The Ill-treatment of Employees with Disabilities in British Workplaces¹

Ralph Fevre, Amanda Robinson (School of Social Sciences, Cardiff University), Duncan Lewis (Business School, Plymouth University) and Trevor Jones (School of Social Sciences, Cardiff University).

Principal author contact details: Ralph Fevre, Professor of Social Research, Cardiff School of Social Sciences, Cardiff University, Glamorgan Building, King Edward VII Avenue, Cardiff CF10 3WT. Tel: +44(0)29 2087 4086 Fax: +44(0)29 2087 4175. Email: fevre@cardiff.ac.uk

Abstract

There are few quantitative studies which show the workplace is experienced in a different way by employees with disabilities. This article fills this gap using data from the British Workplace Behaviour Survey which found that employees with disabilities and long-term illnesses were more likely to suffer ill-treatment in the workplace and experienced a broader range of ill-treatment. Different types of disability were associated with different types of ill-treatment. The survey also showed who employees with disabilities blamed for their ill-treatment and why they believed the ill-treatment had occurred. Drawing on the existing literature, four possible explanations for ill-treatment are considered: negative affect raises perceptions of ill-treatment; ill-treatment leads to health effects; ill-treatment results from stigma or discrimination; ill-treatment is a consequence of workplace social relations. Although some of these explanations are stronger than others, the discussion shows that more research is required in order to decide between them.

KEY WORDS: disability, discrimination, health, incivility, stigma, well-being, bullying, harassment.
Introduction

While society sees employment as the key to social membership, the assumption that employees with disabilities are of less productive worth leads to stigmatisation and discrimination (Barnes and Mercer, 2005; Riach and Loretto, 2009; Scambler, 2004). This assumption may have less to do with limitations arising from people’s impairments than it has to do with the way in which people with disabilities are treated in the labour market and the workplace. If they are kept at the margins of the labour market because they are assumed to be less capable (Barnes and Mercer, 2005), their assumed lack of productive worth becomes a self-fulfilling prophecy. If people with disabilities are ill-treated within the workplace, this will have a similar effect.

Schur et al. (2009) have argued that there has been less research on the experiences of people with disabilities in the workplace than on their employment levels. A focus on the workplace accords with developments in the sociology of disability because it draws (implicitly or explicitly) on the social model of disability (Foster, 2007). In this approach, it is not impairments that prevent people from being productive, but the environment and attitudes they encounter. The way work is organised within a set of social relations, as well as the design of the workplace, are of particular importance (Barnes and Mercer, 2005). This article considers the possibility that there might be evidence that these social relations involve ill-treatment that might adversely affect employees with disabilities and their capabilities.

The article begins by summarising the existing literature and noting that representative quantitative studies have been rare and studies of all kinds use limited concepts of ill-treatment and notions of who might be responsible for it. For example, much less is known about the ill-treatment of employees with disabilities by co-workers or clients than is known about their pay and conditions. Moreover, very little is known about differences in the treatment of employees with different disabilities. For example, are employees with visible disabilities more likely to be ill-treated than those with invisible disabilities, including psychological conditions? The research questions are specified in more detail before describing our own study, the British Workplace Behaviour Survey, which fills several gaps in existing knowledge with a representative sample of workers reporting their experiences with a wide variety of forms of ill-treatment in the workplace.

Studies of employees with disabilities and the social relations of the workplace
Barnes and Mercer (2005) refer to a number of studies confirming the link between the exclusion of people with disabilities and their assumed lack of productive worth. They also explain how the medical model of disability, in which the experiences of people with disabilities are seen as consequences of their impairments, fails to challenge this view. They chart the development of the social approach which focuses on the way societies disable people with impairments, culminating in the social model of disability which requires us to look at disabling environments and attitudes. From the perspective of the social model, Barnes and Mercer (2005) conclude that attention should be focused on the social organisation of the labour market to discover how those with disabilities are excluded from work. One of the grounds for exclusion is the belief that people with disabilities are unable to conform to ‘work discipline’ (Barnes and Mercer, 2005:533). Subjecting such beliefs to critique means looking at the experiences of employees with disabilities within the workplace as well as the labour market (Foster, 2007; Foster and Fosh, 2010).

Barnes and Mercer (2005) refer to UK evidence on people with disabilities being in less well-paid occupations, and in jobs for which they are over-qualified. Other UK evidence suggests that people with disabilities earn less, receive less training and are more likely to exit employment (Rigg, 2005). In the US, they are less likely to get good jobs, and do less well in terms pay and benefits, training, job security, promotions and participation in decisions (Schur et al., 2009). All of these differences may put people with disabilities in less productive positions, but such studies fail to illuminate their day-to-day experiences in the workplace; for example, their experiences of work discipline. UK research on the management of long-term sickness absences, and on the implementation of anti-discrimination legislation in the workplace, has addressed these issues, however.

In various articles (Cunningham et al., 2004; Dibben et al., 2001; James et al., 2002, 2006), Cunningham and colleagues showed that compliance with legislation, including anti-discrimination legislation, informed formal organisational policies on long-term sickness absence, and the management of serious ill-health, but failed to impact on the behaviour of line managers. Managers prioritised other organisational policies, were constrained by cost considerations, and poorly trained or supported. Senior managers tacitly showed compliance was not a priority; for example, when they left the detail of operationalising policies to line managers. Line managers also failed to comply with legislation because policies and procedures on sickness absence and discipline often ran together. As a result, the ability of employees with disabilities and long-term health problems to conform to work discipline was compromised and beliefs about their lack of productive worth were confirmed.
Cunningham et al., (2004) showed that employees with long-term sickness were unfairly treated because their workplace experiences were dependent on the goodwill of individual managers. Foster (2007) noted the same dependence on goodwill in respect of work adjustments in line with anti-discrimination legislation and that this created opportunities for abuse. She found that many of the factors Cunningham and his colleagues blamed for organisational non-compliance to anti-discrimination legislation could also lead to ill-treatment by line managers. It was known that employees with disabilities left employment because adaptations were not made (Meager et al., 1998) but Foster (2007) focussed on the ill-treatment that occurred when employers should have been making reasonable adjustments. According to Foster, the 1995 UK Disability Discrimination Act ‘while aiming to protect employees with disabilities in the workplace, also forces them to beg for conditions that enable them to continue in their employment’ (Foster, 2007: 81). Her interviewees suffered deteriorations to their health, bullying and harassment, less satisfactory work and ill-health retirements as a result of engaging in this process. Foster’s research also suggested that other key occasions for bullying and harassment were the management of sick leave and the process of returning to work after a sickness absence or from lengthy periods of being classed as unfit for work (also see Eakin, 2005).

This research gives us an insight into the ill-treatment of employees with disabilities but it has limitations. Only Foster’s research draws upon data from employees, all of the research is qualitative, and all of it focuses on ill-treatment in relation to sickness absence or the negotiation of reasonable adjustments. In order to address these limitations, and make progress with the issues discussed in the introduction, this article pursues the following research questions:

1. Are employees with disabilities and long-term illnesses more likely to suffer ill-treatment in the workplace?

2. If they are, what kinds of ill-treatment are they more likely to experience?

As well as knowing the prevalence of ill-treatment amongst employees with disabilities, it would be helpful to learn how it might be explained. For example, is there evidence of ill-treatment arising from prejudice and stigmatisation? Once this question is raised it becomes clear that the research cannot treat employees with disabilities as a single category. For example, it is suggested that the stigmatisation of psychological and learning disabilities remains the final frontier in the elimination of prejudice and stigmatisation against those with disabilities, and that the prejudice directed at those with such disabilities exceeds that directed
at other minorities (Social Exclusion Unit, 2004; Cross-Government Strategy, 2009). There is
evidence that such people suffer the greatest employment disadvantage (Equalities Review
Panel, 2007; Smith and Twomey, 2002; Social Exclusion Unit, 2004) and a third of the British
population does not believe that ‘people with mental health problems should have the same
right to a job as anyone else’ (Taylor Nelson Sofres, 2003: 8; also see Manning and White,
1995).

Exploring what lies behind the prevalence rates of ill-treatment means, firstly, exploring the
extent of differences in the workplace experiences of employees with different disabilities. For
example, do employees with visible impairments have different experiences to those with
invisible impairments, particularly long-term psychological and emotional conditions, and
chronic physical ill-health? Benchmark quantitative studies of prejudice and discrimination, for
example Abrams and Houston (2006) or TNS Opinion and Social Network (2008), only report
results for an aggregated disabilities category. In Ireland, Russell et al., (2008) collected bullying
and harassment data on constituent sub-groups but only published results for the aggregated
category. The same is true of the results published from the UK Government’s Fair Treatment
at Work Survey (FTWS) 2008.

Discovering what lies behind prevalence rates for of ill-treatment also means asking who is
responsible for it and whether there may be particular occasions for ill-treatment beyond those
already noted in qualitative studies. Research on the management of long-term sickness
absences and on the implementation of anti-discrimination legislation in the workplace rarely
mentions ill-treatment of workers with disabilities by co-workers, customers or clients. In the
US, Schur et al. (2009) found several studies which refer to co-worker attitudes towards people
with disabilities but no comparable UK studies are available. In the FTWS, employees with
disabilities were nearly twice as likely, in multivariate analysis, to have a range of employment
problems, including problems with employment rights (Fevre et al., 2009). Such problems
might be catalysts for ill-treatment by managers and supervisors.

In order to make progress with the explanation of prevalence rates, it is necessary to pursue
these additional research questions:

3. Are employees with particular kinds of disabilities more subject to ill-treatment than
   others?

4. If so, are these employees with particular kinds of disabilities more prone to particular
   kinds of ill-treatment or is it that they experience more across the board?
5. Who is responsible for the ill-treatment? Is it managers or supervisors, co-workers or subordinates, clients or customers?

6. Why do employees with disabilities think they have experienced ill-treatment; for example, do they blame stigmatisation or discrimination or do they think the roots of their ill-treatment lie in the way work and the workplace are constituted?

In what remains of this section, some possible explanations are introduced which can be considered if it is indeed found that employees with disabilities are more prone to ill-treatment. In order to do this, the salience of the literature on bullying and harassment is considered. Multivariate analysis of the FTWS showed employees with disabilities were more likely to experience a composite measure of sex harassment, bullying and other serious problems with an effect on health or well-being (Fevre et al., 2009). Yet, while some of the behaviours researched in the established literature on workplace bullying and harassment clearly overlap with those of central interest in this article, there is little evidence in that literature to answer the research questions. The literature on bullying at work emanated from Scandinavian psychological research (Bjorkvist et al., 1994; Einarsen and Skogstad, 1996; Leymann, 1990, 1996). These researchers applied the term to something more specific than ill-treatment, namely prolonged and regular exposure to negative behaviours (Einarsen and Skogstad, 1996; Zapf et al., 2011), and usually assumed some significant power disparity between perpetrator and target (Leymann, 1996; Hoel and Cooper, 2000).

Lopez et al. (2009) argue that bullying is more common when employees with ‘low positive status’ are seen as a threat to co-workers’ identity or job security (p. 6). This low positive status is particularly likely when the workers are drawn from minority groups because isolation and exclusion in wider society makes minorities into acceptable targets in the workplace (Lopez et al., 2009; Roscigno et al., 2009). In this case, ‘… mocking, barriers, and sometimes blatant threats are used to exclude certain groups (even potentially forcing them out of the workplace) or to keep members of these groups “in their place”’ (Lopez et al., 2009: 23). Employees with disabilities might constitute a target group for such treatment, although it seems more likely that they would be seen as a threat to identity rather than job security. The literature does not tell us, however, whether these forms of ill-treatment figure in the experience of employees with disabilities. While there is evidence of the exclusion of employees with disabilities from decision-making (Schur et al., 2009), little or nothing is known about general social exclusion by colleagues or mocking and threats. Nor is it known if co-workers and managers are making it harder for employees with disabilities to do their work, perhaps by withholding the
information they need to do their jobs, or whether proper recognition is withheld from employees with disabilities, or whether they suffer rudeness and incivility.

When the literature on bullying and harassment focuses on impairment or ill-health, it views them only as the effects of ill-treatment. Hoel et al., (2004) are unusual amongst workplace bullying researchers in raising the possibility of ill-treatment of employees with (mental) health conditions. The designers of workplace bullying research usually assume that health is the dependent variable in the relationship with bullying (Fox and Stallworth, 2005; Lee and Brotheridge, 2006; Matthiesen and Einarsen, 2001; Zapf and Gross, 2001) and have not debated the direction of causation (Beswick et al., 2006). Data from interviews with bullying victims (Björkqvist et al., 1994; Leymann, 1987), clinical observation (Brodsky, 1976) and cross-sectional studies (Einarsen et al., 1998; Niedl, 1996; Vartia, 2001) have led researchers to conclude that bullying is damaging to health. Most health effects cited in the literature are psychological or emotional (Leymann, 1992; Niedl, 1996; Sá and Fleming, 2008; Normandale and Davies, 2002). Several studies have suggested that victims of bullying display the symptoms of post-traumatic stress disorder (Einarsen et al., 1999; Mikkelsen and Einarsen, 2002).

Finally, some researchers have suggested that employees with disabilities may be more likely to report ill-treatment because their impairment or state of health predisposes them to more negative perceptions of their experiences. Quine (2001) argues that ‘negative affect’ may raise perceptions of ill-treatment amongst depressed people but adds that depressed employees may be singled out for bullying and then, in turn, experience health effects (also see Hoel et al., 2004). Coyne et al. (2003) suggest that, after being bullied, victims may perceive the workplace more negatively and their perception of a conflict-ridden and hostile workplace then affects their health. These suggestions from the workplace bullying literature will be revisited once the methods and findings of the research have been explained.

Methods and approach to the research

To begin to answer the six questions raised by the review of the literature, our own British Workplace Behaviour Survey (BWBS) is utilised. The BWBS assessed the prevalence of ill-treatment at work amongst the general population, and determined whether the type and frequency of these experiences differed to a significant extent according to the socio-demographic background of the worker, and the characteristics of their jobs and workplaces. It
also sought to ascertain workers’ perceptions about those responsible for ill-treatment in the workplace, and why it occurred. The BWBS constituted the initial quantitative phase of a larger research project which included a qualitative phase (not reported here) involving case studies of ill-treatment in different organisational contexts.

The British Workplace Behaviour Survey

A structured survey was administered to a representative sample of UK employees (or those with experience of employment in the previous two years) during the winter months of 2007-2008. Respondents for the survey were identified by screening participants in Taylor Nelson Sofres’ face-to-face Omnibus survey. The Omnibus interviews a representative sample of around 2,000 adults per week in Britain (England, Wales and Scotland). It is carried out using a quota sample, with sample points (and addresses within these sample points) selected by a random location methodology. The total weighted numbers responding to the BWBS were 3979. Of these, 14.6% were not employed but had experience of employment in the previous two years.

TNS fieldworkers used the CAPI (Computer Assisted Personal Interviewing) method to administer the survey in respondents’ households. A range of topics was covered in the survey; however, a central element was a revised version of the Negative Acts Questionnaire (NAQ) (Einarsen and Raknes, 1997) which asks respondents about the frequency of their experience of 21 different types of ill-treatment at work which could have a direct or indirect effect on their productive worth. Respondents were given an opportunity to confirm or deny the choices they made about which of the 21 items they had experienced; subsequently there were some small reductions to the prevalence rates across the items. The extensive development and cognitive testing of the survey is discussed in (Fevre et al., 2010).

The BWBS also gathered data on individual demographic factors including age, income, ethnicity, gender, and sexual orientation. In order to gather data on ill-health and impairments, the UK Government harmonised question (e.g. as used in the Labour Force Survey (LFS)) about long-standing conditions including problems due to old age was used. Three broad categories are represented in the data gathered with this question:

1) employees with a physical disability (those who reported deafness or severe hearing impairment, blindness or severe visual impairment), or a condition that substantially limited one or more basic physical activities;

2) those with learning disabilities, psychological or emotional problems; and
3) those with some other (unspecified) type of disability or long-term illness.

The BWBS was also used to collect data on job and workplace characteristics including occupation, industry, size of workplace, trade union membership, gender/ethnic/age composition of workplace, and respondents’ views about their levels of control over the pace and nature of their work. Finally, respondents who said they had experienced three or more of the 21 types of ill-treatment were asked a series of questions about who was responsible. They were also able to offer their own judgment about the causes of the ill-treatment. This information was gathered by offering 20 potential reasons that respondents could select, falling into four broad categories: characteristics of the workplace (e.g. your position in the organisation, or feeling that ‘it’s just the way things are at work’), characteristics of other employees (e.g. people have a group or clique and exclude you from it), and the respondent’s demographic characteristics (e.g. race, age, disability) or other characteristics (e.g. accent, trade union membership).

**Analytic Strategy**

Later in the article descriptive statistics and the results of bivariate analyses are presented; however, the heart of the analytic strategy used here is a series of logistic regression models (one for each of the 21 types of ill-treatment). These models were run to determine the relative impact of a person’s impairment or health condition (none/physical/psychological/other) on the likelihood of each type of ill-treatment occurring, net of statistical controls. The models included a variety of demographic variables (e.g. gender, sexuality, ethnicity, religion, age, education) job and workplace variables (e.g. time in job, managerial responsibilities, part-time worker, permanent staff, trade union member, size of organisation or sector, what employees thought of the type of work they did and the demands it made on them) in order to more fully ascertain the relative importance of a person’s disability status for accounting for ill-treatment at work. As extant literature indicates the importance of all variables as potential predictors of ill-treatment at work, none were considered to be simply control variables. All variables were entered simultaneously rather than in a stepwise procedure given that there were no clear hypotheses to support block or hierarchical entry of variables.

**Findings**
In respect of the first two research questions (on prevalence), most of the sample did not report a disability or long-term illness of any kind. In all, 302 types of disability were reported, affecting 284 respondents (some respondents reported more than one type of disability), comprising 7.1% of the sample. Collapsing this information into the three categories of disability used for further analysis of the data indicates that 117 respondents reported a physical disability, 52 reported a psychological condition, and 115 had some other type of disability or long-term illness. Of these, 131 conditions were deemed by the respondent to cause substantial difficulties carrying out their daily activities.

Table 1 summarises the reports of ill-treatment amongst those who reported any type of disability or a long-term illness (n=284). Across all 21 types of ill-treatment, larger percentages experienced ill-treatment at work compared to their counterparts who did not report impairments or health conditions. In 20 of the comparisons (denoted with an asterisk), the difference was statistically significant (p<.05 or less), providing clear answers to the first two research questions. Furthermore, in many cases the difference was substantial; for example, more than double the proportion of employees with disabilities reported experiencing physical violence at work.

[Table 1 about here]

The FTWS included seven of the 21 types of ill-treatment included in the BWBS and bivariate analysis of those items against disability produced very similar results (Fevre et al., 2009). In short, bivariate analyses of both surveys suggest that employees with disabilities had profoundly different experiences at work from the rest.

Multivariate analyses show whether the association between disability and ill-treatment persisted when other variables were introduced. The 21 items from Table 1 were retained as dependent variables in logistic regression models. In order to bring research questions three and four into the analysis, employees with disabilities were no longer treated as a single group and instead a categorical measure was used to reflect the different types of disabilities (physical/psychological/other/none). Table 2 presents a condensed version of the results (full models available at [http://www.cardiff.ac.uk/sosci/resources/feb2010.xls](http://www.cardiff.ac.uk/sosci/resources/feb2010.xls)). The Exp(B) value represents the change on the likelihood of a particular type of ill-treatment occurring, net of statistical controls. A positive value would be interpreted as the increased odds of the type of ill-treatment occurring for that particular subgroup of employees with disabilities (physical, psychological, other) compared to the reference group (no disability). These models provided a robust fit to the data; for example, the model fit statistics indicated that all were statistically
significant (p < 0.001) and each classified between 73% and 95% of the cases correctly. The pseudo R² estimates indicated that the models explained between 15% and 31% of the variance in the dependent variables.

[Table 2 about here]

Findings from the models support the bivariate results presented earlier that workers with disabilities were far more likely to be ill-treated at work, and experienced a broader range of ill-treatment. Measuring the total impact of having a disability across the 21 multivariate models is another way to illustrate the robust nature of these findings. For those with a learning difficulty, psychological or emotional condition, the likelihood of experiencing any ill-treatment at work was increased by 177%; those with ‘other’ by 102% and those with ‘physical’ by 15%. In contrast, other important variables across the models were: sexuality (being gay increased ill-treatment by 56%); public sector (increased by 53%); third sector (increased by 67%); and feeling that the pace of work was too intense (increased by 56%). The significance of these other predictors of ill-treatment will be discussed in other publications, but for present purposes it simply needs to be noted that the importance of having a disability or long-term illness relative to other socio-demographic and workplace characteristics was pronounced.

In order to make progress with research questions three and four, results from Table 2 show that, in contrast to the bivariate analyses summarised in Table 1, not all types of ill-treatment were significant for all types of disability. Specifically, those with a psychological disability were the most likely to experience nine types of ill-treatment, whereas those with other types of disability were the most likely to experience six types of ill-treatment. The amount of overlap between the groups was very limited: items 7 and 10 were significantly more likely amongst both the ‘psychological’ and ‘other’ categories; and item 17 was significantly more likely amongst both the ‘physical’ and ‘psychological’ categories. This variation in the experience of different forms of ill-treatment across different types of disabilities would not have come to light had each of the 21 items not been modelled separately, using a categorical measure of disability. Nor would as much have been learned about the detailed nature of the ill-treatment which could be used to judge the merits of possible explanations for the findings. For example, it would clearly be relevant to the work of Foster, and Cunningham and colleagues, if it was found that employees with disabilities were more likely to be pressed not to claim an entitlement, or if such employees found their employer was not following proper procedures.

Finally, research questions 5 and 6 are now considered. As noted previously, a series of follow-up questions was asked of some respondents to gather more information about incidents of ill-
treatment. Respondents with disabilities said clients or customers were responsible for 28.1% of the more serious types of ill-treatment they had experienced at work. Employers, line managers or supervisors were said to be responsible for 44.8% and co-workers or colleagues for 17.5% (subordinates or the organisation itself accounted for the remainder). It is, however, important to remember that these figures refer to the more serious kinds of ill-treatment and may not be a reliable guide for other kinds of ill-treatment (recall endnote #2).

Respondents were also asked what they felt to be the root causes of this ill-treatment. It might be expected that people with disabilities who were subjected to persistent criticism, being shouted at, or even threats or violence at work, would have felt that this had something to do with their impairment, but this was rarely the case. Only 11 out of 284 respondents considered their impairment a factor in their experiences of ill-treatment at work. This was despite the fact that they could ‘tick all that apply’ when citing factors they felt to be contributing towards their ill-treatment. Similarly, only 25 out of 284 felt that the ill-treatment was due to their long-term illness or other health problems. So, although the study shows that the prevalence of ill-treatment at work was much higher for employees with disabilities, they did not perceive their disabilities to be a contributing cause.

Employees with disabilities, like the majority of other types of workers in the sample, were most likely to attribute their ill-treatment to the nature of the workplace; for example, citing ‘it’s just the way things are at work’, their position in the organisation or their performance at work. Of course, employees with and without disabilities may have had quite different things in mind when they cited these reasons. For example, some employees with disabilities may have been thinking of the way their employer dealt with sickness absence, or the reasonable adjustments required by anti-discrimination legislation. It is, nevertheless, important to note that employees of all types saw their ill-treatment as deeply-rooted in the social relations of the workplace. This insight is explored in greater detail in the next section.

Discussion

At least in respect of British workplaces, this article has gone some considerable way towards answering the research questions. Employees with disabilities are more likely to suffer ill-treatment than others and it has been shown which types of ill-treatment, taken from a wide range, this is more likely to involve. It has also been shown that some employees within different categories of impairment or ill-health experience distinctly different types of ill-
treatment at work, and to different degrees. Moreover, while line managers and supervisors are responsible for the largest share of ill-treatment, the discussion should take into account the significant contributions made by co-workers and clients or customers. Finally, it has been shown that, from the employees’ point of view, it rarely looks as if they are being ill-treated because of their disability.

There appear to be four types of explanation which can be drawn from the existing literature to help us to explain these findings. First, it is possible that negative affect may play a part in the way discussed at the end of the literature review. Negative affect might possibly explain the higher rates of ill-treatment reported by those with psychological or emotional conditions, as these types of disability may be more likely to affect perceptions. Caution should be exercised, however, about suggesting that much, if any, of the ill-treatment in the study could be explained by negative affect alone. Moreover, if employees with disabilities are predisposed to see their situation in negative terms, this may have more to do with their beliefs about the extent of stigma and discrimination against employees with disabilities than it has to do with the impact of their condition on their feelings.

If negative affect is to play a role in the explanation of ill-treatment, it is more plausible (as in Coyne et al., 2003) to see it as exacerbating a vicious spiral of ill-treatment and health problems which also involves the second potential explanation: the consequences of ill-treatment for health. The research was not predicated on the assumption that disability (or health) was the dependent variable – data were gathered on disability and *long-standing* conditions, and questions asked about ill-treatment in the recent past – but the study remains a cross-sectional one and this leaves open the question of causation. Some of the association found between ill-treatment and impairment or ill-health might be explained by health effects. This might, for example, be possible in respect of the finding that having psychological/learning disabilities has a huge impact on the chances of experiencing physical violence at work. Some of this association might, indeed, be explained by post-traumatic stress disorder (Einarsen et al., 1999; Mikkelsen and Einarsen, 2002).

While it is possible that the health effects of bullying and harassment explain some of the association with an emotional or psychological condition, this is much less likely to be the case for employees with learning disabilities. Nor is this likely to be the case for employees with ‘other’ health conditions. These include problems with heart, blood pressure and circulation; diabetes; stomach, liver, kidney and digestion problems; a progressive illness not elsewhere classified; skin conditions and allergies; and epilepsy. These conditions are rarely mentioned in
the literature on the health effects of bullying and harassment, which instead focuses on psychological, emotional and psychosomatic disorders.

The third possible explanation for the findings is that workers with disabilities suffer more ill-treatment because of stigma and discrimination. The great majority of employees with disabilities reporting ill-treatment in the study did not cite their disability or health as a reason for it. There are, however, many reasons why people do not think they have been subjected to stigma or discrimination. For example, its illegality makes it covert, the opacity of organisational behaviour gives it ‘natural camouflage’, and people’s normal expectations in the workplace are of reasonable behaviour (Fevre et al., 2011). It may not be surprising, then, that there is very little evidence in the survey of a person with an obvious physical disability being openly discredited and excluded because of his or her stigma. As Table 2 shows, the patterns of ill-treatment reported by respondents with a ‘physical’ disability had more in common with those reported by their employees without disabilities than with those of employees with ‘psychological’ or ‘other’ types of disability or illness.

On the other hand, evidence was found of the kind of ill-treatment that Lopez et al., (2009) describe when they suggest that bullying occurs when minorities are seen as a threat to co-workers’ identity or job security. It is possible that the existence of wider stigmatisation, for example of those with a psychological or learning disability, may lead to a perceived threat to identity when employees with these disabilities are encountered in the workplace. Of course, the BWBS suggests ill-treatment of employees with disabilities was more likely to come from managers or supervisors than co-workers. Stigmatisation and discrimination may play a part in such ill-treatment, although this might entail some other mechanism than a perceived threat to identity. The same would be true if customers had objections to the presence in the workplace of some employees (e.g. those with psychological or emotional conditions or learning disabilities) which were not voiced in terms of prejudice but nevertheless expressed in ill-treatment.

The fourth explanation of the findings that can be drawn from the existing literature receives less qualified support. The respondents to the survey attributed their ill-treatment to the nature of their workplace, rather than to stigma or discrimination. This result lends support to the research of Foster (2007), and Cunningham and colleagues, discussed earlier. Their research, based on qualitative studies, including interviews with managers, suggested that ill-treatment, including unfair treatment, arose from the way in which organisations managed sickness absence and their responses to anti-discrimination legislation. For example, Foster (2007)
described ill-treatment in relation to the reasonable adjustments to performance and attendance norms which may be required of employers under anti-discrimination legislation. According to Foster, this typically involved public humiliation and drawing attention to the requirement for special treatment. This kind of behaviour seems particularly consistent with the items listed for those with ‘other’ conditions in Table 2 (5. pressure from someone else not to claim something which by right you are entitled to; 7. Your employer not following proper procedures).

It is possible that further differences in ill-treatment recorded for different types of impairment or condition reflect the ways in which different sub-categories of employees with disabilities find themselves embroiled in different types of conflicts over workplace norms. In order to explore this, the explanations developed by Foster and by Cunningham and colleagues would be extended to cover ill-treatment occasioned by conflicts over workplace norms beyond those which ensue over reasonable adjustments and sick leave. As noted earlier, multivariate analysis of the FTWS showed that employees with disabilities were nearly twice as likely to say they had a range of problems with employment rights. Bivariate analysis showed they were particularly likely to say they experienced problems with sick leave or pay but also with holidays, rest breaks, number of hours or days, pay, contract, set procedure for a complaint, set procedure for a grievance, health and safety, and retirement (Fevre et al., 2099). While problems with employment rights do not necessarily entail ill-treatment, it is plausible that some ill-treatment may arise from conflicts about norms in relation to issues such as holidays, breaks, hours, pay, contracts, health and safety and retirement as well as over reasonable adjustments and sick leave or pay.

Complaints about procedures for a complaint or a grievance might well be a secondary catalyst for ill-treatment where conflict has already occurred. Conflict over workplace norms may extend to co-workers, and clients and customers. For example, co-workers may ill-treat employees with disabilities because of what they believe to be unreasonable or unfair variations in workplace norms for such employees. If ill-treatment is immanent in so many aspects of employment, it may be that the most important element of a sociological explanation of the findings reported in this article is not to be found in stigma and discrimination. This may be what most respondents had in mind when they said ill-treatment happened because this was ‘just the way things are at work’.

Conclusions
The assumed lack of productive worth of people with disabilities becomes a self-fulfilling prophecy when they are pushed to the margins of the labour market (Barnes and Mercer, 2005). Evidence on their labour market marginalisation has been more plentiful than workplace data, but this representative study shows that employees with disabilities also suffer a wide range of ill-treatment in the workplace. Of the 21 forms of ill-treatment for which data were gathered, only four failed (in multivariate analysis) to reach statistical significance for one or more categories of employees with disabilities. Any one of these forms of ill-treatment could have an adverse effect on their productivity and, in turn, shore up assumptions about the lack of productive worth of people with disabilities. The efforts employees with disabilities make to escape ill-treatment may also exacerbate their marginalisation in less productive (and well-paid) jobs, or even lead to their withdrawal from the labour market altogether (Meager et al., 1998; Rigg 2005). The survey therefore provides support for the social approach which suggests that it is not people’s impairments that make them less productive but the way work is organised within a set of social relations (Barnes and Mercer, 2005).

The ill-treatment uncovered by the survey cannot simply be explained by harsh sickness policies or conflict over anti-discrimination law becoming an occasion for abuse. Employees with disabilities said co-workers and clients and customers were responsible for their ill-treatment as well as managers and supervisors. Moreover, employees with invisible conditions or impairments were as, if not more, likely to be ill-treated as those with visible disabilities. These findings informed the previous discussion and, while none of the explanations for the differences in workplace experiences which could be drawn from the literature can be ruled out, the survey suggests that the ill-treatment of employees with disabilities is embedded in the social relations of the workplace.

Further representative studies should sample sufficient numbers of employees with disabilities to allow the separate analysis of sub-categories of impairment and health conditions. For example, over-sampling should ensure that results for employees with learning disabilities can be analysed separately from those for employees with psychological and emotional conditions. There is also a need for psychological studies of the extent to which the negative feelings accompanying disabilities or illnesses increase the perception of ill-treatment. Such research should investigate the possibility that negative affect is bound up with people’s anticipation of stigma and discrimination. Researchers on health effects could also consider whether experience of ill-treatment exacerbates any tendency towards negative affect. They have usually neglected to investigate whether there is any evidence of health effects of ill-treatment beyond those categorised as psychological. Further inter-disciplinary research which collected
data at the frontier between psychosomatic symptoms and ‘other’ health conditions could help to explore the second explanation considered in the previous section. Similarly, further sociological research is needed to investigate the degree to which stigma and discrimination are experienced by employees with disabilities. More quantitative research on employers’ attitudes, particularly towards employees with psychological or emotional problems, would be useful. It was noted above that it was rare for employees with disabilities to think that they were targeted because of their disability, but qualitative research may be better able to explore their experiences of stigma and discrimination. This is one of the key interests in our recently concluded qualitative research but it would be helpful if qualitative researchers studying workplace bullying and harassment could, in future, pay special attention to the experiences of employees with disabilities.

Finally, the survey data presented in this article support Foster’s conclusion that the requirements of equality law regularly conflict with what employers see as organisational realities. This conflict was in part accommodated through the institutionalisation of a disconnection between formal policy and its front-line implementation (see the work of Cunningham and his co-authors cited above) but it was also leading to the ill-treatment of employees with disabilities. It is unlikely that the recent reform of UK equality law (with the passing of the 2010 Equality Act) has made a substantial difference to this situation because it bears the imprint of the individual, medical model of disability. The 2010 Act may do something to address ill-treatment by clients and customers but, unless a way is found to increase the influence of the social model on the behaviour of managers and employers, they will remain resistant to the notion that any ‘provision, criterion or practice’ in their organisation should be applied in a different way to different employees. It is the social model that shows managers they are not giving some employees preferential treatment when they do this but removing barriers which prevent some employees from making an equal contribution.⁴
REFERENCES


Table 1. Experience of 21 types of ill-treatment at work amongst employees with a disability or long-term illness.

<table>
<thead>
<tr>
<th>Type of ill-treatment</th>
<th>No disability or long-term illness</th>
<th>Reports any disability or long-term illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – Someone withholding information which affects your performance</td>
<td>14.1%</td>
<td>17.2%*</td>
</tr>
<tr>
<td>2 – Pressure from someone else to do work below your level of competence</td>
<td>11.8%</td>
<td>17.3%**</td>
</tr>
<tr>
<td>3 – Having your opinions and views ignored</td>
<td>26.9%</td>
<td>34.4%**</td>
</tr>
<tr>
<td>4 – Someone continually checking up on you or your work when it is not necessary</td>
<td>17.2%</td>
<td>24.3%**</td>
</tr>
<tr>
<td>5 – Pressure from someone else not to claim something which by right you are entitled to</td>
<td>8.5%</td>
<td>15.5%**</td>
</tr>
<tr>
<td>6 – Being given an unmanageable workload or impossible deadlines</td>
<td>28.8%</td>
<td>38.7%**</td>
</tr>
<tr>
<td>7 – Your employer not following proper procedures</td>
<td>20.4%</td>
<td>33.8%**</td>
</tr>
<tr>
<td>8 – Being treated unfairly compared to others in your workplace</td>
<td>14.5%</td>
<td>20.4%**</td>
</tr>
<tr>
<td>9 – Being humiliated or ridiculed in connection with your work</td>
<td>7.4%</td>
<td>12.3%**</td>
</tr>
<tr>
<td>10 – Gossip and rumours being spread about you or having allegations made against you</td>
<td>10.0%</td>
<td>18.7%**</td>
</tr>
<tr>
<td>11 – Being insulted or having offensive remarks made about you</td>
<td>14.3%</td>
<td>24.3%**</td>
</tr>
<tr>
<td>12 – Being treated in a disrespectful or rude way</td>
<td>21.8%</td>
<td>31.0%**</td>
</tr>
<tr>
<td>13 – People excluding you from their group</td>
<td>7.6%</td>
<td>13.0%**</td>
</tr>
<tr>
<td>14 – Hints or signals from others that you should quit your job</td>
<td>6.9%</td>
<td>13.3%**</td>
</tr>
<tr>
<td>15 – Persistent criticism of your work or performance which is unfair</td>
<td>11.1%</td>
<td>19.3%**</td>
</tr>
<tr>
<td>16 – Teasing, mocking, sarcasm or jokes which go too far</td>
<td>10.8%</td>
<td>15.1%**</td>
</tr>
<tr>
<td>17 – Being shouted at or someone losing their temper with you</td>
<td>23.1%</td>
<td>34.5%**</td>
</tr>
<tr>
<td>18 – Intimidating behaviour from people at work</td>
<td>12.7%</td>
<td>22.9%**</td>
</tr>
<tr>
<td>19 – Feeling threatened in any way while at work</td>
<td>10.6%</td>
<td>17.6%**</td>
</tr>
<tr>
<td>20 – Actual physical violence at work</td>
<td>4.5%</td>
<td>10.5%**</td>
</tr>
<tr>
<td>21 – Injury in some way as a result of violence or aggression at work</td>
<td>3.5%</td>
<td>7.4%**</td>
</tr>
</tbody>
</table>

N=3979

Asterisks (*) denote statistically significant differences between the two groups of employees: * indicates p<.10 and ** indicates p<.05 or less.
Table 2. Logistic regression results: Impact of type of disability across 21 types of ill-treatment at work.

<table>
<thead>
<tr>
<th>Type of ill-treatment</th>
<th>Physical disability</th>
<th>Psychological/learning disability</th>
<th>Other disability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Exp(B)</td>
<td>S.E.</td>
<td>Exp(B)</td>
</tr>
<tr>
<td>1 – Someone withholding information which affects your performance</td>
<td>0.71</td>
<td>.39</td>
<td>1.40</td>
</tr>
<tr>
<td>2 – Pressure from someone else to do work below your level of competence</td>
<td>1.43</td>
<td>.37</td>
<td>1.43</td>
</tr>
<tr>
<td>3 – Having your opinions and views ignored</td>
<td>0.67</td>
<td>.34</td>
<td>1.29</td>
</tr>
<tr>
<td>4 – Someone continually checking up on you or your work when it is not necessary</td>
<td>1.25</td>
<td>.35</td>
<td>0.78</td>
</tr>
<tr>
<td>5 – Pressure from someone else not to claim something which by right you are entitled to</td>
<td>0.84</td>
<td>.49</td>
<td>2.21</td>
</tr>
<tr>
<td>6 – Being given an unmanageable workload or impossible deadlines</td>
<td>1.41</td>
<td>.33</td>
<td>2.03</td>
</tr>
<tr>
<td>7 – Your employer not following proper procedures</td>
<td>1.01</td>
<td>.33</td>
<td>2.60**</td>
</tr>
<tr>
<td>8 – Being treated unfairly compared to others in your workplace</td>
<td>1.04</td>
<td>.37</td>
<td>3.01**</td>
</tr>
<tr>
<td>9 – Being humiliated or ridiculed in connection with your work</td>
<td>0.60</td>
<td>.52</td>
<td>1.43</td>
</tr>
<tr>
<td>10 – Gossip and rumours being spread about you or having allegations made against you</td>
<td>1.12</td>
<td>.41</td>
<td>4.60**</td>
</tr>
<tr>
<td>11 – Being insulted or having offensive remarks made about you</td>
<td>0.76</td>
<td>.39</td>
<td>2.87**</td>
</tr>
<tr>
<td>12 – Being treated in a disrespectful or rude way</td>
<td>0.71</td>
<td>.34</td>
<td>2.13</td>
</tr>
<tr>
<td>13 – People excluding you from their group</td>
<td>0.85</td>
<td>.46</td>
<td>3.91**</td>
</tr>
<tr>
<td>14 – Hints or signals from others that you should quit your job</td>
<td>1.55</td>
<td>.44</td>
<td>1.99</td>
</tr>
<tr>
<td>15 – Persistent criticism of your work or performance which is unfair</td>
<td>1.66</td>
<td>.37</td>
<td>1.56</td>
</tr>
<tr>
<td>16 – Teasing, mocking, sarcasm or jokes which go too far</td>
<td>0.81</td>
<td>.44</td>
<td>2.81**</td>
</tr>
<tr>
<td>17 – Being shouted at or someone losing their temper with</td>
<td>1.87**</td>
<td>.30</td>
<td>2.46**</td>
</tr>
</tbody>
</table>
18 – Intimidating behaviour from people at work & 0.92 & .37 & 2.24* & .48 & 1.81* & .35
19 – Feeling threatened in any way while at work & 1.20 & .37 & 7.10** & .47 & 1.31 & .40
20 – Actual physical violence at work & 1.46 & .50 & 8.87** & .56 & 1.01 & .61
21 – Injury in some way as a result of violence or aggression at work & 2.24* & .47 & 1.49 & .78 & 2.51* & .50

N=3979

Asterisks (*) denote the coefficient was statistically significant in the logistic regression model: * indicates p<.10 and ** indicates p<.05 or less). Please note full statistical details (Pseudo R², model chi-square, etc.) for all models are available at http://www.cardiff.ac.uk/socsi/resources/feb2010.xls


---

1 This article reports research funded by the Economic and Social Research Council (award number RES-062-23-312).
A methodology was employed to select the three types that the researchers judged to be most serious for follow-up questions. Therefore the data on perpetrators of, and explanations for, ill-treatment at work reflect respondents' experiences of the more serious behaviours rather than the full complement of 21 items.

Overall percentages were calculated by summing the individual percentages for the disability variable, for each of the 21 models, using the formula [percent=(1-(SUM(1-expb))/1)*-1], see Long (1997: 228).

The involvement of trade unions, and bringing reasonable adjustments within formal bargaining, may be of considerable help in this process (Foster, 2010; also see Cunningham et al., 2004).