Title: Silent Hell. Workplace violence and bullying

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Abstract

This paper reports on one of a series of ongoing studies into violence among women in their formalised working relationships. It analyses female abuse and reveals that in a hostile, unsafe, and unhealthy work environment any one can be targeted – seniority is no protection – and more often than not the employing organisation will actively support or at least condone this behaviour, in part, because it is less problematic and consequently the approved organisational goals are met.

This ugly phenomenon of workplace violence is an important matter that needs to be addressed urgently because of the harm it is doing not only to women and in this context, nurses, but also to the nursing profession as a whole. Such violent acts are sending out a negative message about women, nurses and nursing.

The paper begins with background issues, the research approach and significance of the study, not only to nurses, but also to all women who either work in a predominantly female occupation and/or in male-defined organisational structures and cultures. This is followed by the result of the analysis of female nurses accounts of their experiences. The next section examines how individuals know that they are being targeted and how they process this knowledge before progressing to the next phase of surviving, or failing to survive. The final section concludes with suggestions for further research and a discussion of potential professional implications of workplace violence.

This paper is aimed at several audiences including academics and students engaged in the study of occupational health and safety, human resource management, health, sociology and law.

Reference:

Hockley, C. (2003) *Silent Hell.* Peacock Publishers: Norwood, S.A. Reprint.

Introduction

I felt compelled to write this book – *Silent Hell* – because I believe there was an important story to be told. In a way, it is not a nice story but it is a book about survival. Antisocial workplace practices such as abuse, bullying, mobbing, harassment, and stalking among women-as-nurses is the dark side of the caring profession.

My research showed clearly that such behaviour is widespread. Everyone knows about the disease of workplace violence, yet nobody has been successful in proposing a cure. By writing this book, I was hoping to expose this damaging phenomenon by reducing its occurrence and making workplaces a safer and healthier environment.

This story began in nursing but it could have easily happened wherever people work.

Violence *against* women pervades human society, and takes many forms. By contrast, this book concerns violence *among* women. This book is about violence among nurses in their formalised working relationships. It examines how women-as-nurses make sense of this behaviour towards themselves and others. Nurses, like many others in the workforce, are confronted with various antisocial workplace behaviours. How nurses make sense of these behaviours, and how they process this knowledge is identified through their responses.

Although only one group of women were studied in the book, I know that the ideas, issues and reactions to these workplace behaviours are transferable to other services and occupational groups. Indeed, it is this general applicability that makes this book important not only for nurses and for women in general, but also for groups interested in management practices.

Background

This book evolved from my experiences as a woman, nurse, manager, and researcher. I completed a research project for my Masters degree entitled *Social Characteristics of Nurses who had become CEOs in the South Australia Health Care system* (Hockley 1990). An outcome of that study was that healthcare selection committees did not see nurses as leaders. Consequently, female nurses found it difficult to be promoted to positions in the health care sector outside the nursing stream. I began to ask why nurses were not seen as leaders. One of the most frequent

responses from other nurses was 'as nurses are promoted they do not care for nurses or nursing.'

This response began me thinking – "why are women-as-nurses not seen as caring managers?"

I began to explore the concept of nurses at management level 'not caring', a term that was rarely applied to 'non-nurses' at senior management level.

When I decided to inquire into this phenomenon I began by asking 'why' questions. I soon realised, from the literature and other empirical sources, that the feminist perspective centring on the analysis of women's roles in society – particularly in areas of oppression, domination, and social and economic equality – had been well researched. Therefore, although this analysis provided many of the answers to my initial questions, the issues still had not been resolved.

My thoughts were moving away from female nurses at management level not caring, towards female nurses at any level having antisocial workplace behaviours that caused harm to another person in the workplace. At this time in my thinking, 'not caring' implied passive behaviour, such as lacking compassion or concern. By contrast antisocial workplace behaviour had an active connotation, resulting in others being oppressed, or dominated or feeling powerless. Although the acts of antisocial workplace behaviours exhibited were many and varied, the outcome was that someone was harmed. To harm someone was identified in many of the definitions on violence. The literature on the subject of violence generally implied that it was male-inflicted, and that for women to be violent was a rarity.

This led me to my next question – "Why are women-as-nurses not perceived as being violent?"'

Most if not all, of the literature on violence against women came from a feminist perspective. In the main, women in the workforce gained attention from the feminist writers from the 1960s onwards. I began to ask why after nearly 40 years of analysis on women's role in society, women continued to take the subordinate role in society, in the home, at work, and particularly in nursing. As my thoughts expanded upon these 'why' questions, I began to look at this phenomenon from a different perspective.

I began to ask – "Why do women-as-nurses tolerate violence?"

Nursing is a predominately female occupation that has been traditionally male-defined in its organisational arrangements. Why nurses continue to accept this

definition is difficult to understand in contemporary society. I considered that the answer to that question was that it made their world less problematic. Therefore, the behaviour of people in organisations, and the meanings they ascribe to their behaviours and actions to make sense of them, must be taken into account when exploring violence among nurses.

The 'why' questions then turned to 'how'. "How do women-as-nurses accommodate violence?"

The literature showed that this perspective had not been addressed, so I needed to find my own answers. With a background in nursing, I initially turned to nursing theorists, then to management theorists, but there was very little work being undertaken in the area at that time.

I eventually turned to the literature on social theories because what I was researching was about human interaction and how to make sense of our behaviour whilst being constrained by the world we live in.

It is important to acknowledge that there are males in nursing (approx 10 per cent). The need to exclude males from this study became apparent from the literature on male nurses, and their responses which showed that the experiences, and the reactions, of males in nursing were generally different from that of the females. An example of this is the following excerpt from an interview with a male nurse:

So in some ways I was in a privileged position. I could do things that I would get 'tut tut' for and females would be told off very severely. Things like making the bed and putting the linen on the floor. It was really a 'no no' I would do that and they [female senior nursing staff] would smile at me and shake their heads at me. They accept that men were untidy but women weren't.

Typology of Workplace Violence

In recent years there have been typologies developed (Bowie 2002; Mayhew and Chappell 2001; Hockley 2005) to categorise workplace violence. To appreciate where violence among nurses fits into these typologies I have outlined the eight basic categories. These categories have been adapted from the previously mentioned authors' typologies.

Typology of workplace violence within the healthcare area

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Internal violence – In this form of violence, the perpetrators are employees within the same organisation. e.g. employer/employee. Client-initiated violence – Is when patients/clients and their families act violently towards staff. Organisational violence –This type of violence refers to the harm that may occur to staff per *se* when an organisation is experiencing economic pressures resulting from restructuring, redundancy, redeployment, or resignations. External violence – This form of violence occurs when perpetrators enter the workplace with criminal intent, such as armed robbery for drugs or gang reprisals in emergency departments. Third party violence –This type of violence refers to the witnesses of violence, either directly or indirectly, by other staff or the targeted persons families. *Staff-initiated violence – This form of violence occurs when staff act violently towards those in their professional care.* Traumatic work related events violence – Repetitive exposure to traumatic events can cause staff in turn to become victims of trauma. (Michael 2003). This form of violence may occur once (e.g. a terrorist attack; school yard or work massacres) or at special events (e.g. football final season, such as in Europe and USA) or during wars or working in specialised volatile areas, such as highly dependant care units. *Client to client violence –Where a resident/patient attacks another resident/patient.*

The type of violence I will be discussing here today is 'internal violence' – that is, where the perpetrators and the victims have a formalised working relationship within the same organisation. e.g. employer/ employee.

Definition

In my study, I proposed that the concept of violence be viewed as the outcome of an act. An 'act' is any behaviour, the consequences of which causes harm to another person. For example, the essential and critical distinction between antisocial workplace behaviour and violence is that antisocial workplace behaviour focuses on the act and violence on the outcome.

In the context of my research workplace violence was defined as:

'Any antisocial workplace act that causes harm to another person'.

Central tenets to this study

- women are capable of being violent towards each other
- women use a variety of violent strategies to reach personal goals in the workplace
- nurses learn how to be violent to each other as a part of their socialisation when they enter nursing.

Analysis of data

The focus of this study was to explore how female nurses manage workplace violence when their nursing colleagues are the perpetrators. I used ethnomethodology, after Garfinkel, to study this behaviour. Ethnomethodologists are interested in the tacit rules people use to accommodate day-to-day practice which is often modified by workplace location and the context where violence occurs. Therefore, throughout the analysis of the data the formal, informal and tacit rules nurses use to manage these behaviours were explored. The five main themes derived from the data were:

- Rules
- Context
- Location
- Source/type
- Language

Theme 1: Rules

Nurses individually and collectively apply rules of interaction that maintain social order. Which rule they use depends upon a variety of factors, but in the main, the rule is chosen to make their world less problematic. The first exemplar is as follows:

...calling names is abuse, but being yelled at I don't consider abuse.

This nurse is applying her own rules to what is, and what is not, violence. When I asked how she felt when she was yelled at, she replied "*I felt angry and I yelled back".* She continued: *I will treat people the same way they treat me... if someone is abusing you, you have the right to abuse them back.*

Nurses discussed various rules that they use in their day-to-day practice depending upon the context, time and location. Some discussed the workplace rules, which were organisational policies, whilst others discussed rules that were self-imposed and derived from experience.

There are many rules within nursing that nurses are expected to follow in their practice. For example,

- Organisation rules
- Rules imposed by authority
- Rules of conduct
- Rules for nursing work.

I will, for this paper expand on rules imposed by authority. This category encompasses the rule on behaviour to enforce authority. Such rules, like the law, are not volitional. They are imposed, and their function is to trigger mechanisms that will produce a response by authority if certain condition are not met or are violated.

Simple rule-dissonance

> A district nurse knows that the speed limit is 50km/h in the metropolitan area but she also knows from experience that at 2.00am between two adjoining suburbs she can safely do 80 km/h. She does 74 km/h. Why does she restrain herself? In part, it is because she is not happy with the conflict inherent in the two sets of rules. If nothing happens, nothing happens, If she is caught she automatically knows which rule system will apply.

This is a relatively simple example. A more complex example within a hospital context is a medication error.

Complex rule-dissonance

> You are a nurse on a ward and discover that you have made a harmless overdose. What rule systems apply to this situation and what imperatives must be faced in formulating a response?
>
> - Self-preservation – should the nurse admit to it?
> - State law – must the nurses report?
> - Organisational law – should the nurse report it?
> - Professional culture – does action depend upon the situation?

The question marks are not accidental. They are the crux of the dissonance. Which is the first rule the nurse will take? There is an assumption that the nurse, once having identified the situation, will automatically follow the appropriate norms germane to the situation. This is simplistic and the numerous bodies of situationally appropriate rules do not automatically decide or highlight the response that will give the nurse greatest satisfaction.

I will now turn to playing the game and then onto breaching the rules.

The first exemplar discusses how a nurse, through experience, recognises the rules that should be followed so as not be targeted at work.

> *I was working at one place not too long ago and it was a very old fashioned place. My background came into good standing because of 'yes ma'am, no ma'am, can I make you a cup of tea ma'am' as a part of the game, and if you could play that game you were left alone and I could manage it because I saw it as a game.*

This nurse made up her own rules to make her world less problematic. However, another new nurse working at the same hospital did not know the rules. Therefore, many of the day-to-day activities routine expected of nurses were criticised by the DON.

> *This new nurse did not know the rules, did not know how to play the game and the DON took a savage disliking to her and despite everything she did, it wasn't done properly. The DON would criticise her work and another nurse took her aside and told her 'you are meant to get upset'.*

Eventually the new nurse learnt the rules the hard way. The nurse telling me her story explains:

The new nurse did not learn the rules and when a promotional position came up the DON suggested she apply for it and she got it. She only got it because it would put her into the position to be criticised more; it was really vicious manipulation. After 6 weeks she walked out. She could not work as an RN for a long time. She had no confidence. The DON threatened to report her to the NBSA if she continued this emotive behaviour because it was unprofessional conduct. That nurse was absolutely broken.

Theme 2: Context

Nurses, generally, employ more ethnographic (background, contextual) detail when orally describing their violence than when they are writing about it. On the other hand, when two nurses observe a nurse being targeted such as having rumours spread about her; words were generally not needed between the two observers. There appeared to be a tacit understanding between the two observers that what they were watching was an act of potential workplace violence.

For example, a nurse tells me how she was an expert in violent behaviour before she told me of her experiences in the workplace as follows:

I am the oldest child of a German mother and a Yugoslav father. I was born after the war so the Germans were not too popular anywhere particularly with the Yugoslavs. I was brought up in a community where the man was in charge and the woman was subservient. My mother was not really a subservient woman but she learned to be. I because aware of power, status, racial discrimination and all those unpleasant things very early and then I married a man who was in wife beating. So my skill in reading body language were honed very tightly.

Not only does the above account illustrate how violence can be readily identified if one has previous experience of violent behaviour but it also shows that being subservient makes a persons world less problematic.

Theme 3: Location

The nurses in this study generally did not consider that location was important when they were the primary targets for violence. However, they did discuss the fact that third-party violence occurred more often in some locations than others. The victims of third party violence are those that witness workplace violence or its

outcomes, such as colleagues and family members. For example, one nurse discusses how different locations reacted differently to workplace violence as follows:

> *Psych and General are entirely different. Yes, yes. In general [hospitals] I never felt like the patients were being done over by a dirt truck. Never. There maybe small incidents of it but it might be a bad day, wrong staff or something like that but never like I do now [in psych].*

Nurses did talk about some locations being at higher risk, not for themselves but for the patients/residents/clients. For example, aged care, mental health and midwifery were at higher risk than the acute care sector or community health nursing. That is not to say that all aged care facilities, for example are high risk or all acute care sector is a low risk because at times it depended upon the person's ability to communicate how they were being treated and how much they were believed. In other words, minority groups such as indigenous, non-English speaking background, drug addicts, disabled, aged or mental health patients were more likely to be abused.

Theme 4: Source and type

The analysis showed that some organisations contribute to violence more than others did. An organisation's support, or at least condoning, of violence in the workplace depend upon factors such as the organisation culture and sub-cultures. The type of violence used often depends upon the source. In my study, I identified that this source ranges from the organisation to managers, registered nurses and enrolled nurses. In other words, anyone within the organisation, including the organisation itself can be a source of violence.

The variety of types of violence used by these different groups of people and the organisation was one of the most difficult aspects when attempting to define workplace violence. One of the reasons why this behaviour is so difficult to define is that there are many who consider violence to be a uniquely physical act and bullying to be child like school behaviour. At that time, concepts such as mobbing was generally unheard of and stalking only involved disgruntled husbands and movie stars. It certainly did not occur in the workplace. However, what nurses were recognising as acts of abuse were posters and emails. One manager had this poster on her door and many staff found it intimidating particularly when they had a problem they wish to report. The poster is as follows:

When things go wrong, as they usually will
And your daily road seems all uphill
When morale is low and the works pile high
When you try to smile but can only cry
And you really feel you'd like to quit
Don't run to me…
I don't care a shit

Some may perceive this poster as humorous however there were some who did not. Posters were sent to me as examples of an indirect form of abuse. The most insidious part of a poster is that the nurses were not quite sure who was being targeted.

Other types of antisocial workplace behaviour included:

- Exclusion and alienation
- Maximising power and powerless relationships
- Fear
- Sabotage
- Guilt by association
- Favouritism
- Harassment
- Physical e.g. 'threatened to slap my face' or 'pushed me into the autoclave'.
- Verbal abuse
- Rumours/gossip
- Silent perpetrators
- Silent participants

An area that I would like to expand upon here is a manager's perspective of using harassment to force an employee to leave. It is unusual to get a perpetrator to discuss their actions and therefore I think it is worthy of discussion.

This manager reflects upon the rules she puts in place depending upon the context. As a participant in my study she was coming from a 'victim's perspective' but as we talked she realised some of her behaviours as a manager.

I suppose it is in the eye of the beholder but I mean when I think about being on[rostered] with staff where somebody's performance is not up

to par or may be they are dangerous to patients or just has poor judgement or …. In most instances, I am sure they say they have been harassed. I would say it is progressive discipline. …
I think people fold very easily when they have been confronted with performance deficiencies. It is under-estimated. People underestimate how easy it is to get rid of people. It really is, if you only talk to people, about 'can't you shape up'. People do not like it. People don't work well. It is only a matter of time.
Very few people can survive that kind of hostile, confrontation, or whatever you call that stuff that happens when manager have had their fill. They make it known that you don't fit or your are not wanted here, or you are not part of the game, or I don't like the colour of your hair, or you're not the right colour or sex. …
Harassing people out of a job is underestimated. Harassment is very powerful mechanism, or giving someone feedback, however you want to couch it [it] is only a matter of time because very few people can stick it out. When I look back I bet it is only two or three times that it has gone all the way to termination and that they actually had to be fired. Most of the time their resignation was on the desk at some point.

The use of harassment as a tool for violence is a confrontational form of violence, an unusual form for nurses to take as generally they use a non-confrontational style.

Theme 5: Language

The choice of words used to describe violence among female nurses was pivotal to the study. Rarely, if at all, did the nurses in this study see themselves as perpetrators or victims. They did not use terms such as bullying, mobbing, or even violence. Occasionally they used the term abuse. They were more likely to use metaphors or euphemisms instead.

One participant discussed her experiences as follows:

Last week was truly the nail in the department coffin. We propose we do two things. One, bury the coffin and get the hell of the cemetery. And two: meet and discuss some new plans. We're not sure which needs to come first.

Often nurses used military terms such as *'going back to the bunker'* after having a bad time at a meeting or *'I feel like I have just walked through a minefield*,' in reaction to violence or potentially violent circumstances. Some nurses used metaphors to imply that they had been personally attacked by using sexual connotations such as 'I feel like I have just been raped' or 'screwed'. Non-nurses observing this behaviour made statements such 'working with nurses is like watching the Christians being led to the lions'.

Survival strategies

This part of the paper gives an overview of how nurses survive this behaviour. The first part of surviving is 'knowing' about this behaviour. Nurses have different ways of constructing their reality and yet come to a common conclusion. Nurses, generally, know eventually that they are being targeted, no matter how subtle the approach may be.

This process of knowing I have called the 'nursing rites of passage'.

For reporting purposes these three phases: recognition, re-evaluation and redefinition, are linear but in practice a nurse may enter any phase at any time and return to any of the phases before proceeding to the next.

Phase 1: Recognition is the first of the three phases in acknowledging workplace violence. This phase is illustrated in the next account that follows:

> *It was my first year of nursing working on a paediatric unit. I was working with an enrolled nurse who had given me a hard time since first coming to the ward. One evening my sister, who is also a nurse was relieving on the ward and was making a bed in a darkened corner of the ward. This EN spoke sharply about the way the bed was being made. She spoke rudely and then realised who it was she said it to. 'Oh it's you. I thought you were your sister. I am sorry.' I will never forget that. It was my first introduction to the 'real' world of nursing.*

What this other nurses' behaviour did to the student was to make her recognise that nursing can have violent overtones. This nurse had to experience that then recognise it as such. Until this recognition occurs, the rest of the process of understanding cannot take place.

Phase 2: Re-evaluation of the current position is the way in which nurses are able to assess the situation in which they find themselves. Once they have re-

evaluated the situation they act. Thus, while they are acknowledging the tensions and contradictions that have led up to this behaviour they are entering the next phase of action.

Phase 3: Redefinition phase which is to choose strategies that are culturally appropriate for the individual and/or the organisation. Redefining culturally appropriate strategies depends upon the context in which individuals find themselves. For example, a particular strategy may be appropriate in one workplace but not in another. In some workplaces, there are meetings that allow staff to talk about specific issues whilst others may discourage this form of free speech. What action the individual chooses depends upon the meaning they have attached to the event or behaviour. For instance, a person who is articulate may speak out, whilst another may use other forms of communication to express their feeling. Some may even choose to be silent, which is a strategy in itself.

In the next exemplar, a new staff member to the organisation discusses how she was befriended by a group of nurse who were being target by another group of nurses within the same organisation. Prior to the recognition phase the new staff member was unaware that by being friends with the targeted group of nurses she would also become a targeted.

The exemplar that follows ties these three phases together.

Phase 1 Recognition

Did I go bat for these people? In a real roundabout way, I did that just by befriending them. I don't remember exactly. This is how I remember it. Maybe I block stuff out, but I remember the target was me, I spoke to [a senior person] and I said something in absolute confidence at the time, and there was this atomic breach of confidentiality. This was me, it was not about someone else at the time, this was me, and all of a sudden this was me.

Phase 2. Re-evaluation

I am not talking about a colleague. This was me, the recipient of this. It was kind of, I have had my fill, I am up to here with this kind of behavior, and I am not taking this kind of behavior. I am not defending anyone else. This is my situation. I am going to take it on. I don't have to call on anyone else to support this. This is going to happen to me. I

am not going to depend upon anyone else , or saying this is what happened, I am going to attest to this situation as it happened to me.

Phase 3 Redefinition

I can remember organising my thoughts, and I wrote it down in a coherent, what I thought was coherent, way. Maybe it was not and there was this breach of confidentiality. There was a discussion about me when I wasn't there. I was out of town or something, there was a discussion about me that had something to do with me, and it was totally inappropriate. I remember writing it all down, outlining management principles that had been violated, and reading it ultimately, at a department meeting. I remember….

In taking on these issues the new staff member is attempting to take some control of her work life by changing the definition of the event, and the structures that support that definition, so that it can be managed. In this instance she redefined the social situation in which she found herself by recognising that the organisational social structures that she thought were in place were not there; as a result she attempted to create a social structure that she could make sense of, and give meaning to the situation.

One of the reasons advanced by the participants for the lack of professional nursing support is the fear of being considered guilty by association and therefore being targeted because of friendship or identification with the primary target. Therefore, to maintain some sense of stability they separate or distance themselves from people who are the targets.

After a particular bad day at work, I once wrote in a journal entry the following:

When a nurse is violent towards a colleague, they are challenging society's stereotypical view of woman and the image of nurses, which is that women, generally, and nurses particularly, are not violent. The general proposition of this work is that this assumption is not true and that women, and therefore some nurses are capable of behaviour that can have devastating effects on them and their colleagues, both professionally and personally. In particular, there are women who use violence to coerce, control and gain power. This is particularly so, because women do not generally have social power.

One nurse wrote on surviving –

This journey has taken me through enormous self-doubt and insecurity, depression, thoughts of suicide, memory lapses, days I can't remember and days when I only functioned on routine. So that I would have to keep going, I kept on studying. I kept on telling myself that 'they' could not take that off me; the only person who could do that was myself, if I gave up.

Nurses in this study generally went through a variety of stages seeking support from within and outside themselves in order to survive. I divided types of strategies into two main groups: accommodating strategies and active strategies.

Accommodating strategies

The responses suggested that nurses initially select three main strategies to accommodate violence. Firstly, they relied on themselves, such as self-awareness, or less frequently, used outside sources, such as counseling. Secondly, they considered socialising as an outlet such as going to parties, taking drugs, or abusing alcohol. The third most common strategy was leaving metaphorically. One nurse describes this approach as follows:

They do leave. They do leave or they take up the attitude that they are going to work and not get involved in anything that is going to put me in a vulnerable position. [They say] 'I am not going to take on any CN work or take any promotional positions. I just want to work the shift, come to work, do my work for the patients and go home again. They do not get involved in any organisational culture. They don't get involved in nursing culture, like the ANF, the College, or whatever, so they cope by earning their money and getting out. ....

I imagine that we have all seen staff who leave metaphorically. Staff who miss meetings, or do not become involved in the day-to-day activities other than doing only what is requested of them.

Active strategies

Two main active strategies that nurses chose were leaving physically and to a lesser degree whistle blowing. One nurse describes her feelings about leaving.

I had weathered it to a certain point and then because it was really not about my work. I felt it was about some kind of professional

inadequacy that was being projected on to me. I really didn't want to wear it any more so in the end I left.

Leaving nursing for some was like a divorce. Some felt extreme sadness. Some grieved. To attempt to understand the depth of grieving is difficult. If a person loses a loved one in an accident, then people can relate to that and send messages of support. However, when a nurse loses her self-esteem, pride, or a goal aimed for, there is difficulty for those around the nurse to respond in a helpful manner.

Whistleblowing

Whistle blowing is not generally a strategy many nurses choose. Whistleblowers can suffer a wide rang of official and unofficial reprisals that can affect them personally and professional such as experiencing ill health or loss of promotion opportunities. One nurse describes her experiences of whistleblowing as follows:

Whistleblowing is very much a tortuous journey of each individual, and very often, there is no resolution to the problem. I will use the analogy of rape. I often describe how I felt as though I had been intellectually raped, and then discarded like a used disposable item. I was never given the justice I was owed, and when no justice can be accessed or accorded, then no resolution is possible.

There is one strategy that, interestingly enough, only one nurse offered during the study and that was revenge. This nurse was appalled by the unprofessional conduct that the perpetrator had shown towards patients. Her excitement, even on retelling the story showed how much enjoyment she got out of that action.

I dealt with it in a sort of round about fashion I was comfortable with. So, the last day I got him. It was appropriate to me because it was the last day. I don't have to see him anymore after that. That is intelligence to me. ... I got him. He got redder in the face and I was thrilled. I thought it was great. It just gave me more joy to do something about him.

Conclusion

I began this study by reviewing the literature on violence in society, in organisations and in nursing. This to me, appeared to be the best way to go. This approach was vindicated when I identified that there were many similarities between

the violence that occurs in society, such as domestic violence, and that which occurs in nursing.

There were many methodological challenges I experienced along the way. One of the most difficult aspects of studying this subject matter was that some of the participants had not ever told anyone about their experiences or if they had not for a long time. For some, it was cathartic. For the first time they were able to talk to someone who understood and non-judgemental. At the other end of the spectrum, some nurses were very critical of me studying such a topic as they thought it would give nursing a bad name. Nursing gatekeepers' accusations came in various forms, such as this is not real nursing research because it is not clinical. I was often criticised for using the term 'violence' to describe this phenomenon but that is another story.

However, I want to end this paper on a positive note. I believe that any person who has survived mobbing, bullying, stalking or any of the various types of abuse are survivors. Whatever strategy people use to survive it is important to recognise that one solution is not the answer for everyone and we need to offer multiple strategies to assist those who need help.