants of school bullying.

The Olweus Bullying Prevention Programme has been developed for use in schools for over 20 years. The programme is built on four key principles which are translated into a number of specific measures at school, class and individual levels, (for example survey, school conference day, teacher discussion groups, meetings with parents, class rules, individual intervention plans), all of which can be described as a re-structuring of the school social environment. Teachers, students are parents are all involved, 'experts' such as school counsellors, psychologists are involved as coordinators and in the handling of serious cases (Olweus 1993a). Adults both at home and in the school act as authorities and are encouraged to take responsibility for the children's total situation,

not only regarding learning but also social relationships. The programme has been implemented and evaluated in a series of studies, involving 82 schools in Bergen, Norway and has also been applied in the UK, Germany and most recently in Ireland. It typically results in a marked reduction in the number of bully/victim problems, a clear reduction in anti-social behaviour generally, and an improvement in student satisfaction with school life. Further, in the school setting it has been shown to be a good 'entry point' for dealing with related difficulties (Olweus, 1993a; Olweus, 2003).

Other whole-school approaches, such as the 'Friendly Schools and Families Programme' in Western Australia similarly address the problem at a number of levels. This programme contains six components, namely policy development. school ethos, student management and support, classroom practice, family links and physical environment. Rigorous evaluation across a number of randomly selected primary schools demonstrated that the programme results in a very significant reduction in bullying behaviour, increases in both feelings of safety and happiness at school and social skills, and increased knowledge and skills on the part of parents and teachers to assist children (CHPR, 2007).

Workplace Bullying

There are many definitions of workplace bullying, some very lengthy, as workplace definitions may be a reference point for legal actions against individuals and employers. Across these definitions there is general agreement that bullying is characterised by negative acts or acts with negative effect, which are persistent, enduring and systematic, and occur in a situation where the individual finds it difficult to defend themselves due to a power imbalance between the target and the perpetrator. Typically, the bully has a degree of power over the person being bullied and seeks to abuse this. Power can be either physical, psychological or social/organisational.

Approaches to understanding bullying in the workplace include those that focus on the individual, on social processes, or on the organisation. The former have been shown to have limited usefulness in the workplace context (Cowie *et al.,* 2002), not the least because of difficulties determining whether traits like low self-esteem are an antecedent or a consequence of bullying.

An approach that has received more public and research attention is the work-environment model. This model offers organisational factors and work conditions such as conflicting goals and priorities, high task and responsibility ambiguity, poor information flow, and lack of consultation. There is considerable empirical support for the association between reported incidences of bullying and negative work environments (O'Moore *et al.,* 1998; Vartia, 1996; Report of the Task Force, 2001). Further, there is a relationship between organisational change and bullying, with several studies demonstrating that bullying coincided with changes of either ownership or management or the introduction of new technology (Report of the Task Force, 2001; Hoel *et al.,* 2001).

The attribution of wider organisational factors such as climate and culture as a cause of bullying is a related model, also with some empirical support. There is evidence for example that bullying is more commonly reported in large organisations, public

sector organisations and male-dominated organisations (Report of the Task Force, 2001; Einarsen and Raknes, 1997). Organisational culture can act as a 'filter' through which behaviours are variously interpreted (Einarsen, 1997). Shouting and name-calling may be unequivocally unacceptable in a white collar or professional work setting but far more tolerated in the construction industry, for example. Cultural factors may influence any or all of the following; what is perceived as bullying, what degree of seriousness it is afforded, how bullying is investigated and what actions are taken.

Finally, there is what can be termed a systemic approach in which the organisation itself it seen to be the bully. Negative work conditions are in and of themselves seen to be a harassment, as opposed to prompting or eliciting aggressive behaviour. Liefooghe and Davey (2001) explore this idea in more depth, finding evidence for concerns with organisational power systems and institutional bullying .

Unlike school-based bullying, there is a dearth of published studies on workplace anti-bullying interventions. It is increasingly apparent however, that tackling workplace bullying will require complex interventions, that not only address the problem at a number of levels but address core issues within the workplace setting -in other words not only the different parts of the whole, but the 'spaces in between' (Baric & Baric, 1995, as cited in Dooris, 2006).

The very structures within workplace can uphold and even facilitate bullying behaviour -the organisational hierarchy. The nature of the employer relationship is inherently, and unavoidably, inequitable. The nature of a work organisation is that good/services must be produced and in order for this to happen employers must exercise their 'right' to get workers to undertake a job of work. While this does not include the 'right' to bully, it can be difficult to draw the line between legitimate management practice and harassment. Further, in a more general way, as long as workers are economically dependent on work, they are in a weaker position than their employer, and are likely to feel compromised if bullied by management or even if reporting bullying to management. This position has been argued cogently by Ironside and Seifert (2003), who claim that 'bullying is endemic in the labour management practices associated with making a profit' (p.386) and that when bullying is located within the context of the employment relationship, it cannot but become 'enmeshed in the fabric of workers' and managers' rights (41, p.390).

As Collins and Thompson (2006) point out, anti-bullying procedures which place the responsibility on the individual to report bullying and prove that it is happening cannot hope to address workplace bullying. This position is supported by evidence from qualitative studies that workers do indeed feel highly compromised with regard to confronting bullying behaviour in the workplace, and recount experiences of the abuse of power within the workplace (Liefooghe & Davey, 2001; Hodgins, 2006; Tracey & Alberts, 2006; Lewis, 2006).

CONCLUSION

In conclusion, the case is strong for taking a what we call in health promotion, a settings approach to dealing with bullying. This requires a recognition that the health

of individuals within organisations such as schools and workplaces, is effected by the whole organisation and way it conducts itself, and will only be effectively resolved by addressing the difficulties, although experienced at an individual level, through the organisational policies and practices. We have evidence of the success of such interventions in schools, and await the application of the approach in the workplace. Only a whole-organisation, ecological approach can hope to address bullying in the workplace. In particular, an analysis of power is central to any understanding of bullying and the development of interventions to confront it.

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