World Journal of Advanced Research and Reviews
eISSN: 2581-9615 CODEN (USA): WJARAI
Cross Ref DOI: 10.30574/wjarr
Journal homepage: https://wjarr.com/

(RESEARCH ARTICLE)

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Moral harassment in university hospital of Marrakesh: Epidemiological investigation

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World Journal of Advanced Research and Reviews, 2024, 22(01), 1990–1999

Publication history: Received on 20 March 2024; revised on 27 April 2024; accepted on 29 April 2024

Article DOI: https://doi.org/10.30574/wjarr.2024.22.1.2609

Abstract

Introduction: moral harassment in the workplace is a growing phenomenon worldwide. Leymann defined it as a form of psychological terrorism that manifests itself over a relatively long period of hostile words or actions expressed or manifested by one or more people towards a third person (target) at work. It causes damaging consequences on the mental and physical workers health, with negative economic impacts on the company.

Objectives: our objective was to study the epidemiological characteristics, the clinical aspects, and the consequences of moral harassment among the medical and paramedical staff of the Mohammed VI university hospital in Marrakech.

Methods: We carried out a descriptive transversal study over six months covering 329 caregivers working at the Mohammed VI university hospital in Marrakech. The support of the investigation was an individual, and a strictly anonymous questionnaire containing the French version validated by the questionnaire of Leymann entitled Leymann Inventory of Psychological Terror; sociodemographic, mental health, and professional data were also collected.

Results: In our study, the prevalence of moral harassment was 27.5%, according to Leymann's criteria (exposure to at least one situation, at least once a week for at least six months). Moral violence targets were between 25 to 35 years old (76%) and less than five years seniority (55%). The victims were represented mainly by residents (65.5%) and interns (33%). There was no correlation between sex and exposure to psychological violence (p=0,36). The supervisor was the main harasser (80%). Anxiety, depression, and symptoms of post-traumatic stress disorder had been the most observed consequences on the mental health of victims.

Conclusion: Moral harassment at work seems, by its prevalence, to invade the hospital environment, and young doctors constitute a particular target. Exposure to this phenomenon has a negative impact on an individual's mental health. Our results are alarming enough to prompt us to continue investigating and put in place recommendations to limit and prevent the consequences.

Keywords: Moral Harassment; Health Care Workers; Workplace; Epidemiology; Investigation

1. Introduction

Harassment is a particular form of psychological violence inflicted in the workplace since antiquity [1], It can be equated with psychological harassment, bullying and mobbing and the terms used often reflect the country of origin of the study [2] [3]. This phenomenon is still largely unknown and underestimated. Popularized in the French-speaking world in 1998 by Marie- France Hirigoyen [5], she conceives it according to an individual approach as a process of moral

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destruction perpetrated by a narcissistic pervert, which begins with the abuse of power, continues with narcissistic abuse, where the other loses all self-esteem and which can lead to mental illness or suicide [6]. According to H. Leymann, this phenomenon is defined as a "formof psychological terrorism which manifests itself by a series of hostile words or actions, expressed or manifested by one or more people towards a third person (the target) at work, overa fairly long period. These words and actions may seem harmless in isolation, but their constant repetition has pernicious effects [7][8]. Other authors have a more organized approach to harassment, such as Dejours [9] [10], who defends the idea that mobbing at work is not reduced to a specific relationship between two people, an aggressor and a victim, but results from new forms of work organization, which generate competitive relationships between employees. Mobbing can be vertical top-down and wish means harassment of subordinates by the boss [11], The consequences of mobbing on the employee's health and safety are not always clear. The consequences of mobbing on mental and physical health are numerous, and these devastating effects can also lead to professional exclusion and, therefore, a repercussion on the company's economy [12]. On a national scale, the evaluation of moral harassment among health personnel at the University Hospital of Fez [13] showed a prevalence of 34.2%. It appears to be a threatening reality within our healthcare institutions [14][15]. Faced with this high prevalence, we were interested in studying this phenomenon in the Mohammed VI University Hospital of Marrakech to describe the forms and techniques used in mobbing within the public hospital as well as their repercussions on the person, to evoke some of the contributing factors, and to make proposals to remedy this situation.

2. Methodology

This is a descriptive and cross-sectional survey spread over six months, from September 2019 to February 2020.

The target population is represented by the medical and paramedical staff of the Mohammed VI University Hospital center of Marrakech (UHC): teachers, doctors in training (residents and interns) and those attached to them, nurses, biology, radiology and anatomopathology technicians.

To be included in the study, participants needed to have a minimum of six months of seniority. We excluded medical students doing their training at the UHC, office workers, administrative agents and secretaries. Data collection was based on a questionnaire containing the validated French version of the Leymann questionnaire [16]. The LIPT: "Leymann Inventory of Psychological Terror" is a reference instrument in the international literature. It includes a list of 45 situations of violence at work, supplemented by other questions concerning the frequency, the duration of exposure, the perpetrator of the violence, his or her hierarchical position and the resource persons to whom the victim was able to speak. And to meet our objectives, the LIPT has been completed with other items related to Sociodemographic data, personal history, consequences of harassment and job satisfaction. Five hundred (n = 500) caregivers were asked to participate in the survey. Of these, 350 completed and submitted their self-administered questionnaires, for a participation rate of 70%. There were 329 usable questionnaires.

The participant's consent was obtained before the questionnaire was administered and after they had been informed of the objectives of the survey. Anonymity and confidentiality of the data were ensured throughout the study.

The statistical study is carried out with the SPSS software version 23.0. Qualitative quantities it is based on the Chi2 study. The significance level chosen corresponds to a p-value of 0.05.

3. Results

3.1. The socio-demographic and professional characteristics of the study population

The average age was 28 years, with extremes ranging from 23 to 57 years. 63% of the participants were women. 60% were single. More than the majority of the participants worked in medical service. The distribution by professional category placed doctors in training as the first responders 62%, followed by paramedical staff (30%) and teachers (8%). The majority of the participants had a seniority of fewer than five years. Concerning personal history, 15% of the respondents were followed for psychiatric disorders, and 20% were consumers of toxic substances, mainly tobacco.

3.2. The prevalence of moral harassment And the description of the 45 situations of the LIPT questionnaire

Leymann defines exposure to psychological abuse as being exposed to at least one of 45 situations at least once a week for at least six months. According to this definition, the prevalence of psychological violence at the University Hospital of Marrakech is 27.5% (n =91). The most frequent situations were: people say bad remarks about you behind your back

(item 24), other people forbid you from expressing yourself (item 3) and people spread false rumors about you (item 25) (Table 1).

The frequency of exposure was greater than or equal to once a week for 56%. The average duration was 17.35 ± 21.3 months.

Table 1 Prevalence of exposure to different LIPT situations among the study population during the last 12 months

The 45 situations of LIPT	**Total =330 N**	**Prevalence of exposure (%)**
1. Being silenced by superior	43	22.1
2. Being continuously interrupted	48	24.6
3. Being silenced by others	63	32.3
4. Being scolded and yelled at	53	27.2
5. Being criticized regarding work assignments	54	27.7
6. Private life being criticized by others	15	7.7
7. Being terrorized by means of phone calls	28	14.4
8. Receiving verbal threats	42	21.5
9. Receiving written threats	5	2.6
10. Being exposed to irritating gestures/looks	54	27.7
11. Physical presence ignored, addressing only others	46	23.6
12. Not being talked to	30	15.4
13. Not being allowed to physically contact others	18	9.2
14. Being isolated from others at work	4	2.1
15. Conversation with colleagues is forbidden	4	2.1
16. Physical presence being ignored among others	27	13.8
17. Being addressed only in written ways	12	6.2
18. Not being given any work assignments at all	7	3.6
19. Being given meaningless work assignments	36	18.5
20. Being given work assignments far below capacity	30	15.4
21. Continuously being given new work assignments	18	9.2
22. Being given humiliating work assignments	18	9.2
23. Being given difficult work assignments far above capacity	24	12.3
24. Being gossiped	73	37.4
25. Being exposed to slanders and lies	63	32.3
26. Being ridiculed	22	11.3
27. Being said to have a mental illness	10	5.1
28. Being forced to go through psychiatric exams	2	1.0
29. Being mocked due to a handicap that you have	3	1.5
30. Voice, gestures, and way of moving are imitated to tease	9	4.6

31. Suffering verbal attacks because of your political and religious beliefs	9	4.6
32. Being teased due to your ethnic background	6	3.1
33. Being forced to do work assignments which are against your conscious	9	4.6
34.Being judged for your work in an injustice and humiliating way	28	14.4
35. Your decisions are questioned by others	32	16.4
36. Being reviled using obscene or degrading terms	3	1.5
37. Being sexually threatened	6	3.1
38. Being given dangerous work assignments for your health	40	20.5
39. Despite your bad health you are forced to do work assignments that heart your health	51	26.2
40. Being physically threatened	8	4.1
41. Being physically threatened in the form of mild violence as a warning	9	4.6
42. Being physically attacked	8	4.1
43. Being forced to spend big amounts of money	3	1.5

3.3. Data on the Characteristics of the harassed population

3.3.1. Socio-demographic and professional data

Among the 91 health care personnel harassed, the average age of the doctors (doctors in training and attached doctors) was 27.4 years and 29.5 years for the paramedical personnel. The victims of violence were mostly women (75%) and (64%) were on medical service. More than half (55%) of the victims had a seniority of less than five years, with an average of 36.4 ± 9.2 months.

The targets of violence are mainly represented by doctors in training and attached doctors (71%) (figure 1), followed by paramedical personnel (28%) and teachers (1%). (Table 2)

The distribution of those exposed to psychological abuse by medical status placed residents first (65.5%), followed by interns (33%), and finally attached doctors (1.5%).

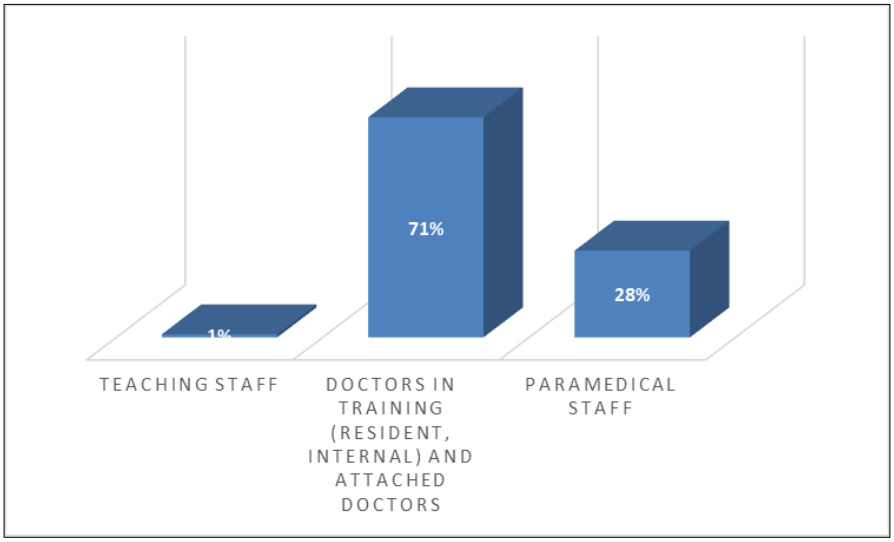

Figure 1 The distribution of the harassed population by occupational category

Table 2 Sociodemographic data of our general and exposed population

		Total (n =329)	**Exposed (n =91)**
Average age in years ± standard deviation		28 ±4	27±1.4
Gender	Male	121 (37%)	22(25%)
	Female	208 (63%)	69(75%)
Civil status	Single	197(60%)	64(70%)
	Married	125(38%)	25(27%)
	Divorced	7 (2%)	2(3%)
Professional Status	Teacher	26 (8%)	1(1%)
	Physician Residents	150(73%)	42(65.5%)
	Resident Physician	47(23%)	21(33%)
	Attached physicians	8 (4%)	2(1.5%)
	Paramedical staff	98(30%)	25(28%)
Seniority	<5 years	217(66%)	51(55%)
	5 years and 10 years	82(25%)	27(30%)
	> 10 years	30(9%)	13(15%)
Service	Medical	253(77%)	58(64%)
	Surgical	76(23%)	33(36%)
Psychiatric history	Yes	15%	25%
	No	85%	75%

3.3.2. Data on the characteristics of the moral harassment

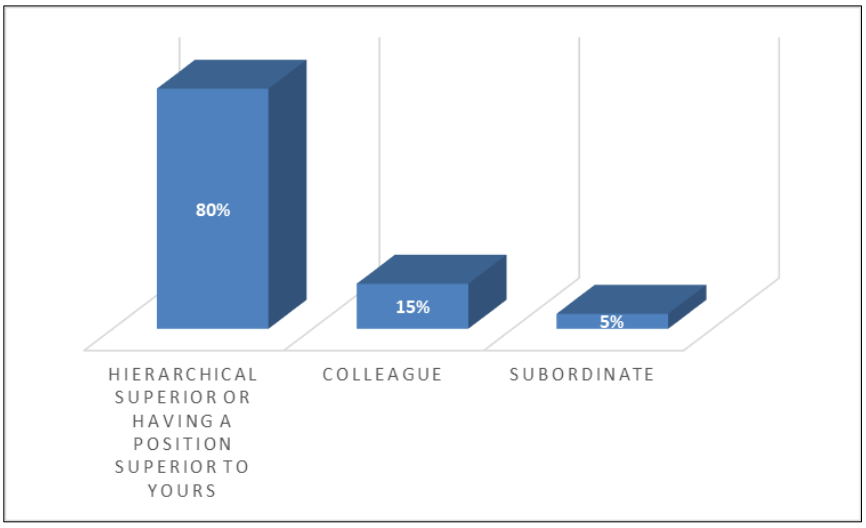

Figure 2 Hierarchical position of the harasser

Vertical harassment from the hierarchy was reported by (80%) of the harassment, while the horizontal form from colleagues was only (15%) (Figure 2). The majority of the perpetrators were female (45%) and belonged to both sexes in (30%) of the cases. The number of perpetrators was attributed to one person (43%). The average number was 1.5±2.4. Most people are still facing violence.

3.3.3. Application for support

More than half of the participants had asked for support, while (47%) did not need it. This request was addressed by (41%) of colleagues, followed in decreasing order of frequency by family members or relatives, friends or acquaintances outside the UHC and supervisors.

Three-quarters (75%) of the respondents witnessed psychological abuse of others in the workplace.

3.3.4. The sources of moral harassment

Psychological abuse was attributed mainly to a poor general work atmosphere and poor work organization, which had rates of (25.7%) and (20.8%) respectively. (Table 3)

Table 3 Sources of moral harassment

The sources of moral harassment	**Percentage**
A poor general atmosphere at work	25.7%
Poor work organization	20.8%
Management and supervision problems	16.5%
A poor general atmosphere at work	25.7%
Problems of competition between people	11.8%
Envy, jealousy	10.8%
An unresolved conflict or dispute at work	7.5%
I do not know	5.4%
Because I am different from others because of my age, gender, nationality, or disability	1.0%
Because they want me to leave the service	0.5%

3.3.5. Consequences of moral harassment

On the job

Temporary interruption of work was reported in (15%) of the cases, and more than half of them reported absenteeism for more than eight days.

The mean duration of absenteeism was 21.04 ± 4 days.

On mental health

Sleep disorders were reported by more than half of the participants (57%), while substance abuse was reported by 5%. The consequences of psychological violence on mental health are, in decreasing order of frequency, concentration problems (30%), anxiety and fear (25%), reliving of traumatic scenes (16%), diagnosed depression (12%), memory problems (10%) and, lastly, intrusive nightmares (7%).

On dignity and social functioning

The majority of the subjects (54%) reported a loss of dignity and an impact on their social functioning.

Job Satisfaction

The majority of victims of psychological abuse reported job dissatisfaction.

3.4. Correlation between exposure to psychological abuse and socio-demographic data:

- Concerning the gender of the victims, there was no statistically significant difference between men and women.
- Young subjects under 36 years of age are statistically more exposed to psychological violence.
- The average professional seniority of the exposed subjects was lower than that of the unexposed (Table 4).

Table 4 Correlation between gender and exposure to moral harassment

Gender	Total (n =329)	Presentations (n=91)	Not exposed (n=238)	p
Female	208 (63.2%)	54 (26%)	154 (74%)	0.36
Male	121(36.8%)	37 (30.6%)	84 (69.4%)	

3.5. Correlation between job dissatisfaction and prevalence of psychological abuse:

Job dissatisfaction was significantly higher among those exposed to psychological abuse (Table 5).

Table 5 Correlation between age and exposure to moral harassment.

Age	Total (n =329) n (%)	Presentation (n=91) n (%)	Not exposed (n=238) n (%)	p
36 years old	212 (64.4)	69 (32.5)	143 (67.5)	0.04
36 years old	117 (35.6)	22 (18.8)	95 (81.2)	

4. Discussion

The Leymann study conducted in Sweden in 2000 showed a prevalence of 3.5% of bullying in the working population [7]. In Germany, studies show an index of existence of the phenomenon of 1.2% to 3.5% and a notable overrepresentation of victims of harassment in the health and education sectors as well as in public administration [17]. In the SOARES study, 13% of people were targets of psychological harassment [18]. While in France, the study conducted by the National Institute of Health and Medical Research in 2004 showed a prevalence of 10% in the employed population of the Provence-Alpes-Cote d'Azur region [19]. On the national level, the prevalence of psychological violence was 34.2% in the university hospital of Fez [13] in Morocco, which is approximately in line with the results of our study. Differences between countries may be partly explained by the decade between surveys and cultural factors. Some countries have more egalitarian and feminine cultures than others, resulting in a more limited tolerance of psychological violence in the workplace [20][21].

According to the literature, harassment mainly affects the 40-50 age group and those with morethan five years of service [16]. These results disagree with the data from the survey of Elghazounia et al. [13] and our results. This difference in age and seniority is explained by the population studied, our study is conducted in a university hospital where young people have less seniorityand a lower hierarchical position compared to older staff, while the other studies are done in a general population of employees.

Some studies confirm the overrepresentation of women targets of workplace bullying [22]. Thestudy by Figueiredo et al conducted in Brazil among university teachers, which sought to study the influence of gender on mobbing, indicated that among the 76 participants, 38.2% weresubjected to mobbing, of which 34% were women and 41.5% were men. The study concluded that there was no genderpreponderance regarding the sex of the aggressors, and colleagues in the same hierarchical condition were the main perpetrators [23].

According to Dassisti et al. [24], most of the studies selected in their literature review show that women are mostly victims (n=10 articles), and the aggressors are mostly men (n=2 articles). Gender-related issues and discrimination due to children and the family management are frequently associated with the aggression suffered by women (n=6 articles). The consequences on the mental health were majored in women compared to men (n=7 articles). However, in our study there was no significant difference between the two sexes which can beexplained by the lack of inequality between men and women in their positions, in the roles assigned to them or in the professional hierarchy.

Concerning the hierarchical position of the perpetrators of violence, the vertical form coming from the hierarchy was in the majority compared to the horizontal form coming from colleagues [25]. In the majority of studies, the perpetrator of moral harassment was frequently the hierarchical superior.

In our study, psychological violence was correlated with a poor general atmosphere, poor work organization and management. Concerning the organization of work, some studies have been interested in the relations between several organizational determinants such as time constraint, autonomy, variety of skills and monotony[21]. Based on these works, we postulate that employees subjected to low autonomy in their work, high time constraint, and low variety of skills are more likely to be harassed [26].

We note that the data concerning the prevalence of harassment worldwide are quite heterogeneous due to various aspects, including the difficulties of the conceptual definition of harassment [27], the different measurement tools used and the different professional sectors in which the studies are conducted.

Harassment affects the victims' mental and physical health [28], the victim can develop over a more or less long period of non-specific functional disorders characterizing the alert phase, such as sleep disorders, nightmares,

fatigue, irritability, a paranoid character of distrust with a psychic rigidity and various somatic complaints [18]. It also happens that the person who undergoes harassment develops anxiety and mood disorders that can evolve more or less quickly to a severe depressive state accompanied by suicidal tendencies.

The symptomatology can also evolve towards an "adaptation disorder" or be similar to a "post-traumatic stress disorder." The recognition of its psychological origin is relatively recent [29], and it is distinguished not by the intensity of the symptomatology but by the loss of individual reference points that can lead to an avoidance of interpersonal relationships and the acquisition of an invalid status [30]. The quality of life deteriorates little by little and often leads to family conflicts, separations and divorces [31].

Eating disorders (anorexia, bulimia) and addictive behaviors such as smoking and alcoholism can also be observed [27]. Quine et al note an increase in the consumption of tobacco and alcohol, respectively, in 50% and 20% of subjects who complain of harassment [29]. Damant et al [32] specify that people who experience violence at work have weaker interpersonal skills and are less committed. This set of things will result in lower motivation, disinterest and dissatisfaction at work and absenteeism, which results in significant financial losses for society [33].

4.1. Recommendations

According to the results of our study and the literature data, a collective and global approach is needed to fight against the moral harassment [10][34]. This can only be achieved with the participation of health professionals, policymakers, administrators, human resource managers and workers. Thus, we have taken the liberty of making some recommendations:

- Reorganization of work and responsibilities within the various departments [35].
- Establish a climate of tolerance and relaxation between all the nursing staff.
- Discouraging disobedience and abusive behavior [36].
- Implementing information and education activities about harassment and its consequences [37].
- Create a listening unit within the UHC to intervene in time, once a harassment situation has begun, by calling on a confidant and a mediator.
- A rapid diagnosis of the effects on health can help limit the consequences at all levels (individual, family, social).

Set up awareness groups to bring together victims of harassment to share their experiences, to become aware that they are not responsible for what is happening to them, to recognize the aggression, and if necessary, to adapt their behavior.

Legislative measures to protect and assist victims and even punish harassers.

5. Conclusion

Moral harassment in the workplace seems to invade the hospital and university environment, and young doctors are a particular target. This exposure has a negative impact on the mental health of the individual, on his professional and family life, and constitutes a heavy socio-economic burden on society. Experience shows that early intervention can allow the suffering person to find a solution before the health damage is too significant.

Finally, our results are sufficiently alarming to encourage us to continue investigations through other epidemiological surveys that must be initiated at the national and international levels.

Compliance with ethical standards

Disclosure of conflict of interest

The authors did not submit a conflict-of-interest statement.

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