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# Bullying And Work Related Post Traumatic Stress In Nurses

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Vol 2

PENN/CORE ratio emphasises, their PENN went up again but their CORE continued to go down. Their general psychiatric condition improved, yet they were experiencing a second episode of what this time was moderately severe but uncomplicated PTSD. This was not a simple relapse of their previous PTSD, some PENN items in which they had previously improved did not deteriorate, and some items to which they gave a '0' score when they first came for counselling, they gave a '3' response to at the follow up. The second episode of PTSD had a markedly different profile of PENN item responses. Either they were a late onset PTSD following an initially mild condition or they were re-traumatised by their new circumstances. Whatever the underlying dynamic, these observations suggest that PENN and CORE can change independently of one another in an individual. Care is needed in drawing conclusions from these observations.

### 3.6.2

### Using the Regression Plot to Compare Markers on the PENN and CORE Scales

The regression line formula was used to compare experimentally determined PENN and CORE marker values such as diagnostic thresholds and clinical significance cut-offs.

The measured pre-treatment CORE mean for 36 clients was 2.42; this would be equivalent to a calculated PENN score of 47.4. The actual measured pre-treatment PENN mean for 51 clients was 49.5.

The measured post treatment CORE mean for 36 clients was 1.19; this would be equivalent to a calculated PENN score of 26.9. The actual measured post-treatment PENN mean for 51 clients was 22.5.

The graph in Table 3.44 and its regression formula in Table 3.45 would appear to be a reasonable representation of the mean relationship between CORE and PENN values over the clinical and non clinical ranges.

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The formula was therefore applied to other important marker values on the PENN or CORE scales to give the following results.

The CORE System has determined the female population cut off value between the clinical and non clinical general psychiatric distributions to be 1.29. By the regression formula, this would be equivalent to a PENN Score of 28.5.

In this present study, based on the Working Well Survey nurse control group, the CORE clinical / non clinical cut-off value for nurses was recalculated from measured data as 1.127. By the regression formula, this would be equivalent to a PENN Score of 25.8.

In this present study, the upper and lower cut-off values of the general psychiatric distribution on the PENN scale were calculated. The lower cut off value, which distinguishes between the non clinical and the clinical general psychiatric distribution, was calculated as 23.5. By the regression formula, this would be equivalent to a CORE Score of 0.988.

Consolidating and averaging these above findings, the cut-off value which distinguishes the non clinical and the clinical general psychiatric distributions are a PENN score of 24.3 or a CORE score of 1.04. Any score above these values on the respective scales are more likely to belong to the distribution of those with general psychiatric problems than the non clinical group.

In this present study, the upper PENN cut off value for the general psychiatric group on the PENN scale was calculated as 42.5. By the regression formula, this would be equivalent to a CORE Score of 2.12. Anyone scoring above 2.12 on the CORE scale or 42.5 on the PENN scale is more likely to belong to the clinical PTSD distribution than to the distribution of those with general psychiatric problems.

The psychiatric 24.3 cut-off on the PENN scale and the PTSD 2.12 cut-off on the CORE scale are not validated for diagnostic assessment, but are trigger points that strongly suggest that additional clinical assessments or diagnostic tools be employed

to ascertain or clarify a diagnosis in individuals with scores above these thresholds on the respective scales.

The strong positive correlation between CORE and PENN suggests that clients with PTSD in addition to the more characteristic PTSD symptoms such as intrusive thoughts or images, heightened arousal and avoidant behaviour, also experience a strong underlying psychological disordering across a wide range of markers for well being, symptoms and functioning, which are common to many other disorders. This general disordering could mean mild cases of PTSD could be mistaken for anxiety, depression, or a stress breakdown, all of which the clients symptoms may resemble. Without a history of a classic traumatic event, the client's doctor may not be alerted to the possibility of PTSD and may simply put them on tranquillisers or anti-depressants without referring them for more specialist trauma counselling.

In mild cases of PTSD, where characteristic symptoms such as flashbacks may be absent (see Section 3.2.16, Table 3.22), the ability of the PENN scale to differentiate PTSD cases from non-PTSD cases would appear to be based on the combined weight or intensity of this general disordering over a number of markers, most of which are not in themselves unique to PTSD. If this general disordering as well as specific unique symptoms constitute the condition of PTSD then treatment must address all aspects of that condition and not just the set of diagnostic criteria for PTSD laid out in the DSM-IV. Assessment of the effectiveness of treatment and the extent of an individual's recovery must also take a wider view than whether or not a client still

that the treatment approach used in this present study, trauma counselling based on a Cognitive Behavioural Counselling model, effectively addressed all aspects of the clients' presenting problems with an overall 92.2% recovery from PTSD and a 69% full recovery rate from all indicators of general psychiatric problems, assessed 6 months after completion of treatment, measured in terms of Reliable and Clinically Significant Change, and determined in comparison with a socially and clinically meaningful control group (nurses).

## 3.7 CORE RISK FACTOR

Before completing this examination of the CORE System, and the present study client group, a number of observations about the Risk subscale must be made. The naming of this subscale is problematic in that it implies that it measures a particular thing 'Risk' when its ability to recognise suicidal or violent intent has not been validated against clinical assessment or other psychometric tools for this purpose.

A number of observations made during this present study and with this particular group of clients with PTSD-like symptoms, would question the construction of this subscale and its validity.

The Risk subscale is one of the four main subscales of CORE, but behaves quite separately and differently. The other three subscales, Well Being, Symptoms and Functioning, all showed strong positive correlation with each other before and after treatment (at the $p = .01$ level), but Risk showed much poorer correlation with each of the other three subscales. Risk only showed correlation with the Functioning subscale at the $p = .05$ level before treatment but not with the other main subscales. After treatment Risk only showed correlation with the Well Being subscale at the $p = .05$ level. Low correlation is not a problem in itself if it is an independent scale.

The Risk subscale of CORE contains six items, C6, C9, C16, C22, C24 & C34. Items C6 & C22 make up the minor subscale of 'Risk to Other People' while the other 4 items make up the minor subscale of 'Risk to Self.'

By naming the main subscale Risk and the minor subscale Risk to Self, and by including items such as C16 ' I have made plans to end my life,' it is implied that the Risk subscale measures suicidal intent. However, the Risk subscale has not, in any study so far, been compared with, calibrated against, or correlated with any established scale for measuring suicidal intent or depression. As will be shown below, this present study found that the inclusion of the minor subscale of Risk to Others within the main Risk subscale or dimension, compromised the overall responsiveness of the Risk subscale to recognise risk to self.

The concept of a Risk to Others minor subscale is very relevant and of special interest to this present study. The clients of the present study are nurses, many of whom have experienced prolonged victimisation (bullying) in the workplace, yet during this period they continued to have charge of, and responsibility for, dependent others in their care. How this affected their ability to care for others, and whether it made them a risk to others, is an important question. Unfortunately, with only two items and with over half the clients not responding at all to these two items, it was not possible to extract a lot of useful information.

To combine Risk to Self and Risk to Others into one main subscale assumes some sort of relationship between the two subsets of items. However, when correlations were determined between the Risk to Self and Risk to Others minor subscales, a small but significant negative correlation was found between the scales before treatment ($n = 36$, Pearson's coefficient = -0.330, $p = <.05$). For this client group, Risk to Self and Risk to Others were inversely related to each other. After treatment there was no significant correlation between the minor subscales. At best, these two components have no relationship; at worst they have an inverse relationship.

Only a detailed examination of the individual items themselves and changes in the responses of individual clients explained these observations. A very complex set of responses emerged in which some clients actually go down on some items of the Risk scale during treatment and up on others.

Item C22, acts of threatening or intimidating others, fell from a total score of 15 points for the 36 clients before treatment, to 10 points after treatment. But behind that overall reduction, two clients, clients 2 & 10, went from 0 (Never) before treatment to 3 (Often) after treatment. A further two clients, clients 19 & 36, went from 0 (Never) before treatment to 1 (occasionally) after treatment. Whilst the overall score for the item fell from 15 to 10, 4 new individuals, who reported no problems in this area

before treatment, reported problems after treatment.
Altogether 8 clients reported verbal or violent risk to others, C6 and/or C22, before treatment and 7 clients reported verbal or violent risk to others after treatment. But these were not the same clients; behind those figures 5 of the 8 clients originally reporting problems in these areas before treatment, no longer reported them after treatment, but 4 new clients developed the problem during treatment.
So while an individual's CORE reduces during treatment, some individuals risk to others goes down, but some individuals risk to others goes up.

Of the 36 clients tested by CORE, 27 (75%) reported at least one item of risk to self or others. Of these 27 clients, 7 (26%) only ever reported risk to others and 15 (56%) only ever reported risk to self, with 5 (18%) reporting a mixed risk, either before or after treatment. Among the clients who report a response to Risk items, 82% only report a single dimension, either Risk to Self or Risk to Others. The two types of risk appear to be mostly mutually exclusive. This became clearer when the 5 clients reporting a mixed risk to self and others were examined in more detail. In 4 of these cases during treatment, there was a rise in one form of risk and a fall in the other form of risk. This indicates a mutually exclusive or reciprocal relationship between risk to self and risk to others in the traumatised client group in this present study. This is confirmed by the small but significant negative correlation between risk to self and risk to others in clients before treatment.

When components which are mutually exclusive, reciprocal, or have a negative correlation are combined in one scale, that scale will behave unreliably. For example, 15 clients had scores on the Risk (R) subscale which were below the published clinically significant cut-off point of 0.56 for the Risk (R) subscale (CORE 1998b). Between them, these 15 clients accounted for 80% of the Risk to Others in the 36 clients assessed by CORE. Although all their Risk subscale scores were below the clinical threshold, closer examination of their individual responses would indicate that

some posed a small but definite risk to others, but because they were only responding to a subset of 2 items out of the possible total of 6 items in the Risk (R) subscale, this was insufficient to raise the mean score, averaged over the 6 items, above the clinical threshold. The standard procedure for CORE would only calculate total Risk (R) and not it's minor subscales so this risk to others could be overlooked.

Violence, either physical or verbal, perpetrated by those who are cast in the role of victim is not a phenomenon that is often described in adult bullying literature. But in this study, 8 (22.2%) of 36 victimised nurses, before treatment, reported being violent to others or threatening and intimidating others, 2 reported doing this occasionally, 2 reported doing this sometimes, 3 reported doing it often and 1 reported doing it most or all of the time. These 8 clients are detailed below.

- Client 28, a victim of bullying, reports being violent to others all or most of the time before treatment and often after treatment.
- Client 17, a victim of bullying, reports occasionally being violent and occasionally threatening and intimidating others before treatment but not after treatment.
- Client 3, a victim of bullying, reports occasionally threatening or intimidating others before treatment but not after treatment.
- Client 30, a victim of discrimination (legally-forbidden bullying), reports being often threatening or intimidating to others before treatment but not after treatment.
- Client 15, a victim of discrimination, reports sometimes threatening or intimidating others before treatment but not after treatment.
- Client 6, a victim of a complex work situation involving bullying, reports often threatening or intimidating others before treatment.
- Client 14, a victim of false allegation in the workplace, reports sometimes threatening or intimidating others before treatment and occasionally after treatment.
- Client 8, a victim of false allegation in the workplace, reports often threatening or intimidating others before treatment but not after treatment.

Fortunately, most of these clients were on sick leave at the time of reporting this behaviour, and presumably were doing this within the context of their family and friends, but 3 clients, clients 3, 14 & 30, were still working at the time of this report. None indicated in interview that this behaviour was to patients in their care, but the potential was there

Four test subjects who have been victims of mistreatment in the workplace but who reported no violence or threatening or intimidating behaviour to others before treatment did report being threatening or intimidating after treatment.

- Client 10, a victim of bullying, reports often threatening or intimidating others after treatment, but this goes away again by the 6 month follow up.
- Client 2, a victim of false accusation in the workplace, reports often threatening or intimidating others after treatment but this goes away again by the 6 month follow up.
- Client 36, a victim of false allegation, reports occasionally threatening or intimidating others on completion of treatment; there are no follow up results on this client.
- Client 19, the victim of a complex situation in the workplace, reports occasionally threatening or intimidating others after treatment and sometimes threatening or intimidating others at the 6 month follow up. However, by this stage they were experiencing a second episode of PTSD.

A transient period of outwardly focused anger in the form of violence or threatening and intimidating behaviour to others appears to occur in about 22% of victims traumatised by mistreatment in the workplace as they are going into or coming out of a time of functional incapacity. The anger is at what has been done to them or an anger that no one is going to do anything like that to them again. This anger at others or outside circumstances probably turns in and becomes anger at self, a common basis

of depression, as they become more incapacitated, hence the reciprocal relationship or negative correlation between risk to others (aggression) and risk to self (depression). This reverses as they come out of their incapacity.

This risk to others was found as commonly in those systematically bullied as in those victimised by a single act of false accusation in the workplace. Because of this, and because of its transient nature, especially in the recovery stage, it would appear to be a feature of traumatisation or PTSD rather than being an expression of bully/victim roles by the client, aggression being a recognised symptom in PTSD but not included in the diagnostic key

One client however, client 28, had a more consistent history of aggression, both verbal and physical, to others but was in counselling because they had experienced a singular act of victimisation, not bullying. The difference between singular traumatic victimisation and bullying will be explained later in Section 3.9. This client had similarities to a bully/victim but since their traumatic workplace experience was not one of bullying, no further conclusions could be drawn from this observation.

This risk to others, even if transient, does put the clients themselves at risk of acting out of character and mistreating others, adding to the general problem in the workplace or perhaps casting them in the light of a perpetrator and having disciplinary action taken against them. An example would be client 13 (described in more detail in Section 3.94), who lost their cool after prolonged bullying and shouted at the line manager who was bullying them. This single act got them formally disciplined for being verbally threatening and intimidating towards their manager, who was the real bully and was never investigated. Client 13, however, is now officially recorded as a verbally aggressive bully.

On the Risk to Self minor subscale only 11 (30%) of 36 clients before treatment and 6 (17%) after treatment reported responses to any of the 4 items of self risk. Of these 11 clients responding before treatment, 9 made a response to the most explicit item, C16, making plans to end self, only 2 responded to this item after treatment. So the counselling did reduce this clear item of risk. The three clients who reported the strongest risk to self on the CORE test and who the counsellor considered a potential risk for self harm or suicide, clients 11, 12 & 34, reported no items of risk to self or risk to others after treatment.

A number of clients showed very mixed responses on their self risk items following treatment with some items going up and others going down. The internal consistency of the Risk to Self minor subscale is not very high, Cronbach's alpha = 0.4167. When this is combined with the reciprocal minor subscale of Risk to Others this reduces even further. Cronbach's alpha for the main subscale of Risk (R) = 0.2878. This is very poor compared to the other main subscales, Well Being (W) Cronbach's alpha = 0.7814, Symptoms (P) Cronbach's alpha = 0.8138, Functioning (F) Cronbach's alpha = 0.8433. Certainly with this particular client group and this particular disorder, the Risk (R) subscale or Dimension shows poor validity. What the Risk (R) subscale and its minor subscales are trying to measure, and even what they are actually measuring, is very unclear.

Because of this unreliability of the Risk (R) subscale in relation to the study client group, and since Risk was not a significant feature of the client group as a whole, relative to controls, the Risk subscale and its items were not extensively analysed in relation to the client group.

## 3.8 ASSESSMENT OF POST TRAUMATIC STRESS DISORDER

Moving from the analysis of the CORE system, the study now turns to look at the assessment difficulties for determining PTSD in the study's client group.

### 3.8.1

### Clinical Symptom Assessment

In the present study, PTSD in the clients was assessed by a bimodal approach. One method of assessment was using the PENN Inventory and taking a score of 35 as the threshold, as described by Hammarberg (1992) who developed the test.

In the present study, 51 of the 51 clients before counselling had scores >35 and would be assessed as having a strong indication of PTSD.

The second method used was assessment by the counsellor using the diagnostic criteria for PTSD as laid down by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV). See appendix A for details of the criteria. By this method, 51 of the 51 clients met Criteria B, C, D & F for assessment of PTSD. This method was based on direct interviewing of the clients. All 51 clients were assessed as having PTSD by both of the above methods.

As an extra check the clients' individual responses to particular items from the CORE and PENN questionnaires were retrospectively checked. These were items which corresponded to specific DSM-IV criteria for PTSD. All 51 clients again met sufficient numbers and frequencies of items from DSM-IV criteria B, C & D for PTSD, to be considered as having PTSD.

As explained in Section 3.2.15, a group of 13 clients had PENN scores falling between 35 and 42 who clinically had mild PTSD, but whose assessment by PENN varied depending whether Hammarberg's (1992) original 35 threshold, Scott & Stradling's (2001) proposed 39 threshold, or this current study's suggested 42.5 threshold was applied. Closer examination of the histories of these 13 clients identified that 5 had come for counselling within 2 weeks of the critical incident and their full symptom profile had not yet developed at the time of the first questionnaire, but their symptoms actually continued to develop and intensify during the first few

weeks of counselling. Another 6 of these clients came for counselling over 6 months after their critical incident, and their symptoms had been more severe during the intervening time than they were when they first came for counselling. In these latter cases, some aspects of their symptoms had either improved or the clients had learnt to manage them. The remaining 2 clients scored above both the 35 and 39 thresholds and only narrowly missed out on the strictest 42.5 threshold.

The 35 threshold originally proposed by Hammarberg (1992), therefore, seemed the most appropriate to be inclusive of those with early stage PTSD and those in the recovery stage. This was the threshold used in the present study to make the initial assessment of the clients' condition. This observation, that many of the clients scoring in the lower ranges of PENN were either early cases or recovering cases, adds another dimension to the threshold value debate as to what threshold is most suitable to apply for different stages of the disorder. Hammarberg and Silver (1994) reported on a group of 40 war veterans with chronic PTSD, an often lifelong manifestation of the condition resistant to all forms of treatment. These veterans had a comparatively low mean PENN score of 40.9. If Scott and Stradling's (2001) recommended threshold of 39 were applied to this group of veterans, a significant proportion would fall below the 39 threshold, and this value would clearly be inappropriate for assessing the clinical state of those with long-term or chronic PTSD.

**3.8.2**

**Diagnosis of Post Traumatic Stress Disorder**

For Medical and Legal reasons, the use of the word 'assessed' in these statements is very specific. PTSD is a recognised mental disorder and as such can only be 'diagnosed' by a suitably medically qualified person. Since the counsellor is not medically qualified, the term 'assessed' is more appropriate.

In addition to the DSM-IV symptoms criteria, B, C, D, & F, two other non-symptom criteria must also be fulfilled for a diagnosis of PTSD to be possible.

**A.** The person must have been exposed to a traumatic event.

**B.** The symptoms must have persisted for at least one month.

Exposure to a traumatic event (A) is implicit in the PENN Inventory which was designed for use with disaster and combat exposed subjects, and is explicit in Criteria A of the DSM-IV diagnostic criteria for PTSD, see Appendix A.

Data on the intensity, frequency, and duration of PTSD symptoms experienced by the clients prior to counselling, was collected from counselling interviews and case notes.

In the counselling interviews, it was retrospectively determined that the 51 clients had full PTSD symptoms for a mean of 14 weeks before counselling, this ranged from 2 weeks to over 1 year. 'Full symptoms' means they had a sufficient range, intensity, and frequency of symptoms to meet the DSM-IV diagnostic criteria for PTSD.

Onset of full symptoms was coincident with or closely followed an event which was referred to in this study as the critical incident. Some clients experienced a single incident in which they were suddenly and unexpectedly victimised in some way, such as a serious false allegation. For these clients, they had no symptoms before the critical incident. Clients who had been bullied and experienced a series of incidents over an extended period culminating in a last straw event did report some symptoms before their critical incident.

The range of symptoms, their frequency and their intensity were not sufficient prior to the critical incident to be considered PTSD. The symptoms experienced by bullied victims prior to the critical incident and their psychological collapse would be indicative of anxiety, depression or stress, stress being a recognised effect of bullying. They do, however, indicate deterioration in the bullied clients' mental health prior to traumatisation, suggesting that they are undermined mentally prior to being overwhelmed by a relatively minor last straw event. These early symptoms were in addition to more general effects reported by clients who had been bullied, which

included loss of self esteem, loss of confidence, loss of sense of competency, loss of joy and social withdrawal. The critical incident which precipitated a rapid collapse in the client's ability to cope was simple to pinpoint in time; similarly, the point when bullying began was often simple to time, since it commonly followed a move in post by either the bully or the victim. They recognised that it was affecting their functioning, not simply that they did not like the treatment they were receiving.

The mean duration of full PTSD symptoms before counselling was 14 weeks. All 51 clients met the diagnostic criteria for PTSD consistently over the 4 weeks prior to counselling, apart from the 4 clients who came for counselling within two weeks of the critical incident and onset of full symptoms. Since they were still fully symptomatic 2 weeks into counselling, they were assessed as meeting the 4 weeks of symptoms required to meet criterion E of the DSM-IV diagnostic criteria for PTSD.

Criterion F for PTSD states that the 'The disturbance causes significant distress or impairment in social, occupational or other important areas of functioning'. In this present study, going on sick leave was taken as corroborating evidence of Criterion F; the client was no longer able to function in their occupation. They also experienced substantial problems in social functioning, this was confirmed by CORE Functioning (F) subscale scores above the clinical cut-off value of 1.3 (females).

Five clients were not on sick leave when starting treatment, 1 subsequently went on sick leave after starting counselling, client 21. Two further clients had come at a very early stage with mild symptoms and were able to be managed in such a way as to allow them to keep working, clients 16 & 30. The remaining 2 clients were not on sick leave but had PENN scores above 50 and CORE scores above 2, indicating a sufficient disruption of normal functioning to meet Criterion F. All 51 clients were assessed as meeting criterion F.

### 3.8.3

### Personal Sources of Stress or Trauma in Clients

Although it was once thought only very unusual events can cause PTSD, it is now recognised that quite common events such as car accidents can cause PTSD. In order to establish a causal link between more novel causes such as bullying and PTSD, it was important to exclude the possibility of more conventional causes of these clients condition.

As part of the normal counselling process, the counsellor explored and assessed all possible causes of the client's problem and not just those presented by the client. None of the clients in the study had experienced any major traumas in their personal life in the previous 24 months. None of the clients had experienced a single major personal life stressor from Holmes' and Rahe's Social Readjustment Rating Scale (1967), with an individual score >30. No clients had experienced a series of lesser events with an accumulative score >100 in the previous 12 months before the critical incident. Apart from what was happening in the workplace, no other single or cumulative sources of stress could be identified in the clients' lives in the previous 2 years.

Some clients did report family problems with partners and children, but the timing and nature of any relationship problems which clients were experiencing suggested that these flowed from the effects their workplace were having on their behaviour. Someone with PTSD will suffer significant impairment of their social and relational functioning (Criterion F).

No major sources of stress or trauma were identified in the client's family and social settings or relationships with the possible exception of 5 clients (clients 3, 14, 38, 40 & 43) who had additional responsibilities as a carer in their home setting. It was observed that 2 of these 5 clients with carer responsibilities, clients 3 and 14, did not go on sick.

They verbalised that if they took time for themselves, in being sick, they may not get such favourable consideration when they needed extra time or extra flexibility to fulfil

their carer role. They felt if they were sick, it would be blamed on their carer role, and they would loose sympathy and support for this role and be forced to choose between work and caring.

For clients 3 and 14 it took great determination to keep on working, when both were strongly clinical with PENN scores of 54 and 56 respectively before treatment. Client 14, who experienced a single act of public humiliation, did not respond well to treatment and still had full PTSD six months after treatment. By contrast, client 3, who was the victim of bullying, was one of the group of ongoing improvers attaining full recovery from both PTSD and general psychiatric problems by six months after treatment. The other 3 clients with carer roles were on sick leave and made comparable recovery to those with no carer roles during the treatment stage. Because of this additional carer role, it is more difficult in the case of these 5 clients to establish unequivocally a sole causal link between their workplace problems and their psychological disorder. The counsellor works with an exclusively nursing clientele; it is not unusual for nurses to take on an additional role as a carer in their family. The counsellor has not observed among over 500 clients, a nurse in the role of carer, who had PTSD, who did not also have a history of workplace victimisation. In this present study, 46 (90%) of clients who had PTSD did not have carer roles. Caring brings its own pressures, but no evidence was found in this present study to indicate that it caused PTSD or contributed to PTSD or interfered with recovery.

In summary, all 51 clients were assessed as having PTSD by the PENN Inventory (cut-off 35) and by the symptom criteria, B to F of the DSM-IV diagnostic criteria for PTSD.

The only obstacle to confirming that these 51 clients had PTSD was the nature of the event or events that had precipitated this condition; for a full PTSD assessment the clients must have experienced a particular type of event as defined by Criterion A of the DSM-IV criteria. Criterion A and the nature of the event or events experienced by the clients will be explored in greater detail next.

### 3.9 THE EVENT

The bimodal symptom assessment approach above confirmed the observation that the 51 clients were exhibiting a sufficient number and range of symptoms for at least one month, and these symptoms caused sufficient distress and disturbance of functioning to be considered PTSD.

However, for a diagnosis to be possible, there must be evidence of exposure to an event which most would find traumatic. In the PENN Inventory the occurrence of such an event is implicit, but the DSM-IV criteria for PTSD goes further, making it explicit and prescriptively defining the nature of such an event.

#### 3.9.1

#### DSM-IV Criterion A Event

The DSM IV Criteria A for Post Traumatic Stress Disorder states.

> A. The person experiences a traumatic event in which both of the following were present:
>
> 1. the person experienced or witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others;
>
> 2. the person's response involved intense fear, helplessness, or horror.

All 51 (100%) of the clients identified a critical incident which they saw as the cause of their present situation. For15 clients this was a single event, for the remaining 36 clients there was an event, but it was part of a series of events. All 51 clients reported that the onset of full symptoms coincided with or closely followed this event, described as the critical incident.

The natures of these critical incidents are categorised in Table 3.46 below.

**Table 3.46**

**Description of the Critical Incident**

NATURE OF PRECIPITATING INCIDENT

| | Frequency | Percent |
|---|---|---|
| Denied a just request | 7 | 13.7 |
| Threat of discipline or job loss | 8 | 15.7 |
| Falsely accussed | 18 | 35.3 |
| Threat of or actual agression | 3 | 5.9 |
| Suspended or dismissed as a result of an accusation | 6 | 11.8 |
| Humiliation | 9 | 17.6 |
| Total | 51 | 100.0 |

Many of the categories in Table 3.46 have a strong verbal attack component including threats of unfair treatment, false accusation, and being put down or humiliated.

In their interviews, 46 (90%) of the 51 clients believed they had been unjustly treated in the critical incident, denied their rights, denied natural justice or not given due process. Their sense of injustice was very strong.

Those who had been bullied had a prolonged period of interpersonal conflict with the significant other in the incident. But 7 (46.7) of the 15 clients who experienced a single incident in which they were unexpectedly victimised, reported having at least one interpersonal conflict with the significant other involved in the incident, during the previous 6 months. In the cases of those experiencing a single victimisation, these interpersonal conflicts would have included differences of opinions, various working frictions or confrontations, but would not fit a description of bullying.

The significant other referred to above being a term used to include those who are key in moving or acting against the client, whether by bullying, making false accusations, or even dismissing them without having all the facts.

Overall, a history of interpersonal conflict between the client (victim) and the significant other in the critical incident or series of incidents was reported in 44 (86.3%) of the 51 cases.

The core experience for the 51 clients, including those dismissed as the result of managerial incompetence rather than maliciousness, could be described as follows:

> An unresolved interpersonal conflict or unresolved communications problem in the workplace which resulted in an event or events in which the subject was singled out for unjust treatment and through which their standing and their position in the organisation was seriously threatened or actually harmed. In the course of this incident, the person is verbally assaulted and as a result sustains a loss.

The loss referred to in the last line includes both psychological and physical injury (somatic illness). The term verbal assault would include the implied statement that one is not fit to work when one is wrongfully dismissed. It is a statement against the person.

### 3.9.2

### Nature and Background of the Critical Incident

The clients in the present study were not selected on the basis of having a history of being bullied in the workplace. They were selected primarily on the basis that they had symptoms suggestive of PTSD and that their problems were work related. This had the effect of drawing in a wider group of possible causes of workplace victimisation and traumatisation than just bullying.

Three underlying dynamics or groups of critical incidents were observed.

**Group A**--15 (29%) of 51 clients. Typically this is a single incident. The incident is sudden, unexpected and one which most people would find very distressing to be confronted with.

**Group B**--29 (57%) of 51 clients. Typically there are multiple incidents. There is a

prolonged period of duress and interpersonal conflict with the significant other, running up to a 'last straw' incident which may be a relatively minor event or may be distressing enough in itself to be considered a Group A incident.

**Group C**--7 (14%) of clients. The incidents were very unique, perhaps each meriting an individual category. To define these individuals' experiences would raise an unnecessary risk of identifying them whilst only yielding anecdotal information of little significance. These typically start out as a single incident or series of incidents as above, but are seriously mismanaged when reported to senior management. Events in the handling of the original situation are traumatic in themselves or transform the original situation into much more traumatic consequences.

The PENN and CORE scores for each of these dynamics are shown in Table 3.47 below.

**Table 3.47**

**DSM-IV Assessment, PENN Score and CORE Score for Each Critical Incident Dynamic**

| | Group A | Group B | Group C | N |
|---|---|---|---|---|
| Clients Assessed With PTSD by DSM-IV | 15 | 29 | 7 | 51 |
| PENN Mean | 51.1 | 49.02 | 46.6 | 51 |
| CORE Mean | 2.5 | 2.43 | 2.4 | 36 |

Inspection of Table 3.47 shows that Group A, B & C type incidents had similar effects for the clients experiencing these incidents in terms of their DSM-IV assessment and their PENN & CORE scores. There were no significant inter-group

differences found on either the PENN or CORE scales, subscales, or individual items. Irrespective of the triggering mechanism, the symptom profiles for each group of clients were indistinguishable.

Each of the groups will now be examined in more detail, giving examples of each.

### 3.9.3

### Description of Group A Dynamics

In this present study, these will be referred to as Single Traumatic Victimisations. These subjects experienced a sudden unexpected incident. The main component of the incident was a formal allegation against the client by another member or members of the workforce. This was followed through by the clients' direct line or senior manager with formal investigation and disciplinary procedures. These allegations were serious and included incompetence, wilful misconduct and mistreatment of patients or other staff. There was little or no build up to or forewarning of the event. 6 (40%) of the 15 clients reported 'one off' disagreements with the accuser in the 6 months prior to the allegation being made, which they had assumed were past and resolved.

In most of these formal or informal procedures, the client either fully or substantially cleared their name of all but more minor misdemeanours. Whilst the final outcome appears positive, having to go through the process was overall a negative experience. The small number of cases where the charges were substantiated would suggest an over zealousness in initiating formal disciplinary procedures. A breakdown of the initial disciplinary action taken and the final outcome of the procedures is shown in Table 3.48.

**Table 3.48**

**Comparison of Initial Formal Action and Final Outcomes of Formal Procedures**

| | | OUTCOMES FOR TEST SUBJECTS EXPERIENCING A SINGLE TRAUMATIC EVENT | | | | |
|---|---|---|---|---|---|---|
| | | Won their case or cleared name | Internal discipline | Dismissed | Left job | Total |
| Type of Discipline | No Investigation | 1 | | | | 1 |
| | Formal Investigation | 6 | 1 | 1 | 1 | 9 |
| | Informal Investigation | 2 | 2 | | | 4 |
| | Dismissed on Spot | 1 | | | | 1 |

From Table 3.48, it can be seen that in 10 cases, a formal action, which would involve the employer's personnel department, was carried out against the clients. In 7 (70%) of the 10 formal actions, including one on-the-spot dismissal, the clients subsequently won their case and were cleared. Sufficient proof in these proceedings is only reasonable suspicion 50/50 and not beyond reasonable doubt, as it is in criminal procedures. The low (30%) success rate of formal cases brought suggests that most of the clients were put through an unnecessary stress when there was no sound evidence. In the remaining 3 (30%) of cases where the clients were found guilty of an offence, the charges on which they were found guilty were lesser charges than they were initially accused of. The proven charges were mainly on matters to do with breeches of the employer's own rules or procedures and not the matters of professional misconduct of which they were originally accused. None of the matters they were found guilty of merited reporting to the UKCC, the official body in the UK which oversees and investigates matters of unprofessional conduct by nurses. Yet 6 of these nurses who went through formal disciplinary procedures were suspended on the basis of the original allegation, and spent 6 - 24 weeks on suspension; 50% of these suspended nurses fully cleared their name. In view of the number and low grade of charges finally substantiated, this suspension would seem unjustified. Suspension is

experienced as a discipline; it is an act of discipline in advance of the outcome of investigation; in three cases it was shown to be unjustified, and in 3 cases it appeared to be excessive.

Of the 3 nurses who went through formal investigation and hearings and were subsequently disciplined; one was down graded, one was dismissed, and one resigned from their post before proceedings were completed. The latter case will be looked at in detail later in this section.

Informal investigations by the client's' line management were carried out in 4 other cases; 50% of these clients cleared their name, the other 50% received a verbal or written warning. This is the level at which minor misdemeanours or straightforward misunderstandings are sorted out, so 50% clearance at this level is not surprising.

From the perspective of the 15 clients, they experienced a serious allegation against them either by their manager, or made by someone else, but taken seriously by their manager. Of the 14 cases where the allegation was investigated internally by formal or informal investigation or externally by an industrial tribunal, 64% were proven to be false allegations and 36% were inflated allegations in which most of the substance of the allegation was false.

Their experience could be described as being wrongfully accused of very serious matters or having very serious suspicions of misconduct raised against them, and finding their line manager and more senior management willing to seriously consider these things to be true of them, and initiating actions against them.

With 10 (66.7%) of the 15 clients fully clearing their name and the remainder substantially clearing themselves of the original accusation, the evidence would support the use of the term false accusation to describe the single traumatic event they experienced. Most people would find such an event extremely traumatic, being falsely accused with a serious offence, finding the accusation so readily believed by others, assumed guilty, not being properly listened to, or allowed to explain oneself, but having to be investigated and having to produce evidence for trial or testing, and being judged on only a balance of probability. What also profoundly shocked some

clients was to discover the far reaching nature of such investigations, which did not just cover the matter in hand but sought to find any matter on which to fault them. The stakes were also very high, the outcome could affect their promotion prospects within their present unit, their job prospects in other hospitals and even their career, especially if the UKCC were to become involved.

This is further complicated by the fact that the proper investigation and disciplinary procedures were not followed in a number of these cases, denying the clients their rights to due process and natural justice. This seriously eroded their confidence of winning their case, a confidence often already diminished from the outset of the process from having previously witnessed similar things happening to colleagues or hearing stories of such events. The clients' view of things and expectations become negative, seeing it as a mess, and not as a misunderstanding which will be easily cleared up. When managers react and don't properly follow procedure, or when actions are taken with only half the facts, the investigation can cease to be a 'let's find out what happened', and becomes a must-win case for management, since a guilty finding on any matter, even an unrelated one, can be used to justify procedural irregularities; after all this person was guilty of something, so it was okay to have acted against them in this way.

One client was singled out to be made an example of for a practice widely done by many colleagues and widely known to their more senior management, but never explicitly forbidden; no warning was ever given prior to the critical incident that the practice was to stop. The practice had no serious consequences and did not affect patient care or safety in any way.

The client became isolated from the support of her colleagues, since they were not standing beside her as co-defendants with a common cause to win. It was in their interests not to back her for fear of being accused themselves, since backing her would amount to stating that they were doing the same thing. This practice was known to management but they had allowed it to continue without corrective instructions. Because the client did not develop the practice herself, but was actually

shown it in her probationary period and induction onto the team, she had a strong defence. However, management widened the scope of investigation against her and sought to solicit criticism of her general conduct, attitude, and relations with other staff. She came to believe that management was out to win at any cost, so to save face and give them the moral victory they so desired, she resigned. However, that did not end the matter. The client got another post with a different employer, but before her probationary period was completed, the previous employer contacted the new employer and made accusations against her. These accusations were not based on the agreed facts of the original case that she had not followed procedure in record keeping, but included some of the more speculative and contested accusations from the original case, that she was doing this to defraud her employer of time. Needless to say, the new employer unfortunately 'had' to let her go at the end of her probationary period. The client now has no recourse against the first employer to clear her name, no recourse against the second employer for letting her go, the fear it will happen again if she takes other employment in the area, a rapidly deteriorating CV and the prospect of totally losing her career and livelihood.

This client developed PTSD following the first accusation, made good recovery through counselling, but had a second episode of PTSD after the incident with the new employer.

Nurse F was originally accused of bullying and charged with gross misconduct. She cleared her name for bullying but was down-graded for a minor detail under data protection, a very harsh punishment when what she was found guilty of was allowing a situation to arise, when in charge of the unit, in which data might have been seen by an unauthorised person. It was a hypothetical situation--no data was actually revealed to a third party, and a third party would have had to be purposefully seeking access to the data; it would not have been found inadvertently. It was a potential risk that would have required intent on the part of someone else to be actualised. This was totally unrelated to the original charge and did not involve the original accuser.

Data protection is a complex legislation in which she had never been given any comprehensive training, and the situation she was considered responsible for was not explicitly prohibited in any rules or operating procedures.
In a court of law this would be an unrelated charge and so would be heard in a separate trial. If someone was accused of shop lifting, and the policeman delivering the summons to their house noticed their car tax was overdue, these would be dealt with in separate cases. This nurse however was tried in a setting in which her reputation was first seriously tarnished by the false accusations of bullying, the formal investigation could not justify finding her guilty of bullying on the evidence presented, but these same individuals then proceeded with the data protection issue and down graded her for that, which was excessive. She admitted that the situation had happened but did not realise it was wrong; if she had realised it was wrong she would not have done it. She expected a warning or reprimand because technically she was in the wrong but was totally shocked to be down-graded. Furthermore because of the seriousness of the first charge she and her representative had put all their effort into defending against it; they had not put up a mitigating defence on the second charge that training was inadequate or that the rules and procedures were not clear. Because of the way in which the hearing was handled she was effectively denied access to her previous good reputation on the second charge because the panel had heard, in detail, serious allegations made against her character. By processing the two charges together she was effectively hampered from preparing a mitigating defence of the second charge.

The following is the story of nurse R falsely accused of a criminal offence. R had been a nurse for 20 years and in the medical unit for four years. She loved the work, was confident, outgoing and knowledgeable in her specialist field. She had not pushed her career in nursing, preferring to have time and energy for her children while they were young, but had been asked many times to apply for more senior posts. She was free, relaxed and unpressured. Staff told her there was always a buzz about when she

was on duty with her easy-going nature keeping a relaxed air about the place. R liked to pride herself on her honesty with patients about their treatment and conscientiously went about her duties

There was a senior nurse in the unit, who was her line manager, always late on duty, making various excuses. R would have said this other nurse kept their distance from the rest of the staff but did their work well so it didn't bother R and she was always pleasant to the other nurse. R did get suspicious when doing a few medicine rounds as she was sure on a few occasions that they were short of some medications, but this senior nurse had reassured her and put her mind at rest.

When R arrived on duty one day she discovered that there had been an investigation underway in which it had been found that drugs had gone missing. To her horror she had been accused of stealing them, but she was not told who the accuser was. She was horrified, proclaimed her innocence, but was escorted to the police station and interviewed. R kept telling herself it was a dream, that she would wake up soon and it would be all over. She was kept in the police station for hours until they were satisfied that she did not take the drugs and ruled her out of the investigation, so she was released.

Although she was free, it was only the beginning of a nightmare that lasted over 12 months, a roller coaster ride with her emotions, taking medication since she couldn't sleep, as well as antidepressants and anti anxiety drugs. When they couldn't immediately find the culprit, it appeared to R that it left a question mark over her name. It took two months to find out who took the drugs and clear her name. Only then did she discover that it was this more senior nurse who had stolen the drugs, and that this same senior nurse who had originally pointed the finger and accused R.

R had nightmares, panic attacks, intrusive images, and sleep disturbance, weight loss, anger outbursts, avoidance, and obsessive thoughts and actions. She felt she was labelled a criminal even though she was cleared. It was the shock that anyone would possibly believe such a thing of her that disturbed her and she could not get the experience or stigma out of her mind of being taken to a police station, cautioned and

questioned.

R came for counselling after 8 months off sick, struggling with all her symptoms, and believing she had been targeted and victimised by her senior manager. Looking back, she could see a pattern of her questioning them about the drugs and their hints at times that maybe she had taken them, but she always believed they were joking. She couldn't leave the house for fear of the police lifting her. The therapy began with debriefing to fill in the gaps about the whole chain of events, parts of which she couldn't remember. After 8 sessions over 4 months of cognitive behavioural therapy focusing on her paranoid thoughts and behaviour she was able to return to work. She had a further 4 sessions to do with stress management. She returned to work in a managerial post, choosing not to return to clinical work because it would still be too fearful. She found it impossible to work on a ward due to paranoia when she had any responsibility for drugs.

Management supported R, giving her all the help she needed and oriented her back into the workplace, giving her management experience to help her get promotion as they realised her fear made clinical work impossible. They also apologised for not catching on sooner about the missing drugs.

R lost a year out of her life and her specialist field through a false allegation. These are tragic situations, not always preventable, and sometimes not attributable to poor management but criminal behaviour on the part of others. Because of the power difference (position in the organisation) between R and her accuser, R was immediately at a disadvantage and presumed guilty. Had more careful low key enquiry been made first, allowing all parties equality of telling their stories, her suspicions about the more senior nurse would have been expressed before any action was taken and might have changed the chain of events for R.

Another client began their story, "Everything was great until one day I walked into work and....." A commonality in these situations which come usually without warning but a large escalating chain reaction of consequences closely follows.

Because everything flows from that initial accusation the word Single is used when describing these as Single Traumatic Victimisations. The incident, however, is ongoing for a few days or few weeks from that point and the clients who developed PTSD usually began to show symptoms within a few days to a few weeks of this initial incident.

These incidents are quite different from the pattern of bullying in which there is typically a prolonged period of interpersonal problems with the significant other of gradual and insidious onset. Although bullying includes accusations of being stupid, being incompetent, not doing something properly, the accusations are initially very low grade and minor and are very interpersonal between the bully and the victim and don't initially progress to official disciplinary action, although they may include the veiled threat of such.

In contrast, although the critical incident which precipitates the onset of PTSD appears to be unexpected, a number of clients do report having had either isolated incidents of interpersonal conflict with their accuser in the previous 6 months or a prolonged period of interpersonal conflict with their accuser over the same period. These would be everyday working frictions or disagreements over work matters, but would not fit a description of bullying.

The single traumatic victims' interactions with their accusers in the 6 months prior to the critical incident are outlined in Table 3.49 below

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**Table 3.49**

**Interactions Between Clients (Single Traumatic Victimisation Dynamics) and the Significant Other Prior to the Critical Incident**

| | | ISOLATED INCIDENTS OF INTERPERSONAL CONFLICT | |
|---|---|---|---|
| | | no | yes |
| PERIOD OF INTERPERSONAL CONFLICT WITH SIGNIFICANT OTHER | No | 8 | 6 |
| | Yes | 1 | |

From Table 3.49, it can be seen that only 1 (12.5%) of the 15 clients who experienced a single traumatic victimisation had a period of ongoing interpersonal conflict or difficulties with their accuser running up to the event. A further 6 (40%) clients had isolated incidents of conflict in the 6 months previous to the event. In the case of the clients with isolated incidents, the clients would have considered these matters relatively minor and that the issues had been resolved at the time. They were not aware of any ongoing serious animosity with the other person before the critical incident occurred.

The significant other referred to above is the primary accuser who makes the initial accusation, but as in bullying, there are many roles. Whilst a line manager can raise their own suspicions, accuse the nurse and initiate informal proceedings, they will require the belief or support of more senior management to pursue more formal procedures. Similarly a colleague or subordinate making an accusation must win the support of the victim's line manager for matters to progress further. Clients say the most shocking thing for them is not the actual accusation but that someone in a position of close authority to them, whom they believe knows them well, should consider them capable of such a thing. Another thing that also shocks them is that colleagues, whom they regarded as close, distance themselves and do not assist them in their defence, thereby passively supporting the accusation, or may even bring up

other unrelated matters which they have been holding against them and join in attacking them when they are down. Again, some of these dynamics of exclusion, being isolated and not supported are similar to what victims of bullying experience.

The only shocking event which any of them has experienced, and which they have all experienced, is that they have been unexpectedly accused of a serious misconduct in their workplace. The onset of their PTSD symptoms closely followed this experience.

There are 15 such cases identified in the present study, this is not based on a single anecdotal story which might have an alternative bizarre explanation. The Single Traumatic Victimisation which these 15 clients experienced in their workplace triggered a PTSD-like disorder: there is no other plausible explanation.
The only remaining thing which prevents them being assessed as having clinical PTSD, is that these events do not contain a threat to their life or physical integrity so they do not meet the current Criterion A description of the type of event that is necessary to call it PTSD.
In the Discussion in Chapter 5 the experiences of these 15 Single Traumatic Victims will be explored further to determine if they can be squeezed into the current DSM-IV Criterion A definition

**3.9.4**

**Description of Group B Dynamics**

These 29 clients have experienced a prolonged period of duress, harassment and interpersonal conflict with a significant other in their workplace. The content of this victimisation and the effect it had on the victim met the MSF (1995c) definition of bullying. All victims had experienced at least 24 such incidents in a 6 month reference period. Two forms of this experience were identified, bullying (B1) and discrimination (B2).

**Group B1, Bullying**

In these 24 cases, the victims of bullying had endured a period of harassment and duress for a mean of 17 months (range 2 to 60 months) prior to the onset of PTSD-like symptoms. In 16 (66%) of these 24 cases, they finally suffered an exhaustion or breakdown of their mental and emotional ability to cope; this coincided with a moderately serious incident of bullying, but not usually the most extreme of the incidents that would have happened to them in this period. This last straw event overwhelmed them more because they had been undermined by the series of events running up to it, rather than because it was any worse than other previous incidents.

Nurse B was recently qualified and moved into a specialist field. She felt she was doing well, although it was a high pressure job, and found it challenging and rewarding. When she first joined the unit, she felt the more senior nurse was being very zealous about keeping an eye on her as a new nurse. They double checked her work, corrected her reports, and got her to do tasks again. But then they began to make jokes about their dress sense or makeup, saying she wasn't very good at her job and kept changing her off duty at short notice. She did not actually put in a complaint herself but, unknown to her, she had joined a unit with a serious bullying problem and was asked to make a statement as a witness for other victims making a complaint. It was only as she was making her own statement that she realised she had been bullied herself. It can creep up very slowly without the person realising that what is happening is bullying. The experience had by this stage profoundly affected her. She had lost touch with her friends because she couldn't cope with socialising. She didn't find things fun anymore and lived in dread of going to work, but as the main bread winner in her home she couldn't walk away. Senior management in an attempt to sort out the problems of the unit decided to move her to another unit but this meant the last shreds of friendship she had, which were with other staff in the unit, were lost. For her this felt like punishment, especially since the accused bully was left in the unit.
The nurse in counselling felt she had now lost her opportunity to pursue this specialist

area, lost friends, lost confidence, lost her joy, and will probably have to move hospital and start her career all over again.

The more sudden onset in this case was probably because a bullying regime was already well established in the unit, and she walked into the middle of it. Whilst she was immediately exposed to a serious level of bullying, she did not recognise it as such and actually took it as being supportive. It was only when it failed to fade away, as healthy support and close supervision ought to with growing competence, that it became more unpleasant and began to deskill and diminish her self confidence. Even though she did not like it, she did not recognise what it was until others put in a complaint.

Nurse S had always wanted to work out on the district, so when a temporary contract, part time, 'F' grade post came up she jumped at the chance. She loved the job and with her quiet manner, she felt this was the job for her. She was early into work each day purely because she was keen to learn and get out to her patients, as she wanted to gain a permanent post if one should come up.

The more senior G grade nurse who was working in the same office with her was really helpful at first giving tips as to how she could work effectively, getting the best out of her time with each patient. S believed the more senior nurse was being helpful but after 6 months of this she thought it should have stopped but it hadn't. The more senior nurse would quietly tell her the mistakes she was making and how she could do better the next time. After a year in the post, a permanent post was advertised and she obtained the post to her great delight.

S became a 'G' grade nurse on the same level with this previously senior nurse who had been bullying her. Four grade G nurses including S, shared the one office and S got on well with the other two making her feel more content in this position. The bully continued to be critical of her work and over the next two or three years, S gradually lost confidence, believing she was incapable of doing the job. S was continually being put down by this bully who appeared, or so S felt, to enjoy finding

fault, telling her she wasn't working hard enough, or yet again that she had made a mistake. S's moods were getting lower and lower until getting up in the morning was becoming too much as she had to face this woman yet again.

One day as this nurse was yet again pointing out S's faults the door suddenly opened. One of the other nurses who shared the office had returned early. The air was cold, and the third nurse looked shocked and made a loud comment to the effect of 'You're not doing it to her too'.

When S and the third nurse talked each of them discovered this one nurse had been putting them all down when they on their own with her in the office. This was the last straw for S as she had been having suicidal thoughts for months, believing it would be better if she were dead, because she couldn't see her way out of the shame and humiliation of being such a stupid person who could not even do her work properly, even though patients loved to see her coming and other colleagues gave her many compliments on her efficiency.

When S started confessing to the other two nurses, she discovered she had been bullied the longest, although it took them all a while to admit to themselves they had all been bullied and ended up in counselling but only one of them, nurse S, was so traumatised that she developed PTSD. As the facts came out, S went deeper and deeper into depression, attended a psychiatrist for one year and was not able to leave her home for fear of meeting this woman.

S was paranoid about her: she couldn't get her out of her mind and even saw her in dreams and nightmares. If a phone rang, she took panic for fear it was the other nurse, and she would jump if she even heard sudden noises. When S started venturing out of the house again, there where places she avoided, such as driving past work just in case she met this nurse, and she avoided the district she worked on.

S eventually came for counselling after she had been off sick for a year since it took that length of time to feel strong enough to leave her home. She was encouraged to come for counselling as one of her other colleagues had been coming and found it beneficial.

S was taken through debriefing and began to put some of the pieces of the jigsaw together, but still jumped about in leaps and logic. S still believed it was all her fault, that she was going mad and losing her sanity. She had to be reassured that 'the situation was abnormal but she was reacting perfectly normally' and that 'she wasn't mad'. This gave S something to hold onto when she felt she was still hanging on by her fingernails. During the counselling S had to work hard on obsessions, which were now trapping her: locking herself in the house or car, not answering the phone, avoiding places and people, talking out loud. She also had to stop over-medicating which she did to block out the world.

While in counselling she had decided she needed to see a solicitor. She and her colleagues took a case against the employer naming the other nurse as a bully and won substantial damages, although they were prevented in the settlement from revealing how much.

S is working again in a new post after nearly two years off and is enjoying her job. Only now can she see she was a victim: her nature did not allow her to face conflict but instead ran from it. Now she believes she has learnt skills to behave differently and talks much more about what is happening with her instead of locking it up inside.

In 8 (33%) of the 24 cases of bullying, there was an escalating scale of harassment and duress culminating in a serious accusation by the bully against the victim, aimed at expelling them from the workplace. The substance of such allegations, in the case of bullying, was more often concerned with incompetence rather than professional malpractice, as in Single Traumatic Victimisations. This final build up and attack was often provoked by the victim defying, resisting, questioning, challenging or otherwise taking a stand against the pattern of treatment they were receiving.

A commonly observed pattern of such an escalation would be the victim going to higher management after enduring many months of bullying by a line manager to complain. This approach by the client was usually in the first case informal and verbal--they simply wanted the behaviour to stop and were not asking for the other

person to be disciplined. When the bully heard of this, when higher management began to ask questions or even informed them, the bully would often immediately file a formal written complaint against the victim, accusing them of various sorts of misconduct, including even allegations that the victim was the one bullying and harassing them. The processing of the formal complaint then took precedence over the informal one, which was ignored; the way the client had been previously treated by the bully was not considered material to the current investigation of the victim's alleged misconduct. The outcomes of these counter allegation investigations varied: 4 (50%) of 8 clients cleared their name, but one of them had to take their case to external tribunal to prove wrongful dismissal. The way in which complaints of bullying are handled are distinct from the experience of bullying itself and may potentially add an additional layer of injustice and of improper conduct towards the victim. A number of victims of bullying and most of the victims of false allegations have experienced complaints or disciplinary systems which at times do not want to get involved, at times do not adequately protect all the parties involved, and whose investigative procedures seem inadequate to determine what is going on.

Of the remaining 4 victims, who did not clear their name when counter-accused after complaining about bullying or standing up for themselves, 2 simply left their job, feeling it was a hopeless cause to defend themselves, and 2 were found guilty of the counter allegation. One of these victims found guilty of a counter allegation had endured over a year of bullying and finally could take no more. During a bullying incident they lost their cool and shouted at the manager, the bullied victim themselves went straight to a senior manager and verbally reported what had just happened: both what they had just done themselves and what had driven them to it. The bully shortly afterwards, on discovering it had been told to senior management, filed a formal complaint that the victim had shouted at them and intimidated them. In a formal investigation, the victim's verbal admission to the senior manager of shouting, was used against them, while the background period of bullying was ruled inadmissible

and irrelevant to the matter of their act of shouting which was under investigation. They were found guilty of using aggressive and intimidating behaviour to their manager and given a written warning; the bully was never touched. As with those who experience a Single Traumatic Victimisation, the prosecutory style of formal proceedings, rather then an investigative style, adds another dimension to the total victimisation.

This sort of counter allegation following a period of bullying is merely an extension of the bullying. MSF (1995c) include abuse of power or unfair penal sanctions in their definition of bullying. It is upping the ante to maintain the power of domination when challenged or provoking a victim into retaliation and then getting them in trouble for it, both of which are recognisable childhood bullying strategies.

The major distinction between bullying and single traumatic victimisation occurs in the run up to either a 'last straw', or rapidly escalating events, in the case of bullying, or a sudden unexpected accusation, in the case of single traumatic victimisation. The actual point of traumatisation appears to be quite singular in both cases and following on from that, both those who have been accused of something and those who decide to take a complaint face a similar set of problems in their organisations' complaints and disciplinary procedures.

**3.9.5**

**Group B2, Discrimination.**

In these 5 cases, the duress had a major illegal discrimination component. The victim's harassment was not so heavily focused on them as an individual but included a dimension associated with them as a member of an identifiable, religious, ethnic or gender group, or because of a registered disability. However, they would at times also be publicly humiliated (bullied) with the underlying reason for that treatment carefully edited out of what the harasser said in front of witnesses. The ratio, 5 discrimination to 24 bullying scenarios in the present study, is similar to the ratio between discrimination and bullying victimisation described by the survey of the

Northern Ireland Civil Service (NICS/NIO 2000), who reported an equivalent of 9 cases of discrimination to every 24 of bullying.

The actual dynamics of bullying and discriminatory harassment were very similar. The only observed distinction was that the components of discriminatory harassment and duress were more low key and insidious, and some victims of discrimination had endured very prolonged periods of such treatment before they were traumatised. The frequency of incidents in some cases of discrimination may be too low to qualify discrimination as a form of bullying. During this protracted period the harassment may not be consistent but may increase and decrease although the victim is always aware of the existence of the problem. Each new incident only reinforces to the victim the fact that, despite the lack of incidents in between, the attitude of the other person towards them has not changed or diminished. It may not always meet the once a week or more often threshold in a six month reference period, even though the victims live with a constant sense of injustice, disadvantage and exclusion which is reinforced less frequently.

One client had been consistently passed over for career advancement because of a disability. Even within her grade, she had to live on a daily basis with being given only the more menial jobs and working well below her ability. It was only when she asked questions or made comments that she met the brick wall. She may not have hit her head on that brick wall once a week for six months, but every day she knew it was there. It only became explicit when she challenged it. The harasser was generally less blatant in their behaviour than in bullying, their behaviour being more hidden or more adapted to acceptable society and workplace norms.

Nurse G came for counselling because she felt she was being unfairly discriminated against within her unit. She had worked many years in her unit but never progressed in grade. She had been refused permission to go on training courses, being told that others were ahead of her, even though they came into the unit after her. These other nurses went on up the career ladder and she remained where she was.

In terms of humiliation theory (Lindner 2001) this is relegation humiliation. She had been put in a low place and left there: she's of bad blood; her sort will never amount to much; her type is not for promotion. These are not actual phrases used but reflect discriminatory attitudes once common in our culture and collective psyche.

Finally she came to the point where she was no longer prepared to accept the excuses and wait quietly for her turn which never seemed to come round. She went to more senior management and requested to be allowed to do further training, stating how long she had waited and the request was granted.

Shortly after starting the course she sustained a physical work-related injury and had to go on sick leave. She was already beginning to question her treatment by challenging over the course but now with time to think she began to realise how much she had been denied over the years and missed out on. She began to feel very isolated. The change in routine was a catalyst for her emotional response to her discrimination to come to the surface. Without her daily visits to work where her lowly relegated position was reinforced--fetch me this, go for that--she began to experience the enormity and the emotional impact of what had been done to her. Something inside her was already stirring before this in response to her treatment

This course was now very important to her. She went by the book and consulted with occupational health whether she could continue with the course while on sick leave and they said it would be okay. Her manager however heard she was going to the course and made a formal complaint against her that she had broken her contract.

The manager instigated a formal process without any investigation: she never enquired of the nurse first or spoke to occupational health to ask for an independent opinion as to whether someone on sick leave should be attending a course.

Personnel accepted the complaint without the least check on authenticity such as asking "Have you spoken to the person about this or got an opinion from occupational health?" The manager thought she knew best and that she could make decisions for the nurse as to what she should or should not be doing. The manager had been making all sorts of decisions for the nurse over the years as to what was good for her and what

she should or should not be able to do.

Nurse G was devastated so she took the situation to more senior management and got the situation sorted. But the emotional impact of this, on top of everything that she was beginning to become aware of, was enormous. The physical injury healed quite quickly but she was off work for many more months as a result of the emotional impact.

In counselling she described the unit as sick, it was not a healthy place to work unless you were one of the 'in group'. Nothing appeared to change unless certain people approved it and the easiest and best jobs were given to an 'in crowd'. It was a sort of upstairs-downstairs regime in which there was an invited elite who got the privileges and a relegated underclass who got the donkey work . This is an example of low grade maintenance bullying which escalated when he victim began to challenge their treatment.

One can publicly humiliate someone for their appearance, competence or intelligence without sanction by one's employer, but cannot do the same about their sexual orientation. This misses the point: the act of public humiliation and ridicule itself distresses people, not the subject matter. The group of 5 victims of discrimination, however, was too small and situations too diverse to draw any definite findings or perform statistical analysis.

### 3.9.6

### Background and Outcomes for the Different Types of Victimisation

A number of demographic details were collected in the present study about the workplace, in which incidents of Single Traumatic Victimisation or Bullying occurred, the contents of the incidents, action taken, and final outcomes. The results are presented as percentages in Table 3.50 below.

## Table 3.50

## Comparison of the Background to the Critical Incident According to Incident Type

| | Group A n = 15 | Group B1 n = 24 | Group B2 n = 5 | Group C n = 7 |
|---|---|---|---|---|
| % | Single Traumatic Victimisation | Bullying | Discrimination | Complex |
| **WORKPLACE CHARACTERISTICS** | | | | |
| Recent change of line MANAGER | 33 | 48 | 20 | 29 |
| Recent extensive changes in w ork PRACTICE | 47 | 83 | 60 | 57 |
| Excessive or unreasonable DEMANDS | 33 | 74 | 60 | 71 |
| **CHARACTERISTICS OF EVENTS** | | | | |
| CRITISCISM critiscism and blame | 20 | 70 | 80 | 57 |
| THREAT threat of discipline made | 27 | 43 | 100 | 14 |
| EXCLUSION w itholding or excluding | 20 | 57 | 40 | 43 |
| **ACTION BY EMPLOYER** | | | | |
| NO INVESTIGATION | 7 | 25 | 50 | 29 |
| FORMAL Investigation | 67 | 44 | 25 | 29 |
| INFORMAL Investigation | 27 | 31 | 25 | 29 |
| **OUTCOMES** | | | | |
| WON AT ENQUIRY | 67 | 33 | 20 | 14 |
| INTERNAL DISCIPLINE | 20 | 4 | 0 | 0 |
| DISMISSED | 7 | 0 | 0 | 0 |
| INTERNAL MOVE | 0 | 21 | 20 | 29 |
| LEFT POST | 0 | 29 | 40 | 43 |
| LEFT NURSING | 7 | 8 | 0 | 14 |
| LONG TERM SICK | 0 | 4 | 20 | 0 |

Inspection of Table 3.50 shows a difference in the working environments in which bullying and single traumatic victimisations occur. Both types of workplaces report a general background of changes in manager, changes in work practices, and excessive demands on the workforce, all of which are recognised as common stressors in the workplace. Such a description of the workplace is not surprising for those working as nurses in Health Care. What is surprising is the difference in the reported rates.

The workplaces where single traumatic victimisations occur are reporting a substantial amount of such stressors but those who have been bullied report twice as many of these stressors in their workplace. Even within a high stress industry such as nursing, bullying appears to be most common in the most highly stressed units.

Additional pressures in these units included the fact that bullying behaviour was being done quite openly in 66% of cases. Even those not directly involved were therefore pressured, threatened and intimidated by witnessing this mistreatment of a colleague.

In 66% of cases, the bully had a history of such unchallenged behaviour against other staff in the present or their previous units, and in 20% of cases there was a conspiracy, several people (colleagues) working together to bully. There appeared to be no group, team or organisational restraint on the behaviour of many bullies, and the bullies seemed to feel no need to personally restrain themselves from openly bullying others. This points to a high degree of social dysfunction within the unit.

The normal stress protective factors of comradeship, mutual support, protecting one another and trust appeared dysfunctional in these units or teams. Everyone was on their own and ripe for picking off for bullying victimisation, or for playing off against each other, or being drawn into conspiracies of compliance.

Inspection of Table 3.50 shows that criticism (70%) and exclusion (58%) were the most common characteristics of the interpersonal conflict experienced by those who were being bullied. Threats (100%) and criticism (80%) were a more marked feature of the experience of discrimination victims.

By contrast, the 7 of 15 Single Traumatic Victims who reported incidents of interpersonal conflict or periods of interpersonal conflict with their accuser before the

critical incident did not strongly identify criticism, threat or exclusion as common components of that conflict, nor would they have described it as bullying. The interpersonal difficulties of Bullying and Single Traumatic Victimisation have different dynamics, and this supports the concept of them being two distinct routes to traumatisation.

Table 3.50 shows that in 93% of Single Traumatic Victimisations some sort of formal or informal investigation of the accusations was carried out. The high rate of investigation reflects the seriousness of the accusations made. In 75% of the cases of bullying, some sort of formal or informal investigation of the victim's complaint or a counterclaim was carried out. This appears high and probably comes about because of the serious impact this experience has had on the victim's health and career which has drawn the attention of the situation to employers and the RCN.

In only 50% of discrimination cases was a formal or informal investigation carried out.

In bullying cases, the outcomes are more difficult to categorise: formally proving that one was bullied (33% of cases) does not mean action is taken against the bully. Even when informal investigation identifies that complaints have foundation, an internal move for the victim was often offered with no progression to formal investigation or discipline of the bully. The 21% of outcomes recording an internal move was not a move of the bully, but a move of the victim. These were 5 victims who were offered an internal move after they had established, through informal enquiry, sufficient grounds for a more formal investigation of the bully, but management did not want to take the matter any further.

The 1 (4%) bully suspended pending investigation was because several complaints were all put in at the same time by a number of different staff, and the unit would have ceased to function had the accused not been removed from it. By contrast, 33% of the single traumatic victims accused of serious matters other than bullying were suspended pending investigation. This illustrates the low level of seriousness given by

employers to claims of bullying compared to accusations of other types of misconduct. The idea that bullying is an act of gross misconduct has not yet been established within the ethos of most organisations.

The most striking difference between single victimisations and bullying cases in terms of final outcomes is that 7 (29%) of bullying victims moved post to escape the situation, but no single traumatic victims moved post. Although shocked by the experience, even traumatised by it, single traumatic victims have a clearer sense of closure, the matter has been resolved and is past.

Within 6 to12 months of the critical incident, 9 (37%) of the 24 bullied victims left their post, 5 of them taking a lower grade position than they had held previously, just to facilitate the move, and 2 left nursing altogether. One victim remained on long term sick leave. A further 2 victims took a relocation to a lower grade post with their current employer just to get out of their present unit. The behaviour of these victims indicated their strong desire to escape the situation where they had been victimised. Even the 1 bullied victim who won an unfair dismissal case after leaving declined an offer of reinstatement. Victims moved not just to escape bullies, but because their trust and relationship with other colleagues was often too destroyed to continue working there. In one situation, other nurses who had witnessed the mistreatment of the victim, and even had experiences themselves at the hands of the bully, would not come forward and support the victim when they took a case against the bully. These colleagues regarded the bully as being too well connected in managerial circles and likely to win, and feared being made a victim themselves if seen to speak out.

Altogether, 12 (50%) of 24 bullied victims took some form of proactive action to move out of the position where they had been bullied, sometimes on their own initiative, sometimes in an offer by senior management. This action was often very costly for them both in terms of career and finances. One victim gave up a specialist field she had been developing and training in for many years, because there was only one unit using her expertise and the bully remained in their post in that unit.

In most cases there appeared to be a great reluctance to remove managers who bullied. Client 3 endured a year of bullying by their line manager, who had treated others this way, until they were wrongfully accused of something by their line manager. They developed severe PTSD symptoms. They had 5 sessions of counselling over 12 weeks, were still in the general psychiatric zone by CORE and PENN after counselling, and were just inside the non clinical zone by the six month follow up. They had endured nearly two years of suffering, being bullied, and then struggling with PTSD and general psychiatric problems as a result. After pressing their case through a formal internal investigation and winning, senior hospital management said of their line manager "They're never going to change", and moved the victim instead to another unit, taking no action against the bully.

The effective filtering out of inter-organisational differences has enabled the recognition of several patterns. First is the recognition of a distinct form of workplace victimisation referred to as Single Traumatic Victimisation which does not fit current definitions of bullying. Secondly is the recognition that complaints procedures, investigative processes, and disciplinary procedures can potentially be as traumatic as the experience of bullying, and can traumatise in their own right or add an additional burden of stress on victims if not properly done. Thirdly is the recognition that even in a high stress employment sector, bullying appears to be most associated with the units experiencing the most work environment stressors.

### 3.9.7

### The Victims' Experiences and Criterion A Events

In both the victims of Bullying and Single Traumatic Victimisation, all other possible causes of traumatisation or major sources of stress were checked for and excluded. Their mental health histories, the timing of the onset of PTSD-like symptoms and the content and focus of their PTSD-like condition clearly identified their workplace experience of victimisation as the cause of their PTSD-like condition.

All the victims met criterion B to F of the DSM-IV diagnostic criteria for PTSD and had PENN Inventory scores >35. All but one showed substantial reliable and clinically significant change in their total PENN and CORE scores and across all aspects of their presenting symptoms in response to a trauma counselling approach.

With victims of bullying, onset of symptoms were sometimes difficult to time since they had typically experienced a prolonged period (mean of 17 months) of bullying prior to developing PTSD-like symptoms and had been under stress from that experience. During this period of bullying, many were having problems with concentration, memory and general motivation.

The workplace experience of the 24 victims of bullying was clearly the cause of their PTSD-like condition. However, when the prolonged period of bullying and the final critical incident were examined in some detail, it became clear that, whilst their emotional reaction met part 2 of Criterion A, the nature of the incidents they experienced did not meet part 1 of Criterion A.

There was no threat of or actual physical violence in their particular experience of bullying. All 24 victims had experienced what is referred to as relational bullying.

So whilst their condition meets the DSM-IV diagnostic Criteria for PTSD, A2 to F, their workplace experience which was the cause of their condition does not meet Criterion A1, so they cannot be diagnosed as having PTSD. They can only be described as having a PTSD-like disorder, even though PTSD is the closest fit description of their condition.

The bullied victim's PTSD-like condition would match several other described conditions but which are not currently recognised as official psychological or mental disorders. One condition would be Prolonged Duress Stress Disorder (PDSD) (Scott et al 1992) with PTSD-like symptoms. Another condition would be Diseases of Extreme Stress Not Otherwise Specified (DESNOS), a condition with PTSD-like symptoms and an extended range of symptoms particularly associated with prolonged events.

Those who have had a single traumatic victimisation have experienced a different type of incident and possibly a more shocking one. The individual events in bullying objectively seem less traumatic than the experience of being falsely accused of serious misconduct. But again, when their experiences are examined in detail, and despite them experiencing a Criterion A2 intense emotional reaction involving fear, helplessness or horror, the lack of threat to their physical integrity means they do not meet Criterion A1.

In Bullying and Single Traumatic Victimisation, the present study has identified two pathways leading to traumatisation of the victims and the development of a PTSD-like disorder. It is difficult to identify a common component in the two experiences which might be the actual event which traumatises, and this suggests that they are two different pathways to traumatisation.

Single traumatic victims appear to be overwhelmed by a lesser event suggesting some greater susceptibility; bullied victims appear overwhelmed in the end by an even lesser single event again. The histories of the bullied victims do not suggest any extreme lifelong susceptibility, so their increased susceptibility is likely to be linked to the current distress of being repeatedly bullied. The experience of the bullied victims would best be described as being systematically undermined or worn down by repeated bullying, until they were overwhelmed by a relatively mundane event rather than being overwhelmed by some awful event.

It is the author's observation, based on working with all types of PTSD or PTSD-like conditions, that the strength of this reaction to the precipitating event is similar in each scenario and is the common point where the differing triggering mechanisms converge, and after which the development and nature of the condition is the same.

Challenges to the current concepts of PTSD will be explored later in the Discussion in Section 5, in particular the very constrictive current definition of a Criterion A traumatic event.

### 3.9.8

### Assessment of Clients' PTSD Status

After counselling, when the client's histories and experiences had been extensively explored, the original assessment of the clients as having a PTSD-like disorder was reviewed.

Those who met all the DSM-IV Criteria (A to F) were assessed as having PTSD. Those who met all the symptom criteria (B to F) but had a prolonged event were assessed as having Prolonged Duress Stress Disorder PDSD or Disorders of Extreme Stress Not Otherwise Specified DESNOS. Those who met all the symptom criteria (B to F), but did not fit the above disorders were assessed as having a PTSD-like disorder. Final assessment of the 51 clients strictly by the current criteria and descriptions are shown in Table 3.51 below.

**Table 3.51**

**Assessment of Clients by PTSD Symptoms and Dynamics of the Critical Incident**

| | Group A | Group B1 | Group B2 | Group C | Total |
|---|---|---|---|---|---|
| Assessment | Single Traumatic Victimisation | Bullying | Discrimination | Complex | |
| Assessed as Post Traumatic Stress Disorder | 0 | 0 | 0 | 0 | 0 |
| Assessed as Prolonged Duress Stress Disorder or DESNOS | 0 | 24 | 5 | 3 | 32 |
| Assessed as a PTSD Like Disorder | 15 | 0 | 0 | 4 | 19 |
| Total | 15 | 24 | 5 | 7 | 51 |

From Table 3.51, it can be seen that no clients met the full DSM-IV criteria for PTSD. As explained previously, this was because the event they experienced and which triggered their onset of symptoms did not contain a threat to their life or physical integrity: it was very much a psychological assault rather than a physical one.

The 24 victims of bullying, 5 victims of discrimination and 3 of the clients with

complex workplace experiences would fit the concept of PDSD or DESNOS, because of the prolonged period of mistreatment they experienced prior to developing the condition.

The 15 clients who experienced a single traumatic victimisation and 4 of the clients with complex workplace experiences did not have a prolonged experience such as that suffered by the victims of bullying who endured a mean of 17 months bullying before their psychological collapse. They do not fit the description of PDSD or DESNOS and can only be described as a PTSD-like disorder.

Despite its broad sounding name, DESNOS is not a catch all term for anything which doesn't fit PTSD. It does require a similar prolonged period of duress to PDSD. It differs from PDSD in recognising a wider range of symptoms. A typical example of DESNOS is childhood physical or sexual abuse: the younger the victim or the more prolonged the mistreatment, the more likely the victim is to develop a profile of other symptoms not included in the standard diagnostic key for PTSD.

Single traumatic victimisations sit in the middle between the classic criterion A event and the prolonged period of mistreatment found in many forms of abuse, which are increasingly being recognised as the cause of unrecognised lifelong PTSD, which has an atypical symptom profile.

For PENN item 8, single traumatic victims had a mean score of 2.533 and bullied victims had a mean score of 1.833 for this item. This difference was only significant at $p = <0.05$ but not $p = <0.01$. No other differences were identified before treatment. Several other small significant differences were observed between these two groups after treatment. After counselling, bullied victims reported more self blame for their difficulties and problems (CORE item 30), and more feelings of being different from other people (PENN item 1).

Self blame and feeling different are among the criteria for DESNOS, and these observations suggest that those who experienced a prolonged period of mistreatment

in bullying have slightly fewer problems with one of the classic symptoms of PTSD, flashbacks, and more problems with some of the symptoms of DESNOS, feeling different and self blame. This may account for the counsellor's impression that victims of bullying needed more work to build self esteem. Single traumatic victims may be slightly closer to more classic PTSD in their symptoms and bullied victims may have slightly more difficulty with symptoms found in DESNOS.

Among the 51 clients in this present study, two major distinct triggering pathways for PTSD symptoms were identified: Single Traumatic Victimisation and Bullying. There is a high degree of homogeneity within each group and very clear distinctions between the groups in terms of what they experienced up to and including the critical event. After the critical incident both groups have full PTSD-like symptoms, though some bullied victims may have a slightly milder profile of the very unique PTSD symptoms and a slightly wider symptomology similar to what is found in other groups who have experienced prolonged abuse.

Whilst it seems valid to recognise single traumatic victimisation and bullying as distinct pathways leading to traumatisation, there is little evidence in the symptoms of the victims to justify dividing them from each other or separating them from those who have experienced extreme threats to physical integrity, into separate disorders. When the Diagnostic Statistical Manual first recognised PTSD as a disorder, the inclusion of a very narrowly defined event criterion gave too much weight and significance to the nature of the triggering event.

The present study very clearly shows how a purely psychological threat with no component of actual violence or threat to physical integrity can cause a PTSD-like condition.

As the criteria currently stand none of the 51 clients in this study could be officially diagnosed as having clinical PTSD, although that would be the best fit description of their condition. They therefore must continue to be labelled as having a PTSD-like condition, which would affect any legal claim involving psychological.

## 3.10 PROFILING OF PARTICIPANTS

### 3.10.1

### Profile of Significant Other (Accuser, Bully, Discriminator)

**Table 3.52**

**The Relationship of the Significant Other to the Client According to the Dynamics of the Critical Incident**

| Significant Other | Single Traumatic Victimisation n = 15 | Bullying n = 24 | Discrimination n = 5 | Complex n = 7 | Total |
|---|---|---|---|---|---|
| Subordinate | 2 (13.3) | 0 | 0 | 2 (28.6%) | 4 (8%) |
| Colleague | 2 (13.3%) | 7 (29%) | 3 (60%) | 1 (14.3%) | 13 (25%) |
| Colleague & Line Manager | 0 | 1 (4%) | 0 | 0 | 1 (2%) |
| Line Manager | 8 (53.3%) | 11 (46%) | 2 (40%) | 2 (28.6%) | 23 (45%) |
| Senior Management | 3 (20%) | 5 (21%) | 0 | 2 (28.6%) | 10 (20%) |

Table 3.52 shows that the Accuser (Group A) in single traumatic victimisation is most likely to be a line manager (53.3%) or a member of senior management (20%). The Bully (Group B1) is similarly most often a line manager (48%) or senior manager (21%). Discrimination seems to be more common from colleagues, although the sample size is the present study is small.

It was observed that line and senior management usually act on their own in situations of bullying or single traumatic victimisation. In only 1 (4.1%) case was a line manager and colleague identified as acting together to bully a client. However, when colleagues are involved in bullying, they often work together as a group: in 4 of 7 cases of bullying by colleagues, they did not work alone. Bullies operate from a position of power, either positional power in the organisation or power of numbers.

In both single traumatic victimisations and bullying, 50% of clients reported that they considered they had a friendship with the significant other until the harassment began or the accusations occurred. This adds to the shock experienced by the victim at what occurred, because there is a breach of trust or relationship. The significant other initially appeared a likeable, friendly and trustworthy person to the victim.

In one case of bullying, the victim was new to the department, and another nurse showed her the ropes and supervised her as she became familiar with all the procedures. This seemed very helpful and supportive at first but the other nurse did not draw back as the new nurse became more competent, but continued to scrutinise, check, point out even minor unimportant errors, and began to erode the new nurse's competence and self confidence.

What at first appeared a warm, close, supportive relationship became a controlling, overbearing and destructive domination. The bullies can be very plausible and charming people. They don't intensely bully from the very beginning. It is often something which develops over time, leaving the victim in a very confused state through experiencing two apparently contradictory sides of the same person. This confusion can freeze the victim from taking sufficiently robust action when the other person steps over the line of appropriate behaviour.

Since 62.5% of bullied victims were grade G & H, and the bullies were mostly in senior positions to them, those who bullied the victims in this present study were in very senior positions of nursing management. A similar picture was found with accusers, where 67% of the victims were grades F to H.

Accusers were 67% female and 33% male. Bullies were 87% female and 13% male. In 80% of cases, the events were female on female and nurse on nurse. There were a few males among the 51 clients and, where the victim was male, the significant other

was also male. Males were found slightly more often among the accusers, and the most blatant act of wrongful dismissal was by a male in a senior management position who was not from a nursing background.

Based on the profile of private health care and NHS employees in the sample, the rates of accusation and bullying in the private and NHS sectors would appear about the same. About 3/4 of accusers and bullies were UKCC registered nurses, and the proportion was the same for both the private health care sector and the NHS.

In the present study a number of different patterns of behaviour or modus operandi were noted for bullying and victimisation. The numbers of incidents of each pattern were too few to analyse and draw conclusions from, but they illustrate the great diversity and range of potential behaviours. One group of accusers was identified. Several individuals who had a history of making serious allegations against others was identified. One serial bully was identified who had driven several staff out of their department over a period of time.

## 3.11 DURATION OF TREATMENT

One of the main components of the present study was to examine the effectiveness of the trauma counselling approach, including Cognitive Behavioural Counselling, for those with PTSD-like symptoms following various forms of workplace victimisation. The overall degree of recovery and patterns of recovery on particular items have been explored above. One remaining component in assessing effectiveness of treatment is treatment time. The number of sessions and the time between the first and last session are shown in Table 3.53 below.

**Table 3.53**

**Number and Span of Counselling Sessions According to Triggering Dynamics**

| | A | B1 | B2 | C |
|---|---|---|---|---|
| Causes | Single Traumatic Victimisation | Bullying | Discrimination | Complex |
| Mean Number of Counselling Sessions | 6 | 8.5 | 6.4 | 6.7 |
| Mean Span of Sessions (weeks) | 10 | 16.2 | 13.2 | 15.7 |
| N = | 15 | 24 | 5 | 7 |

Table 3.53 shows that treatment for single traumatic victims took on average 6 X 1 hour sessions over 10 weeks, about one session per fortnight. Bullied victims by comparison took 8.5 sessions (2.5 more sessions) spread over 16.2 weeks, again about one session per fortnight. The extra 2.5 sessions (40% extra) for victims of bullying was not statistically significant ($t = 1.725$, $df = 37$, $p = .093$). On the basis of this, the number of sessions for all dynamics can be pooled, the mean number of sessions for all 51 clients is 7.2 sessions over 14 weeks. In view of the severity of the client's CORE and PENN scores before treatment, and their extreme psychological dysfunction, this is not a long treatment.

The counsellors overall average session rate for all cases seen through the RCN Counselling Service is 6 sessions ($n = 500$).

Some clients were on medication from their doctors for their psychiatric problems: a greater proportion of the bullied victims were on medication, 59% compared to 38% for single traumatic victims. However, no significant difference was found in the number of counselling sessions needed by those who were on medication compared to those who were not. The present study, however, did not record or examine the appropriateness of the clients' medication.

The fact that both groups take the same number of sessions for treatment, as well as having the same PENN and CORE scores before treatment, further strengthens the argument that there is no substantial difference between their clinical conditions. On reviewing the cases, the counsellor observed a slight difference in the content of the work done with each group of victims in counselling. The work with those who had had a single traumatic victimisation focused mostly on critical incident debriefing, goal setting, and action planning, while the work with bullied victims focused on the same areas but in some cases also involved more cognitive restructuring, rebuilding of self esteem and assertiveness building. Some of those who had experienced a prolonged period of mistreatment had experienced a greater alteration of perceptions of themselves, and greater changes in their cognitive thinking patterns. It was not possible with the data collected in the present study to determine if this was a component of their traumatisation, perhaps pointing to the presence of what are called 'Associated Features and Disorders' of PTSD in DSM-IV, or whether these problems predated the traumatisation.
Repeated criticism for a prolonged period, as in adult workplace bullying, would be expected to create negative thought patterns and reduce self esteem. This may be another effect of prolonged bullying and not a symptom of their traumatisation.

In the present study, there was no significant correlation between the number of counselling sessions and the client's CORE score, but there was a significant correlation between the client's PENN score before treatment and the number of

counselling sessions (Pearson's coefficient = 0.431, p = .002, n = 51). Generally the higher the PENN score, suggesting more intense PTSD symptoms, the greater the number of sessions, but there was a lot of individual variation.

The results suggest that the extinction of, or a substantial reduction of, PTSD-like symptoms was important in determining when counselling was completed. When counselling ended, 92.1% of clients had attained Reliable and Clinically Significant Change on the PENN scale, but at least half the clients were still in the clinical psychiatric distribution of CORE. Therefore Reliable and Clinically Significant Change on the CORE scale, indicating recovery from general psychiatric problems, is not a pre-requisite for the client's readiness to complete counselling.

The correlation between the clients' pre-treatment PENN score, the number of sessions, and the observation that Reliable and Clinically Significant Change on the PENN scale precedes completion of treatment, suggests that it is the clients' recovery from PTSD which is central to them regaining the confidence to manage on their own. The ongoing improvement in most cases after treatment confirmed the accuracy of the client's sense of readiness to manage on their own.

It took 7 X 1 hour sessions of counselling over 14 weeks for 92.1% of clients to attain Reliable and Clinically Significant Change on the PENN scale (35 cut-off), to be no longer assessed as clinical PTSD by DSM-IV criteria, and to feel confident enough to manage on their own without counselling. However, only 52.8% had attained Reliable and Clinically Significant Change on the CORE scale (1.29 cut-off) during treatment.

It took up to another 6 months for 69% of clients to no longer show indicators of general psychiatric problems and be considered full psychiatric recovery.

When treatment began, 47 (92.2%) of the 51 clients had been off work for a mean of

14 weeks, most due to sick leave, but a few also because of suspension or dismissal. A further 2 (3.9%) went on sick leave after the start of treatment and only 2 clients (3.9%) continued working throughout their treatment. By the end of treatment (14 weeks), 55.6% of clients had returned to work, and this rose to 96.1% working at the 6 month follow up, which was 38 weeks after beginning treatment.

The brief number of sessions, ongoing recovery afterwards, the high return to work rate, and the good recovery from general psychiatric problems are a good outcome and indicate an effective use of counselling time.

Of the 33% who do not attain full recovery by the final follow up, 12% were having more long term problems with PTSD-like symptoms. The remaining 21% with indicators of ongoing psychological problems seems high, but according to the findings of the Working Well Survey (RCN 2002), 11% of 4049 normal working nurses have a CORE score above the clinically significant threshold of 1.29. So, many nurses are working with this degree of general psychological and mental health problems.

## 3. 12 MYERS BRIGGS TYPE INDICATOR (MBTI) PROFILES

### 3.12.1

### Profiling of a Sample of Clients

The Kiersey Sorter questionnaire (instrument) was used to determine the MBTI type for 19 of the 51 clients to investigate whether particular personality types were common among the whole group or any sub groups of victims. The findings are presented in Table 3.54 below

**Table 3.54**

**Distribution of MBTI Types According to Triggering Dynamics**

| | | MBTI Types | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Not Typed | ENTJ | ESFJ | INTJ | ISFJ | ISTJ | Total |
| CAUSAL DYNAMICS IDENTIFIED BY COUNSELLOR AND CLIENT | Single Traumatic Victimisation | 11 | | 1 | 1 | 1 | 1 | 15 |
| | Discrimination, (sexual, religious, racial, disability) | 3 | 1 | | | 1 | | 5 |
| | Bullying | 13 | 1 | 3 | 1 | 5 | 1 | 24 |
| | Complex | 5 | 1 | | 1 | | | 7 |
| Total | | 32 | 3 | 4 | 3 | 7 | 2 | 51 |

Inspection of the Table 3.54 shows that the 19 clients sampled fell into 5 of 16 possible personality profiles. Some MBTI types are more common than others in the general population, so these results need to be evaluated against the general population pattern and certain types are more common in certain professions and this also need to be factored into the interpretation of the findings.

A difficult question in the present study was which general population to use as a control, Irish or UK.

A distribution of Irish and UK MBTI types is shown in Table 2.67 below, (UK figures in brackets), and results from the present study are indicated by *.

**Table 3.55**

**Distribution of MBTI Types, Ireland, (UK), and This Present Study***

| | | | |
|---|---|---|---|
| ISTJ<br>11.1<br>(13.7)<br>11* | ISFJ<br>13.9<br>(12.7)<br>37* | INFJ<br>5.0<br>(1.7) | INTJ<br>4.1<br>(1.4)<br>16* |
| ISTP<br>3.9<br>(6.4) | ISFP<br>7.0<br>(6.1) | INFP<br>6.5<br>(3.2) | INTP<br>5.0<br>(2.4) |
| ESTP<br>4.6<br>(5.8) | ESFP<br>5.5<br>(8.7) | ENFP<br>7.2<br>(6.3) | ENTP<br>3.7<br>(2.8) |
| ESTJ<br>8.1<br>(10.4) | ESFJ<br>6.9<br>(12.6)<br>21* | ENFJ<br>3.7<br>(2.8) | ENTJ<br>3.9<br>(2.9)<br>16* |

Inspection of the Table 3.55 shows that a sample size of 19 is rather small when there are a possible 16 categories. At least 100 results would be needed to make a detailed comparison of clients to the general population.

Killen and McKenna (2000) who prepared this table of Irish and UK distributions expressed some caution, because the Irish sample of 901 subjects contained twice as many women as men and a significant number of respondents from what they called the 'not-for-profit sector' which would include health and voluntary organisations. For the purposes of this present study, this may make it a more useful comparative group for nurses. There are some differences between the Irish and UK figures, and there are no figures for N. Ireland. It is not known if it is valid to assume the Northern Irish population is midway between these figures. The Northern Irish distribution of profiles could be quite different again.

It was noted that 58% of the clients in the sample were ISFJ or ESFJ, the types considered most suitable for nursing careers. 69% were SJs a combination also associated with the caring professions. These proportions are well above those expected for these combinations in the general public, but would be typical of those expected for their professional group. They are typical nursing profiles, so there are no indications that their workplace problems are because they are not temperamentally suited to the work.

### 3.12.2

### Profiling of a Management Team

As a comparison group, a team of 18 senior managers from an individual health care trust who were on a training exercise were profiled by MBTI. These were mostly senior nursing managers of similarly high grades to the group of clients in the study. As a functioning team, it was hoped they would reflect the full range and diversity of personalities in senior management. A comparison of the sample of victims and the management team is shown in Table 3.56 below

**Table 3.56**

**Comparison of MBTI Profiles Between Victim Sample (n = 19) and Management Team (n = 18)**

| MBTI | ISTJ | ESTJ | ISFJ | ESFJ | 1NFJ | ENFJ | INTJ | ENTJ |
|---|---|---|---|---|---|---|---|---|
| Managers n = | 3 | 6 | 3 | 4 | 1 | 1 | 0 | 0 |
| % | 17 | 33 | 17 | 22 | 6 | 6 | 0 | 0 |
| Victims n = | 2 | 0 | 7 | 4 | 0 | 0 | 3 | 3 |
| % | 11 | 0 | 37 | 21 | 0 | 0 | 16 | 16 |

Inspection of Table 3.56 shows again a relatively narrow range of MBTI profiles for the total of 37 nurses. Only 8 out of the possible 16 types are represented and 78% fall in just 4 profiles, ISTJ, ESTJ, ISFJ and ESFJ. In the Irish and UK populations, these types make up only 40% to 49% of the population. Between the managers and the

victim group there are differences, the single largest group among the managers are ESTJ (33%) who would be management type people; there are none of this type among the victims. The single largest group among the victims was ISFJ (37%) which is a typical nursing profile; they were a much smaller group among the managers at 17% and make up only 13.3% of the wider population.

A more in depth analysis of these differences and their implications for managers and victims alike will be presented in the Discussion Section.

### 3.12.3

### Comparison of Preference Frequencies

Rather than dilute the clients and managers over 16 possible groups, they can be compared on the four dichotomies, Extrovert / Introvert, Sensing / iNtuitive, Thinking / Feeling and Judging / Perceiving. This is often done in the MBTI literature. Comparison of the Irish, UK and present study (Northern Ireland) findings are shown in Table 3.57 below.

**Table 3.57**

**Percentage of MBTI Preferences, Ireland UK, This Study**

| | Ireland | UK | Present Study Victim Sample | Present Study Management Team |
|---|---|---|---|---|
| Extrovert | 43.5 | 52.3 | 37 | 39 |
| Introvert | 56.5 | 47.7 | 63 | 61 |
| | | | | |
| Sensing | 61 | 76.5 | 68 | 89 |
| iNtuitive | 39 | 23.5 | 32 | 11 |
| | | | | |
| Thinking | 44.4 | 45.8 | 42 | 50 |
| Feeling | 55.6 | 54.2 | 58 | 50 |
| | | | | |
| Judging | 56.6 | 58.2 | 100 | 100 |
| Perceiving | 43.4 | 41.8 | 0 | 0 |

Inspection of Table 3.57 shows that the sample of 19 victims has similar S/N and T/F ratios to the Irish and UK populations. The sample of victims however has a higher

than expected number of Introverts and a much higher than expected number of Judgers.

This very strong Judging preference gives an insight of how all this sample of clients likes to deal with the outer world. They like to live in a planned orderly way; they seek to regulate and manage their lives. They want to make decisions, come to closure, and move on. Their lives tend to be structured and organised, and they like to have things settled. Sticking to a plan and schedule is very important to them and they are energised by getting things done. Scheduled, organised, systematic, methodical, make long and short term plans, like things decided. These are both preferences and strengths. Extroverts tend to show these more outwardly to others while introverts often use these strengths inside themselves. There are also some weaknesses associated with Judging, including being inflexible, unyielding or inadaptable, and they can decide with insufficient data. They find it difficult to compromise or see all sides of an issue. Many of the above preferences of Judgers correspond to items from the PENN and CORE tests such as goal setting, moving towards goals and achieving things. These were the items on which the client group before treatment reported some of the strongest differences from the respective control groups. For Judgers, not being able to function in this decisive, orderly, controlled way which they prefer would be especially distressing for them. The typical traumatised victim coming for counselling was not functioning in this way, and, as someone with a Judging preference, they would find it particularly upsetting and frightening to be 'out of control'. Clients who are Judgers may be more susceptible to background stressors such as changes in working patterns or changes in managers or excessive workloads. They do not like change which is not planned, agreed and systematic, and they do not like situations where they have to crisis-manage with no time to do things as they see properly.

The ratio of Extroverts to Introverts among the bullied victims, at 36% to 64 % compared to more even split in the general populations, may suggest more Introverts

among the bullied victims. However, when this is compared to the nursing management group where the E/I ratio is 39% to 61%; this difference from the normal population appears to be largely explained by the clients being nurses rather than being associated with them being bullied.

Similarly there is no difference in the ratio of Sensing to Intuitive types between the bullied victims at 82% to 18% and the managers at 89% to 11%.

The ratio of Thinkers to Feelers among the bullied victims is 27% to 73%, which is much less than the population ratio of 45% to 55% or the management group at 50% to 50 %. Those who are the victims of bullying show a higher Feeler preference in the MBTI. This refers to the way the individual makes decisions, thinkers decide on logic, and true or false, while Feelers decide from personal values such as like or dislike.

As a group, all 19 clients in the sample who have been victimised in various ways in the workplace have a tendency to introversion and a strong tendency to Judging compared to the wider population. They will, therefore, tend in difficult circumstances to try to control their inner world of feelings, thoughts and reactions. Within the sample, those singled out for bullying compared to the wider population have a tendency to be more sensing and feeling. They need harmony to work best, want to please people, can be too detail-focused, losing the overall picture, have difficulties with new ideas or novel problems, and won't always stand firm. Whilst these features may distinguish them from the wider community, they share a number of these features with the sub population of nurses. Only the higher proportion of Feelers among bullied victims distinguishes them from the nursing management team used as a control.

The author of this study has been using the Kiersey Sorter and the MBTI types over a number of years, first using it in the setting of training counsellors, people from many professional or occupational backgrounds interested in counselling, and latterly as a therapeutic tool with clients initially in a GP setting, and most recently with nurse clients. A consistent observation over this period with over 400 people profiled, was

the high proportion of Judgers, at least 80%. This sample, however, was not random but was representative of people involved with, or drawn to, counselling either as a potential provider or as a consumer of such services. This high proportion of Judgers appears to cut across all barriers male/female, Roman Catholic and Protestant communities, socio-economic groups, professions, and those with and without psychiatric problems.

The only common feature shared by these Judgers was residency in N. Ireland. There may be a distinct population or community profile for the population in N. Ireland, but there are no published figures available for the local community. The author, on the basis of this wider observation, would urge caution that the 100% Judgers in the client sample may not be as extreme as it suggests relative to the community it is drawn from. The management team also shows a similar 100% Judger ratio adding weight to the possibility that this is related to community or professional factors rather than factors associated with victimisation.

Another explanation for the high Judger rate might be that it is an anomaly of the Kiersey Sorter. The current author has worked with a fellow trainer who is qualified and franchised to perform the full MBTI assessment, and has observed the full assessment being performed with counsellor trainees who had also used the Kiersey Sorter as an exercise at an earlier stage of their training. In over 40 full MBTI profiles, no trainee changed from a Judger to a Perceiver using the full MBTI questionnaire. Where changes have occurred, they are very few and were on type dichotomies where the trainees were fairly evenly balanced between the two types in their scores. When individuals are undecided between types, such changes can occur anyway on a test re-test basis. So the Kiersey Sorter is a reliable predictor of MBTI type, and its use does not explain the high rate of Judgers in the samples.

A much larger scale study will be needed to determine if the types found are related to either targeting for victimisation or susceptibility to traumatisation. Extensive control sampling will also be needed of the local general population and the nursing population.

### 3.12.4

### MBTI Profiles and Conflict

As suggested earlier, the experiences of the 51 traumatised clients in the present study such as bullying or single traumatic victimisation can be collectively termed unresolved inter-personal conflicts or communication breakdowns. These forms of victimisation may not so much be explained in terms of absolute personality types of the victims but more in terms of the interactions, conflicts and communications which occur between all the different personalities involved. A group of Thinkers or a group of Feelers will approach resolving a problem quite differently. A mixed group of Thinkers and Feelers may have a lot of internal group conflict and misunderstanding of each other when they try to address a common problem.

The higher number of Feelers among the bullied victims than in the population or the nursing management team may be an initiator of conflict, and the absence of Perceivers (all Judgers) may make such conflicts more difficult to resolve. Judgers want things sealed and finished, which can raise conflict; Perceivers are more comfortable with flexibility and being open-ended which can be a more mediatory approach.

One other observation was of 6 (32%) of the 19 victims who had experienced different forms of victimisation, shared the two profiles INTJ or ENTJ. These types are similar to each other: they would be creative, innovative ideas people, but they would be very different from either the other victims or the management team, 78% of whom were ESFJ, ISFJ, ESTJ or ISTJ. These latter types would be traditional, practical, methodical and rules-driven. These innovative ideas people were only found among the victim sample, and would be quite different from the majority of nurses, which may leave them isolated and vulnerable to being singled out for victimisation. The UK and Irish figures suggest INTJs and ENTJs only make up 4% to 8% of the population, so at 32%, they are over represented among the sample of victims

relative to the population or the nursing management team. In other professional settings, this figure would be more normal, 21.3% of law students and 28.6% of science students (Myers & Myers 1980) are INTJ or ENTJ. Aspects of personality which have potential for marginalising individuals may vary between professional settings. Within nursing INTJ or ENTJ would be uncommon.

The present study has identified the possibility of local (N.Ireland) and professional (nursing) variations in the distribution of MBTI personality types, which will require geographically and professionally relevant control groups to be tested in any further study seeking to establish associations between workplace bullying, traumatisation and MBTI personality types.

The present study has identified a small group of MBTI personality profiles among nurses who have been bullied or otherwise victimised in the workplace. This is taken up in the Discussion Section where the possible problems are explored which might occur between the personalities in the victim sample and the personalities in the management team.

## 3.13 COSTS

The main concern of this present study has been with the human cost for the victims but there is another cost, a financial one. This financial cost is borne both by the victim and by their employer. These calculations are based on figures supplied by the Royal College of Nursing and by the Manufacturing Science and Finance Union (now called Amicus) at an Anti-bullying Conference, addressed by Tim Field in Belfast 18/2/98. The costs directly incurred in respect of the 51 clients to replace them while on sick leave, to investigate complaints, to recruit replacements for those who moved job and to train nurses to replace those who left the profession through retirement, career move or long term illness are shown in Table 3.58 below.

**Table 3.58**

**Actual Costs Incurred by the Employers / NHS in Respect of the 51 Test Subjects in this Study**

| | |
|---|---|
| Lost labour due to sick leave or suspension, (agency cover would be more) | |
| 300 months @ £2010 per month (mid point G scale) = | £603000 |
| Internal formal disciplinary costs 24 @ £1000 = | £ 24000 |
| Industrial tribunal costs, Employment Law 2 @ £10000 = | £ 20000 |
| Industrial tribunal award 2 @ £30000 = | £ 60000 |
| Train new nurses to replace those who left nursing, due to choice or illness. | |
| 6 @ £30,000 = | £180000 |
| Recruitment of replacement nurses for those who left their post either moving job or leaving profession 20 @ £4900 (grade E) = | £ 98000 |
| **Actual Cost to Health Service or Employer =** | **£ 986,000** |

Inspection of the Table 3.58 shows that the major cost items were sickness leave, followed by training and recruitment to the profession, and recruitment to the vacated posts. Replacement cover for those on sick leave or suspension amounted to 61% of the costs, and staff moving post or leaving the profession made up 29% of the costs. Where there were variations in estimated costings from different sources or a range of costings, middle range conservative figures were used. The cost taken for training a new nurse to replace one leaving the profession was based on an entry grade nurse. Those leaving were actually senior grade nurses with considerable experience and specialist training.

Sickness costs, disciplinary costs and legal costs were incurred evenly across the different forms of victimisation, whereas costs for recruiting new nurses to vacated posts or training new nurses to replace those leaving the profession, were more closely associated with bullying or discrimination. This was because 13 (45%) of those who had endured prolonged victimisation subsequently left their current employer, their profession, or were too ill to return to any form of work. Those who accepted an internal move with the same employer were counted as a no-cost item for the employer. The estimated costs for each type of victimisation were rebalanced and are shown in Table 3.59

**Table 3.59**

**Division of Costs Based on Type of Victimisation**

| | | per person |
|---|---|---|
| Bullying /Discrimination | £600,000 | £20,700 |
| Single Traumatic Victimisation | £270,000 | £18,000 |
| Complex | £120,000 | £17,000 |

There are many other incalculable costs: there is the impact on the well being of the witnesses, in 64% of situations others witnessed this victimisation, injustice, humiliation and ultimate breaking of a colleague, but felt too powerless or scared to protect or support them. It has been reported by Quine (1999) that even witnessing such acts markedly affects the psychological well being of the witnesses, decreases job satisfaction, and increases their intention to leave. So in 33 teams or units where victims had been openly abused and victimised, there would have been a detrimental impact on the functioning of that unit and the health and well being of its members. The associated secondary costs of reduced productivity, increased staff turnover, and increased sick leave in these units were not calculated in the present study.

Most clients were on prolonged sick leave, mean of 14 weeks, when they came for counselling. Some were on sick leave considerably longer, were showing no signs of significant improvement, and faced the prospect of having their contracts terminated on grounds of ill health. This could also have ended their careers. Without counselling, this might have been the prospect for many of the clients. Only up to 50% of untreated PTSD cases recover within 6 months (Scott and Stradling 1992). Within 14 weeks of commencing counselling, 92.1% of clients had recovered from PTSD, over half were back working and only 4% eventually remained on long term sick. Between time spent on sick leave before the start of treatment and the time for the clients to sufficiently recover to be able to return to work, the average sick leave for each client was 6 months. A long term sickness outcome of only 4% after six months sick leave with a serious mental illness is good.

Counselling doubled the expected recovery rate, thus reducing the time on sick leave. This also got the clients back to work before contracts were terminated which kept the clients in their posts and the profession. During this present study 3 of the 51 clients strongly indicated a definite intent to leave nursing as a career, but through the counselling, they were assisted and supported to manage their crisis in a way that was more constructive for them personally, since loss of career in the 40s to 50s is a serious matter. They chose to take less stressful or less responsible positions but still

within nursing as part of their programme for recovery. This alone represented a £30,000 training saving for the NHS for each nurse who was retained in the profession.

It was not possible without a control group to determine exactly by how much the counselling reduced the amount of sick leave, which was the major cost item. The doubling of the PTSD recovery rate from the normal 50% (over six months) expected for untreated PTSD, would have reduced the sick leave by approximately a third. Counselling was estimated to have saved £100,000 on sick leave in addition to the £90,000 definitely saved in training costs, a total of £190,000

The costs of this counselling-enhanced recovery was borne by RCN, the total counselling time for the 51 test subjects was 400 hours, the cost of this at the professional counselling rate of £60 per hour was £ 24,000. If even one nurse who might otherwise leave the service was enabled to recover, then the full cost of the counselling provided to the 51 clients would be covered. Apart from the clear personal benefits to the clients of more rapid recovery, counselling was shown to be cost effective for the employers also.

Most clients are relieved just to have cleared their name after formal discipline or to get out of an extremely unhappy work situation by moving to escape the bully, and do not pursue the issue further. This however is changing. In the first phase of the present study, only 7% of all causes took the situation to tribunal; but in more recent cases, 25% of bullied clients are taking their cases to a tribunal, mostly for constructive dismissal, although some are pursuing legal claims for damages to their health. It has only been the unwillingness of victims to face reminders of their trauma or duress that has protected employers so far, but this is changing.

This opens a new area of potential costs for employers which on top of constructive dismissal could include claims for injury, suffering, or hardship against the employer under their vicarious liability for the actions of their victimising and harassing employees.

The 51 cases were reviewed and the potential claims of the clients against their employers were identified and costed; these are shown in Table 3.60 below.

**Table 3.60**

**Financial Exposure of Employer / NHS**

| | |
|---|---|
| Damages for Stress Disorder caused by straight forward uncomplicated cases of | |
| Bullying, discrimination or false malicious allegation. | 37 @£10,000 = £370,000 |
| Consequential long term stress induced mental illness | 2 @ £100,000 = £200,000 |
| Constructive dismissal claims by those who left | 16 @ £10,000 = £160,000 |
| | **Potential Compensation Cost = £730,000** |
| Legal costs would typically double this again | |
| | **Including Legal Costs Against Employer = £1,460,000** |

From Table 3.60 it can be seen that the major costs to employers could come from not just the client proving they had been bullied (constructive dismissal), but from a causal link being established between this and psychological injury or disorder such as PTSD.

Substantial legal fees could be incurred from court action for personal injuries.

The final cost item, and potentially the largest, could be injury caused to patients by these traumatised nurses if they continued working on with PTSD or a PTSD-like disorder. No actual injuries were identified for any of the 51 clients in the present study, but there was a potential risk created which needed quantified. Even before the

point of traumatisation those who were being regularly bullied were in a very distressed and stressed state with reported memory, distraction and concentration problems. Stressed individuals are at a greater risk for causing accidents, making mistakes or making omissions which could result in injury to patients or other staff members for which the employer would be vicariously liable.

In counselling, 8 (16%) clients after the critical incident and in the initial stages of the onset of PTSD actually stated that their principle fear was 'fear of making a mistake', which was why they went on sick leave. They decided to go on sick leave before they reached the point of being incapable of turning up at work because they realised they had become a danger to their patients.

Because of the slow and insidious nature of bullying, clients are often not aware of the resulting changes in their behaviour and functioning, and may have lost a lot of self awareness before the point of traumatisation. The present study identified 8 clients who were extremely stressed before their critical incident and 5 clients who worked on for an extended period with PTSD symptoms after their critical incident. Altogether the 51 clients between them worked for approximately 250 weeks with serious concentration, memory, distraction and startle problems. These clients were in senior and responsible positions, all with direct hands-on care of patients, often in very specialist areas.

To facilitate a risk assessment of the potential hazard to patients, the potential risk from these individuals were amalgamated into a single nurse. If an individual nurse was in a responsible position and having such severe functional difficulties reported constantly over 5 years (250 weeks), one minor injury per year would not be an unreasonable risk assessment, one of these a serious or life threatening injury.

The assessed exposure of the employers to patient injuries and claims are shown in Table 3.61 below

**Table 3.61**

**Employers Exposure to Patient Injury Claims from 51 Clients Working with Severe Stress or PTSD Symptoms**

| | |
|---|---|
| Potential minor injuries to patients, | 4 @ £100,000 |
| Potential serious injury to patient | 1 @ £500,000 |
| Total risk exposure in respect of patient injury | £900,000 |

The actual costs to employers and the NHS for these 51 victimised clients was £986,000. This cost will rise, because a number of personal injury claims in respect of bullying are still in progress. Other indirect costs in terms of impact on their colleagues with whom they worked or the units in which they worked were not determined.

The exposure of the employer and the NHS for damages and legal costs for losses inflicted on the 51 clients is £ 1,460,000. Increasingly, victims are successfully suing for these costs.

The exposure of the employer and the NHS to damages, and legal costs in respect of potential injuries these 51 clients could have caused to patients in their care is estimated at £900,000.

The potential maximum exposure of the employer in these 51 cases is £3,346,000 or £65,000 per case

These 51 cases are a highly selective sample who have been traumatised by their experience and for whom a clear uncomplicated link could be established between their traumatisation and their workplace experiences. They are probably the potentially most expensive cases, but they are only a fraction of the number of nurses experiencing bullying and false accusation.

# Chapter 4: DISCUSSION

## 4.1 BEYOND OBSERVATION

As outlined in the Introduction to this study, the author recognised in a particular group of clients coming for counselling the distinctive characteristic signs of Post Traumatic Stress Disorder (PTSD). Yet most of these clients had not experienced any major single event or an accumulated series of events likely to cause trauma or severe stress in their lives apart from a workplace experience of a prolonged period of bullying or a single traumatic victimisation in the workplace. This prompted the author to initiate a study of the phenomenon while counselling the clients in order to bring about recovery.

There were several reasons which made it important to validate and substantiate these observations. If these clients did have PTSD, this would shape or inform the direction of their therapy. From a pragmatic point of view, the author was already regarding these clients as traumatised by their experiences, taking a trauma counselling approach based on Cognitive Behavioural Counselling (CBC) and including psychoeducation about trauma and its effects.

This study was designed then to confirm, clarify and make specific the observation that these clients had been traumatised by their experience of bullying, that they had PTSD and that the trauma counselling approach being used, based on this concept, effectively addressed all aspects of the client's presenting condition.

This study has focused on the following aims and objectives:

1. Study the effects of counselling on the recovery from PTSD symptoms of a group of nurses traumatized by workplace bullying or other forms of workplace victimization.
    a. Identify and quantify PTSD symptoms in the clients
    b. Establish trauma counselling approach based on Cognitive Behavioural Counselling as an effective approach for clients' full recovery

c. Qualitative and quantitative research to assess the recovery rate before and after counselling and also at 6 month follow up

2. The study and use of the PENN inventory in quantifying the PTSD symptoms of the victims and their recovery
3. The study and use of the CORE system to measure caseness and general psychiatric problems in the victims and their recovery.
    a. Use the CORE in a specific setting
    b. Study the viability of the calibration
    c. Compare CORE and PENN as assessment tools
4. To study the role of personality in victimisation and situational bullying
    a. Use the Keirsey Sorter as an indicator for Myers Briggs Personal Preference Inventory assessment tool
    b. Look at personality disorders and their effects within a work environment
    c. Study other factors contributing to the bullying dynamic amongst nurses.

While the Results section showed the findings of the quantitative objectives, in the Discussion, the patterns observed will be presented and discussed. This will be done in three major sections: the clients and their treatment, bullying and PTSD, and personality factors.

## 4.2 THE CLIENTS AND THEIR TREATMENT

### 4.2.1 The Sample

All 51 clients were nurses and members of the Royal College of Nursing, whose counselling service they were attending. Of these 51 clients, 29 experienced a prolonged period of repeated verbal and/or psychological abuse that could be defined as bullying. A further 15 clients experienced a much shorter or even singular incident of victimisation which was their only probable source of traumatisation but which did not meet the definition of bullying. These were called single traumatic victimisations to distinguish them from bullying.

The 51 clients in the study were not low grade young nurses which might be a popular picture of bullying: 60% were grades G and above and 80% were aged 31 - 50. They were senior grade career nurses with at least 15 years experience and an average of over 20 years service. In 67% of bullying cases, the bully was a line or more senior manager, and in 73% of Single Traumatic Victimisations the aggressor was a line or senior manager. Those carrying out the victimisation were typically one grade higher than the victim. The type of victimisation reported in this study is hierarchic and is occurring at very senior levels in the organisation.

As members of RCN, the clients are in a very specific professional and educational band. It suggests that they may share a certain temperamental disposition and set of values. They are mostly female (the sample also included 4 males, too small a group to analyse separately). The fact they have come for counselling may indicate that they have been more profoundly affected by their workplace victimisation than other nurses or have a more positive attitude to seeking help and care.

These nurses were involved and proactive in the recovery process. The author's experience with those in other professional and socio-economic groups is that there is less proactive involvement and slower recovery in other groups. Nurses are more comfortable giving care to others and very uncomfortable being the 'sick one' or the 'cared for one'. They only come for counselling when absolutely desperate and when

they realise they are not managing to recover on their own. This is probably why the mean CORE score for all nurses seeking counselling at RCN throughout the UK is 1.96, which is well above the test's clinically significant cut off point of 1.29 (McInnes & Mellor-Clark 2000). Nurses typically do not come asking for counselling because of bullying until they are extremely psychologically distressed or injured by the experience, and are often by that stage on long term sick leave and not recovering. They will go to great lengths to cope on their own before admitting their need for help.

Perhaps for this reason, they actively engage in the process without reluctance. This may represent their desire to get out of this state of needing help as much as it represents their desire to recover. These nurses wanted to know what was being done and why to understand the process. The factual Cognitive Behavioural Counselling approach used in trauma work seemed to appeal to them, and they grasped it quickly. Whilst these nurses are referred to as clients, they were active participants who greatly enhanced the author's understanding of bullying and its effects.

Some of the clients coming for counselling in relation to bullying had experienced other major crises in their personal life. Others had experienced potentially traumatic events in the past. Some had a recent series of less serious crises in their lives resulting in a lot of change, stress and upheaval. These clients received counselling, but their background histories hindered attributing their psychological problems or breakdown solely to bullying at work or determining the relative contribution of bullying to their condition. They were left out of the study.

Altogether 51 clients - about half the victims of workplace bullying seeking counselling - were identified over a 3 year period. Their PTSD symptoms had no other possible cause than an experience of victimisation in the workplace. The timing of the onset of symptoms helped confirm that this workplace experience was the trigger of their condition.

The victims of bullying coming for counselling had endured a mean of 17 months bullying before they developed PTSD and went on sick leave. It was a further 4-5

months before they came for counselling during which time they were all under medical supervision and half had been put on medication.

The author's attention was drawn to these individuals in the first place because of a pattern in them, that pattern being a few differences in their symptom profile which suggested trauma rather than anxiety or depression. Counselling concerns itself with details and patterns. The author is from a nursing background and has seen over 500 nurses as clients for counselling on a wide variety of issues over the past 7 years. Apart from their symptom profile the author did not note anything about these particular clients, even during extended counselling interviewing, to distinguish them from other nurses.

In cases where nurses are on extended long-term sick leave, as opposed to intermittent periods of illness, the RCN Officers will always become involved. They work closely with the author and are familiar with her work in this area and will quickly refer any cases in need of counselling or recommend the nurses to refer themselves to the counselling service, a recommendation which nearly all act on. The author would therefore be confident that, during the study period, the sample includes the majority of nurses on long term sick leave who were exhibiting serious psychological problems in connection to victimisation in the workplace. The seriousness of the 51 clients' psychological condition is supported by the fact that their mean pre-treatment score on the CORE System scale was 2.42 when they first came for counselling, which places them among the top 25% most serious clinical cases for counselling or psychotherapy. In addition they all had PENN Inventory scores above the clinically significant cut off point of 35, with a mean value of 49.6 indicating that they had PTSD.

The 24 cases of bullying identified in the 3 year study is about 8 cases a year or 2.5% of the 300 nurses being regularly bullied at any one time. During their 17 months of frequent victimisation they would have experienced a total of between 75 & 300 incidents of bullying before developing PTSD.

In the current study, a control group of 105 nurses completed the PENN Inventory

and only 5 (4.8%) had scores above the clinically significant threshold for PTSD of 35 (Hammerberg 1992). Only 1 (0.95%) had a score above the clinically significant threshold of 39 proposed by Scott & Stradling (2000). No more than 5% of normal nurses had caseness for PTSD symptoms using the PENN Inventory. The author was able to interview briefly and assess these few individuals, and concluded that they were suffering from severe stress but not PTSD.

This study is finding traumatisation in nurses who have been bullied but has found no evidence to suggest that the general incidence of traumatisation in nurses is high or that the traumatisation rate in nurses who have been bullied is high. However because this current study only sampled those referring for counselling and did not take a general sample of those exposed to bullying, it cannot say for certain whether more victims may have developed PTSD but continued working and trying to cope on their own, or found relief in medication until the symptoms remitted. The author may only have been seeing those who were not coping with severe psychological symptoms, but not the majority of those with severe psychological symptoms.

Determination of exposure rates and traumatisation rates is important. A high traumatisation rate clearly indicates the harmfulness of a particular experience but where the rate is low, individual susceptibility factors may play a much more significant role in the development of PTSD.

This sample of 51 clients offers a valuable opportunity to study in as pure a form as possible, and in an in vivo situation, the relationship and dynamics between non-violent relational bullying, or false accusation, and trauma. They had the symptoms of PTSD, but the only major distressing events they had experienced in the previous 18 months were related to their workplace and fell into two main patterns. The incidents closely preceded the onset of their PTSD symptoms.

The first pattern, discussed above, was 24 nurses who had experienced a prolonged period of regular bullying in their workplace. The second pattern was 15 nurses who had experienced a sudden serious event of false accusation in the workplace followed

by a distressing period of investigation and harsh discipline. This second pattern is distinctly different from bullying and is very little described or studied elsewhere. These incidents did not fit this study's definition of bullying as weekly or more often (or 24 incidents) over 6 months, although the description of bullying used includes abuse of power and unfair penal sanctions (MSF 1995c). In one case, a client was confronted with a problem they did not previously know existed and was dismissed all within the space of a few hours. They subsequently proved they were not at fault and won an industrial tribunal. This would be the shortest and most extreme case but would not fit into any definition of bullying using a repetition or frequency condition. However the effect of this experience on the victim, feeling upset, threatened, humiliated or vulnerable would fit this study's definition of bullying. These singular or short series of more intense events, related to organisational disciplinary procedures, were different from the mean of 17 months of verbal and psychological abuse experienced by victims of bullying, although the effect seemed to be the same. Depending on the definitions used, these could be described as bullying, acts of violence or aggression. The author within the constraints of this study's definitions called them Single Traumatic Victimisations, emphasising the shortness, intensity and potential effect of such incidents.

This substantial group of single traumatic victims are a very poignant warning, because for every case of bullying there is by definition someone accused of being a bully. The findings of this study show that to be falsely accused or to be inappropriately disciplined can be as potentially traumatising an experience as being bullied. Therefore when it comes to stopping adult workplace bullying more innovative solutions are needed than rules and discipline. Pursuing witch hunts to oust bullies could, from a trauma point of view, do as much harm as good.

Finally two other minor patterns of experience were found among the 51 clients. A group of 5 clients had experienced harassment of a discriminatory nature and were probably a sub-group of bullying, and 7 were complex, unique or multidimensional

situations that did not fit the two main patterns.

A large amount of demographic information was systematically collected about the study's clients in respect of their workplace, the general background of their incident, and outcomes from it. Detailed symptom information was also collected using questionnaires. The study focuses on the quantitative presentation of their common shared experiences because this is an area often neglected in counselling research and is vital to giving their qualitative stories authority. However, the greatest amount of information collected was qualitative, the accounts told by the clients, since this was a counselling based study and each of these clients spent an average of 7.5 hours in counselling interviews. The next section, therefore will take a closer look at the how the interviewing process supported the study.

### 4.2.2—Interviewing

The counselling based approach of this study sets it apart from other questionnaire based studies or brief interview based studies. The author of this study both interviewed in depth and at length the 51 clients, analysing a lot of the questionnaire material in real time, using it in the counselling. The responses made by the clients to questionnaires were thus confirmed as accurate reflections of the clients' symptoms. Furthermore the author was able to elicit specific examples of various situations the clients said they had experienced and was able to explore them in greater detail. The reported experiences such as criticism or over-supervision were looked at objectively and evaluated as to whether it was excessive and bullying, or whether it might have been merited, or that the client was being overly sensitive.

The author is satisfied with the consistency of the clients accounts, that the 24 clients who experienced bullying were genuinely the victims of regular systematic bullying and were not exaggerating the events or the impact these events had upon their psychological wellbeing. The author is also satisfied with the consistency of the accounts of the 15 victims of single traumatic victimisation, that they were falsely accused and put through unnecessary and excessive investigative and disciplinary

procedures. Their rights were often ignored or denied in the process, and this had a significant impact on their psychological wellbeing.

Counselling creates an atmosphere of unconditional acceptance, openness and trust where the client is safe and free to bring up issues they may have never told even closest friends or partners. The confidentiality of the counselling and the fact the counsellor is outside of the situation mean the client has no need to hide anything from the counsellor. The client is also made aware of the importance of being open and honest for their own wellbeing and recovery. This gives the counsellor access to information that clients would not share in a normal interview or on a questionnaire. The counsellor allows client time to talk about the present situation, but also about their childhood or any traumas they have experienced.

The author believes the clients in the study were open and did not knowingly conceal anything material to the area of enquiry. As a result of this interviewing no historical potential cause of their current traumatisation could be found. However, it should be noted that the counsellor dealt mainly with conscious recall and did not do any unconscious or regression work.

Information was also sought about events running up to and during the time of bullying and, similarly, around the time of onset of severe symptoms. Again the author is satisfied that the 51 subjects had not experienced any recent major life crises, including bereavement or marital problems, or events which are known to traumatise such as assault, crime, accidents or exposure to something particularly horrific in the line of work.

These 51 clients are presented as a high quality sample whose PTSD-like symptoms and general psychological symptoms have been checked, whose accounts of workplace bullying or other workplace victimisation have been scrutinised, and in whom other recognised major stressors or traumatic experiences have been excluded. In depth interviewing allows patterns and general impressions to be picked up from the clients which were not anticipated or specifically sought for in the targeted information. Counselling is interested in patterns of behaviour in an individual's life,

and in this study, it proved very useful in picking up patterns across a specific group of individuals. This is one of the strengths of a qualitative approach to research. The identification of single traumatic victimisation, that people could be traumatised by a short series of events involving accusation, investigation and disciplinary procedures, was such a pattern. This patterning identifies new areas for future research where quantitative methods may be productively focused to confirm the pattern, measure the scale of the phenomenon and further characterise it.

### 4.2.3—Situation Focus

The clients were very focused on a specific event or a specific series of events in work which they saw as the cause of their troubles. They were concerned that they had been harmed in some way by the experience and about the way these events were affecting their ability to function and relate to others.

Although they saw these events in work as the focus of all their problems, when they began to explore the issues, they found it very difficult to talk or think about these events or even to recall many aspects of them. The intensity of this reaction blocked the normal process of talking over with others or going over events in one's mind until they are given a meaning, a context and a sense of scale. Consciously recalling these events was extremely distressing, and they reported memories, images and thoughts of these events intruding into their waking as flashbacks and into their sleep as nightmares. Any form of recollection was extremely disturbing. This is very similar to those who have been traumatised by disasters.

The intrusive recollections they were having were all about their experience of victimisation at work, and their avoidant behaviour was focused on work and particular members of staff. Their condition was event-focused, and those events were in the workplace, so they could be described as having a work-focused or work-related condition.

They were very profoundly affected both by their experience of being bullied or victimised, and its effects upon their ability to function in work, social and family

situations. Nearly all of these clients were on long-term sick leave when they first came for counselling. They dreaded returning to their workplace, and faced the prospect of losing their job and career through ill health.

In contrast to those who had been bullied, those who experienced a single traumatic victimisation had a more focused, sudden, unexpected, distressing series of events to focus on. Some had a singular event, such as the client dismissed on the spot and several others who were immediately suspended. The focus of the emotional and psychological symptoms on these more concentrated events was not dissimilar to someone exposed to a disaster event. Classic trauma events are not necessarily single events but may also be a rapidly developing series of consequences.

Sometimes the victims of bullying were particularly fixed on one last straw event that immediately preceded or precipitated the collapse of their ability to cope. This last straw event was often unremarkable among the series of events they had experienced during bullying. For some it symbolised, crystallised, epitomised all that had been happening to them, and was the point where they suddenly realised what had happened to them and what they had lost.

If these bullied nurses had really acknowledged what was happening during the months and years preceding this last straw, they would have had to do something. That could have meant confrontation, finding fault in others, not being believed, maybe finding out some of the criticisms of them were true. So they denied, minimised, sublimated the emotional response to each incident into something else, buried themselves in their work and sought to be perfect. They were like jugglers, trying to keep the balls all in the air but never touching each other, and then one ball too many or something unbalanced the equilibrium. In one moment it all came crashing together and they experienced the entirety of what had been done to them and the effect it had had upon them.

For others, their experience would be more accurately described as being slowly undermined by a prolonged period of harassment and duress, chipped away at bit by bit until they simply collapsed under the weight of one last unfair or unjust event, but

no worse and often much less than one they had handled before. But with this came a realisation of what they had come to that they couldn't even manage something as small as this. There was a less frantic or stress-filled build up to this second example, but there was a similar sudden realisation of helplessness, as if all your resources were diminished, you had been changed and damaged, a realisation of what you had lost, a sense of impending disaster that you were at the mercy of this person who was not going to change or stop or go away, that they had been out to destroy you and they had won and you were somehow going to lose. It was a mental battle, a mind game, and you had been beaten, you had been broken, you had been brought low.

In bullying there is a prolonged build up to the point where the person is finally traumatised. The mean period of bullying for clients in this study was 17 months before PTSD symptoms developed, which, if bullied once a week or more often, would represent at least 75 incidents.

One area of interest was whether those at risk of developing PTSD could be identified early and some form of intervention taken. Because this was a retrospective question it was dependent on the client's ability to recall details of their psychological health in the year before coming for counselling. Those who were bullied recalled a gradual erosion of their normal functional ability before the last straw event: a difficulty concentrating, focusing, and remembering, and being withdrawn and apprehensive. These would be typical signs of stress and indicate a general distraction of the mind which was busy trying to deal with the emotional turmoil the experience had created. There were indicators of a general loss of self confidence, setting up a vicious circle where general distraction led to omissions and mistakes reducing their self confidence further. Apart from indicators of stress, low self confidence, some social isolation and an emerging dislike or even dread of their workplace and particular colleagues, there were no signs of typical trauma symptoms such as intrusive, avoidant or dissociative symptoms. There did not appear to be any distinctive features in the clients before the last straw event which are not widely reported in most victims of bullying.

From this last straw event they rapidly lost their remaining ability to function, and went on sick leave. Some, 16%, said they intentionally went on sick leave before reaching the point of incapacity because they saw in their precipitous collapse of functioning that they may be a danger to their patients. The others struggled on a little longer until they mentally collapsed, typically within a fortnight of the critical incident. That was where they got stuck. The thought of facing any reminder of their past experiences, like returning to work or having to face the bully to sort out issues, caused them overwhelming distress, and they ended up on long term sick leave.

With the collapse of their conscious mental functioning came an additional set of symptoms to the stress/anxiety or depressive type problems they may have been struggling with: PTSD.

What they experienced is exactly the same type of response as might occur if they went into work one day and an armed man held them up and stole the drugs from the drug cabinet. If that was the story they were telling the counsellor, and with this set of symptoms, it would be an open and shut case of PTSD. But instead they had not been threatened with a gun, rather someone had said things to them, but they had no evidence to prove what has happened to them; they were shocked and ashamed to admit what they had allowed to be done to them and the way it had affected them. In addition they had difficulty finding people to believe their accounts of the bullying or of their symptoms, or to find people to back up their story. The person they said bullied them denied it, and in several cases where the bullying of the client had been witnessed by others, the other nurses did not want to make statements for fear it could happen to them.

This creates a very surreal experience for the victims of workplace bullying, where they know they have been bullied, that something happened in that last straw event which somehow caused their present state, but they don't understand what was happening to them. Those around them cannot explain it either, nor are they helpful. Some people deny it or pretend certain things did not happen; some question that their symptoms are as bad as they claim; some question that their symptoms could be

connected to the bullying and must be due to something else. Some say they are mentally ill, and their whole story is made up or exaggerated. Their often strange behaviour and reactions do seriously undermine their credibility as a reliable witness, so they have difficulty finding others to trust or believe them.

Because of their great difficulty and distress in talking to others about their workplace experiences or symptoms, and because of the difficulty finding someone to believe or understand them, they remain locked in their condition and require professional help to recover. This is taken up in the next section.

### 4.2.4—Treatment Outcomes and Recovery

The term recovery requires some sort of measurement and evaluation or comparison of the product or outcome of the process against a standard. In this study, the performance of two psychometric instruments were compared and contrasted, the PENN Inventory which is essentially a diagnostic tool for PTSD and CORE which is an outcome audit instrument for general psychiatric problems. Recovery is also looked at from a number of different perspectives to give a fuller understanding of the way treatment works and how clients recover.

Before treatment all 51 clients were fully diagnostic for PTSD by assessment against the DSM-IV (APA 1994) criteria and by PENN. After counselling the clients' mean PENN score reduced substantially by 55% to 22.5. No significant difference was found between this post treatment PENN score and that of the control group, mean = 20.4. Treatment was very effective in reducing the clients' mean PENN scores to the normal range.

Looking at this on an individual basis, 47 (92.1%) of 51 clients had scores below the 35 diagnostic threshold after treatment. Three of the other recovering nevertheless made substantial improvement, reducing their PENN scores by more than 2 standard deviations during treatment from severely clinical pre-treatment scores ranging from 62 to 71. However, they were still just above the 35 diagnostic threshold after

treatment.

If the PENN Inventory was the only psychometric test being used in this present study, then the study would have been reporting very favourable outcomes for Cognitive Behavioural Counselling (CBC) and PTSD.

This study found a 92% recovery rate (Reliable and Clinically Significant Change) from PTSD using CBC, showing a clinically significant recovery being interpreted by the PENN Inventory's own published cut-off value of 35, which is the point at which the probability of being in the clinical or non-clinical PTSD distribution is equal. Therefore all 51 clients were more likely to be part of the clinical PTSD distribution before treatment and 92%, having made reliable change, were more likely to be part of the non-clinical PTSD distribution after treatment. The scale of improvement was so large that, even using the more stringent 2 standard deviation improvement method of Foa et al (1991), the recovery rate was calculated as 84. The recovery rate is very strong and compares well with other studies.

The clients in the present study, therefore, were strongly clinical for PTSD before treatment and showed strong reliable and clinically significant improvement in PTSD symptoms when treated with a trauma counselling approach based on Cognitive Behavioural Counselling and taking their workplace experience of bullying or victimisation as the cause of their traumatisation. If the treatment had focused on the wrong cause of their condition, then such strong positive recovery would be improbable. This strengthens the case that the client's workplace victimisation was the cause of their traumatisation.

The PENN Inventory however only looks at the clients in one dimension, as PTSD cases, but many studies such as Shalev & Yehuda (1998) have found that PTSD is not the only or even the most common outcome of being exposed to a traumatic event. Depression and anxiety are more common outcomes in their own right, and even when clients do have PTSD, they often have depression and/or anxiety as comorbid conditions. Recovery needs to be assessed over a wider range of symptoms.

Here the CORE System's perspective of recovery was useful and brought different

results. In terms of individual recovery, immediately after treatment, 47.2% of clients had CORE scores above the 1.29 clinical cut off value, still indicating ongoing clinical psychiatric problems. These findings suggested that even though clients had recovered from PTSD during treatment, almost half still had enough psychological disordering to be considered somewhat different from the normal population.

Despite the fact half the clients still had indications of ongoing psychiatric problems, this was the point when they felt ready to try and manage on their own, an assessment in which the counsellor concurred, and this was confirmed by the non-return rate of the clients, even with an open door return policy. If some of these clients had initially presented to the counselling service with the scores they had on leaving, there would have been justification in offering them treatment.

The clients, on completing treatment however, were different in many ways from when they came for counselling. They had momentum and direction and were on the road to recovery. This was borne out by the follow up study 6 months later in which two-thirds of clients continued making reliable and clinically significant improvement after completion of their treatment. On follow up 6 months later, 69% of clients were fully non-clinical by both the PENN and the CORE scales.

During the present study it was observed that if clients' outcomes are audited up to 6 months after completing treatment rather than immediately on completion of treatment, it can double the reported recovery rates. This raises the question of which is the more valid measure of the recovery or the benefit of treatment.

The present study found 31% of treated clients with ongoing indications of general psychiatric problems at a mean of 60 weeks after initial onset of PTSD symptoms. This poses a question of what is the most appropriate measure of recovery. Is it recovery from PTSD or recovery from all indications of general psychiatric problems? In the present study, specific recovery from PTSD is 92% but full recovery from PTSD and all indicators of general psychological problems 6 months after completion of treatment is 69%.

In the study, the performance of two psychometric instruments, the PENN and the CORE, were compared and contrasted and new cut-off values calculated (see sections 3.2.14 and 3.3). The impact of this calculation was examined using the 36 clients in phase II of the study for whom full sets of both CORE and PENN results were available. The higher PENN cut-off value of 42.5 is much stricter than the 35 cut-off and reduces the number of clients as fully PTSD from 36 to 23, when being assessed by the bimodal approach using counsellor assessment against DSM-IV and PENN. Those scoring between 35 and 42.5 on the PENN scale do have significant psychological problems but it may be difficult to differentiate between PTSD and other general psychiatric conditions without a thorough interview. From a strictly statistical perspective, they are more likely to be general psychiatric than PTSD, but the distributions overlap and this is only a balance of probability assessment. From a qualitative evaluation the author selected these individuals for the study because they appeared to have PTSD type symptoms on initial interview. This was then confirmed by more detailed questioning and assessment against DSM-IV criteria. The PENN Inventory used on its own would not be reliable to distinguish PTSD cases from general psychiatric cases in the 35 to 42.5 region, particularly if it was being used to screen in a non-classically exposed population with a high background incidence of general psychiatric problems, such as nursing. Subjects in the range 35 - 42.5 need a detailed clinical assessment.

Returning to the 23 clients from phase II of the study who had PENN scores above the stricter 42.5 threshold, the recovery rate for these 23 clients from PTSD was 95.2%. During treatment their PENN scores made a reliable and clinically significant change and moved from above to below the 42.5 cut off point. Immediately after treatment, 62.5 % still had scores between 23.5 and 42.5 indicating partial recovery with ongoing general psychiatric problems, while a further 30% had scores below 23.5 indicating a full recovery.

In the sample of 16 clients followed up a further 6 months after completion of treatment using the 23.5 PENN cut off point, 69% of the sample had returned to

normal functioning with no indications of either PTSD or general psychiatric problems.

Taking the follow up sample of 16 clients and assessing their recovery with the CORE scale, immediately on completing treatment, the recovery rate from all indications of general psychiatric problems was 39% and 6 months after completion of treatment the recovery rate from all indications of general psychiatric problems was 69%.

This study would recommend the use of the additional 23.5 cut-off on the PENN scale to give a greater awareness of alternative and comorbid outcomes of trauma and bring greater clarity to the recovery process. The study would also commend the 42.5 cut-off on the PENN scale as a more rigorous value to distinguish between PTSD and other psychiatric conditions. Any client scoring between 35 and 42.5 on the PENN scale should then be considered borderline and have their PTSD status assessed by a second method.

Correspondingly, any client in general counselling practice with a presenting CORE score above 2.12 (PENN 42.5) should be checked to exclude the possibility of PTSD.

**4.2.5—Completion of Treatment**

Improvement during treatment was significant and substantial, but some clients improved more than others, and some clients had such high pre-treatment scores that despite major improvement they still had some way to go after treatment. But treatment was not limited by time or set programme that was followed, and which came to a specific end or exit point. A significant correlation was found at $p < 0.01$ between the initial PENN score and the number of sessions the clients took to reach the point where they felt ready to cope on their own. It was observed that those who had been bullied took on average 40% more sessions (mean 8.5) to reach this point than those who had suffered a single traumatic victimisation (mean 6 sessions), but this difference was not significant. The sessions averaged about 1 x1 hour session a fortnight, but sessions would have been weekly to start with and then spaced out to

fortnightly and monthly towards the end as the clients became more stabilised, so they were already beginning to manage on their own for longer periods of time as the counselling progressed. The counsellor's observation was that both groups of victims needed critical incident debriefing, goal setting and action planning, but those who had been bullied often needed more work on cognitive restructuring, rebuilding of self esteem and assertiveness, which probably accounted for the longer time they spent in counselling.

When the clients decided to end the regular counselling sessions, to complete treatment, they felt confident enough that they had learnt or regained enough strategies to be able to manage. The counsellor did concur with their self assessments and agreed that they were ready to try, that this would be beneficial for them as part of their ongoing recovery process, and that it was safe for them to do so.

They were offered open door and open line support and could make contact or return to counselling anytime they needed. When following up clients later, an important factor they reported in balancing their desire to make it on their own and feeling safe to do so was the counsellor saying they could contact by phone for support anytime they felt they were not coping and could return to counselling. They referred to this as their lifeline, but none of them actually used it during the study period.

On the face value of objective CORE statistics alone, a considerable proportion of the clients, despite significant improvement, would not appear to have been ready to complete treatment and might even be considered treatment failures. CORE is an outcome audit tool that is being introduced into a number of counselling services for service evaluation and inter-service benchmarking. It works strictly on the statistical determination of Reliable and Clinically Significant Change and does not make any allowance for value added or the type of clientele using different services.

Had it not been for the inclusion of the 6 month follow up study or the inclusion of the PENN Inventory, the counselling outcomes for these 51 clients assessed only by CORE might not have been rated highly.

### 4.2.6—Post Treatment Improvement

The follow up study of a sample of 16 clients six months after completion of their treatment found that 10 (62.5%) of them continued to make reliable improvement after completion of their treatment. Even two-thirds of clients who had not achieved either reliable change or clinically significant change during initial treatment continued improvement and attained clinically significant change during the 6 months after treatment. As a result, six months after completing treatment, 69% of clients were found to have made full recovery on both the PENN and CORE scales.

These 10 ongoing improvers made almost as much improvement on their own in the 6 months after counselling as they did during the mean of 15 weeks spent in treatment. To put this in context it must be remembered that the clients had typically been symptomatic with a severe psychiatric condition, PTSD, which was not remitting, for 4 to 5 months before the counselling intervention. The treatment was clearly catalytic in bringing about their recovery, but their improvement continued after completion of treatment.

This ongoing recovery confirms that, in most cases, the clients' sense of readiness to complete counselling and to manage on their own was accurate.

### 4.2.7--Non-Improvers

In the 6 month follow up sample, five (31%) of the 16 clients had continuing problems, four of these five clients, 25% of the follow up sample, had not made further reliable improvement after their initial treatment and remained in the general psychiatric group. The only distinguishing feature between the ones who had not improved and those who had was that the non-improvers tended to have above average pre-treatment CORE scores: above 2.5, while the average pre treatment CORE score for all clients was 2.42. Also regardless of how well they may have improved during treatment on the PENN or CORE scales, they seemed to have had more difficulty continuing or maintaining the momentum of their improvement after treatment on their own. The non-improving clients may have over estimated their

readiness and ability to make it on their own, yet they seemed content to continue managing on their own and not return for further help. This may reflect a lower willingness to receive care and support from others, and they may not have transferred from the counselling support to their own support systems but literally were trying to make it on their own. They were all back at work indicating a reasonable level of functioning.

An alternate view of non-ongoing recovery might be that underlying personality traits such as trait Neuroticism, which is associated with victimisation in bullying (Connolly & O'Moore, in press), would be unlikely to change in response to such a brief course of counselling but may be contributing to the client's responses to the questionnaires resulting in an ongoing raised scores for some of the clients.

Their responses to individual items on the PENN and CORE scales were mixed: some items improved after treatment, but some got worse, including trauma symptoms such as flashbacks and hyperarousal. Notably, they were reporting worsening in their functioning in close relationships, greater discomfort and irritability when with others, and not being able to experience warmth and enjoyment with others. They had a growing sense of isolation and unhappiness. By contrast the ongoing improvers report much better, and even an enhanced, sense of feeling supported and feeling warmth and affection from others compared to the control group, suggesting that the quality of support systems such as counselling or the client's personal support systems after counselling are associated with ongoing recovery.

The 6 month assessment was not an interview but was based on self report by the PENN and CORE scales; none of the non-improvers returned to counselling during the study period, so the counsellor had no opportunity to verify the underlying causes of their stalled improvement.

One useful factor to be used in future for assessing the client's readiness to leave treatment, and a possible area to work on within the counselling, would be helping clients to re-build and use their personal support systems, and recognising those with greater difficulty in that area. The findings also indicate some clients may need a

more proactive follow up and not just the open door option.

These individuals however are currently content to continue coping on their own, and it will only be from a more longitudinal perspective that their recovery can be evaluated. Working with nurses who have experienced various kinds of workplace victimisation is a central part of the service and, in the light of what this study has shown, all the clients in the study will be followed up on a more extended basis and follow up assessment will be expanded to cover all clients using the service.

One further client (3.5%) in the follow up study was still in the PTSD zone after initial treatment and had not progressed any further in the 6 months after treatment and remained in the PTSD zone.

One final client (3.5%), having made reliable and clinically significant change during treatment, developed a new profile of PTSD symptoms and returned to the PTSD group. This last situation was complicated: the client was on suspension and was still going through formal investigations and appeared to have been re-traumatised by further events in this process.

**4.2.8—Ongoing Improvers**

Taking a closer look at the 10 (62.5%) ongoing improvers in the follow up sample of 16, it was found that they attained 53% of their overall improvement during treatment and 47% after treatment. Because of the strength of this ongoing improvement, it cannot be certain that it is yet complete even at 6 months. However the fact the clients are now in the normal population range would likely reduce the scope or probability for further improvement. The six month follow up will be referred to below as final improvement.

Some aspects of their condition improved more than others during treatment: Well Being (CORE subscale W) only attained 45% of its final improvement during treatment, while Functioning (CORE subscale F) attained 62% of its final improvement during treatment. This suggests that the counselling has most direct impact on functioning, which includes coping and problem management.

When choosing to complete counselling, about two-thirds of clients still had problems as indicated by their PENN and CORE, but through conscious work and effort they were able to function normally, engage their situation and cope with the troubling thoughts, feelings and symptoms. These were far less threatening because they understood them, even though the anxiety and panic sensations were unpleasant. They could be described as consciously competent; they could manage but had to work hard at it. As they continued to gain mastery, new ways of coping became more second nature and unconscious; they felt more in control, could put problems to the side; they felt better about themselves, happier and more optimistic about the future, and their sense of well being was regained. Some problems such as aches and pains and sleep problems did not make their main improvement until into the follow up phase.

The CORE Handbook (1998a) suggests a phased response to psychotherapy of first Well Being, then Symptoms and finally Functioning, corresponding to the main subscales in the CORE test. But this study found the order of recovery during treatment to be Functioning (62%), then Symptoms (52%), and then Well Being (45%). This may have been because of the particular disorder the clients had, but it may also be due to the counselling model used with the clients, which was cognitive and behavioural and focused on functioning. The study referred to in the CORE Handbook and cited above used a psychodynamic therapeutic approach.

Even among these ongoing improvers, and despite their better performance than the control group on many items, the results indicated that they still had more problems than the controls in a number of areas, including unwanted thoughts, feelings, memories or images of the workplace events. Some were reporting, on a weekly basis, problems with being prevented from doing things through anxiety or tension, as well as self blame, thinking they would be better off dead, and other depression-related problems. Some were also having occasional difficulty with anger towards others and threatening or intimidating others. In addition, there is also strong

circumstantial evidence of avoidance behaviour with 10 of 24 bullied victims leaving their present post or even nursing, perhaps in an effort to manage the situation and to prevent uncomfortable memories being triggered. Those falsely accused, by comparison, did not usually leave their post. Maintaining balance is still on occasions a very active, conscious, deliberate process, and the client's apparent good functioning and calm composure should not be confused with the easy functioning and relaxed composure of someone with no problems and no history.

The results from the study are reassuring in that the important key issues for the clients are being addressed and dealt with. The strength of the overall mean reduction on the PENN and CORE scales of 50 - 55% is good. On an individual basis, the PTSD recovery rate of 92.1% compares favourably with other studies. The full recovery rate at follow up by PENN and CORE of 69% is good in the light of the severely clinical state of many clients before treatment. Unfortunately, there are no therapeutic studies of PTSD clients and CBC treatment where improvements in general psychiatric problems were also studied.

Recovery statistics may be important to researchers but they need to be put in a human context and what was equally important for the clients in this study was the speed of recovery. The clients had full symptoms for up to 4 months before treatment, were counselled for 3 - 4 months, completing treatment at 7-8 months after the incident and followed up 13-14 months after incident. This meant that most were sufficiently recovered to return to work within the crucial 12 month sick leave cut-off, keeping the person in their job. Within the professional setting of this study, this speed of recovery to normal functioning is an important component of treatment. Both the proportion who recover and the speed of that recovery are important factors in assessing any treatment.

Using purely CORE exit statistics, the effectiveness of the client's treatment might be questioned, but using PENN which is specific for the client's condition of PTSD, the

outcomes compare very well to other published studies. The high rate of ongoing recovery after treatment identified in this study is very encouraging from a counsellor's perspective, but it raises a question for counselling service management of when to measure outcome. A service or counsellor who keeps a client coming back for check ups before administering the CORE on final discharge would have higher CORE outcomes, being credited with more of this ongoing improvement, than this service, where the client is released early with the lifeline offer of open door return and telephone support. This is a good example of the types of subjective decisions which must be made regarding the application of an assessment tool and which can affect its findings and also shows that quantitative assessment must not be assumed to be wholly objective.

Outcome audit needs to take a wider perspective than just 'in treatment recovery'. Even during the treatment period, a significant part of the recovery is self recovery and takes place between the counselling sessions--the counselling facilitating, directing and catalysing that recovery. It is therefore short sighted to assume recovery and the impact or benefit of counselling is finished on completion of the counselling-guided phase of recovery. Exit audit may be biased against short-term-focused counselling, and the generality of some audit tools to cover so many conditions may make them ineffective in recognising specialist treatments for specific conditions. Perhaps some diagnostic tools such as the PENN Inventory need to be refined, as in this study, to assess stages of recovery, as well as being used to make initial assessment of disorder. In addition, outcome audit tools such as CORE need to be refined further for use in longitudinal follow up studies.

### 4.2.9—The CORE

CORE is a relatively new scale but is being marketed for a particular niche in the counselling and psychotherapy sector, where there is a need for a common outcome audit tool. So far its only application seems to have been measuring outcomes and benchmarking between services. This study is one of the first to compare CORE's

performance against another established psychometric tool or to use it in a follow up study as opposed to a treatment exit assessment. CORE is worth using for longitudinal follow up, but its single balance of probabilities cut off is probably too simple to study ongoing improvement and to distinguish between an individual who is static but fully recovered, and one static and stuck in their recovery process. Additional cut-offs and markers need to be put on the scale, because of the large overlap between the clinical and non-clinical distributions. This study has proposed a CORE Four Zone Model by introducing 95% confidence limits on the scale (see Section 3.4.9).

The CORE System was useful in this study, but it does need some improvements, most importantly a complete re-evaluation and re-calibration of its normal and clinical control group distributions. The recent RCN Working Well Survey (RCN 2002) found the mean for a sample of 4049 nurses significantly lower than the CORE's female population mean, which was based on a mainly student sample. Yet most reports such as the Sheffield Study (Borrill et al 1996) consistently find nurses have significantly more general psychiatric problems than the general population, which raises serious concerns. The implication would be that the true non-clinical female population mean lies below the nursing mean of 0.64 and not above it, as the CORE Systems non-clinical female 'student' population mean of 0.81 does.

The other major change needed is a revision of the Risk subscale, there are two subscales within it: Risk to self and Risk to others. With the clients in this study, risk to self and risk to others were found to be either mutually exclusive or shifted reciprocally to each other, as one went up the other went down. The averaging of these two minor scales in the one Risk subscale reduces the definition and clarity of both components and a blending of results.

### 4.2.10—Symptoms Profile

The preceding statistics are just one way of looking at recovery, but recovery is a story that can be told in different ways and different language. Counselling is often

about retelling stories, not changing the material facts, but approaching them in a different way, seeing them in a new light, making different connections, and assigning new meaning. This study is not just about changes in group means or percentages recovering, but about 51 individuals who are struggling to deal with various forms of victimisation in the workplace, being overwhelmed by the experience, and their journey to recovery, a journey on which the author was privileged to join them for a time and on which they entrusted to the author their story.

As we consider the responses these people made to the 60 items from the PENN and CORE scales a very clear picture emerges of their experience of being overwhelmed and traumatised. From the results, it would appear that, despite different stories leading up to the different types of critical event, the experience of PTSD is remarkably similar whether it is caused by bullying or being falsely accused.

Before treatment, the 36 clients in phase II of the study had significantly higher scores than the controls on all 60 items from the PENN and CORE scales. Some of the differences were small with only a proportion of clients reporting one to two grades higher on the rating scale. Other differences were large with nearly all clients reporting two to four grades higher on the rating scales.

The PENN and CORE scales specifically ask for experiences in the last week. Some enquire about frequency with words such as 'rarely' and 'all the time'. Others have an intensity dimension, such as PENN Item 1, from 'I don't feel different from other people' to 'I feel so alien to most other people my age that I stay away from all of them at all costs'.

To have scored above the clinical threshold on the CORE or PENN scales as all these clients did before treatment, some markedly higher, they need to be experiencing multiple symptoms, of high frequency and great intensity in a one week reference period.

The clients have the typical profile of PTSD with disturbance by intrusive thoughts, images and feelings, with increased arousal, alert and indications of avoidant

behaviour. As a result, they do not understand what is happening, they are down and easily upset, and their sensitivity to humiliation, shame and criticism appear to relate to the nature of the experience which traumatised them, a sensitisation to the sort of experiences they have been through. It could be suggested that these clients may have had a pre-existing low self esteem, neuroticism, and sensitivity to humiliation and criticism, explaining why they were traumatised by their victimisation. Differentiating between cause and effect when working with victims is difficult. Only a longitudinal prospective study would clarify if low self esteem and neuroticism not only contribute to victimisation but may also increase the risk of traumatisation.

The present study divided the 51 clients, for whom there were PENN scores, into a borderline, a low, a moderate and a high severity symptom group based on the spread of their PENN scores from the mean of the pre-treatment group. When the symptom profiles of the four groups were compared, it was noted that some symptoms were common across the groups showing a modest increase as the underlying severity of the PTSD increased. Some symptoms were less common and less intense in the low severity cases, but increased rapidly across the groups and became prominent characteristic features of the more severe cases. Feeling different, intrusive thoughts and flashbacks were the most prominent characteristics of the more severe cases, but in low severity cases, they were of comparatively low intensity and frequency compared to items of general confusion, distraction, difficulties in moving towards goals and some symptoms of increased arousal. This would suggest that the profile of symptoms in a client with a PENN score of 37 might be different and certainly less characteristic of classic PTSD than the symptom profile of a client with a score of 60. Low severity PTSD cases appear to exhibit a broad general disorder across a wide range of items making it difficult to distinguish easily from other conditions such as anxiety or depression. High severity cases show a moderate increase in general disorder but with very prominent features of PTSD. It must be remembered that the term low or mild refers only to their PTSD condition. These clients all have CORE

scores above 1.7 indicating serious clinical psychiatric problems.
Some of the clients in this study who scored in this region had only recently been traumatised, and had come for counselling about 2 weeks after the incident and went on within the counselling to develop more severe symptoms. Their low initial score was because they had not yet developed their full symptom profile.
Other clients scoring in this region had been symptomatic for a long time, in some cases over a year, and had previously been experiencing more severe symptoms which had reduced in intensity by the time they came for counselling but were not going away. It would appear that in order not to miss early PTSD, recovering PTSD, or chronic PTSD, it is important to get a wider perspective of the client's story.

**Change in Symptom Profile Following Treatment**

After counselling, the statistics (see section 4.2.4) showed improvement in response to treatment. The PENN and CORE items which made most change during treatment were the items whose intensity and frequency were most strongly reported by the clients before treatment. This indicates that the counselling not only dealt with the PTSD symptoms in 92% of cases, but it also addressed the wider range of the client's key presenting issues and made most progress in the areas which the clients had indicated were giving them most difficulty. This significant and substantial improvement in the client's main symptoms again confirms that the therapy is effective and that traumatisation by workplace victimisation, the issue on which the therapy focused, is the appropriate diagnostic assessment.

The clients reported significant improvements in

- Arousal: they were less jumpy and on edge; they were less troubled by tension and anxiety or sleep disturbance; they were able to concentrate better and focus more;
- Intrusion: they were less disturbed by unwanted images, thoughts and feelings, and more able to handle these when they occurred; and better at managing panic;

- Avoidance: they felt less isolated and were more able to find enjoyment in others company;
- Other Symptoms: they felt more in control and on top of their problems; they were happier and less despairing or emotional, feeling more OK about themselves; they had less feelings of humiliation or shame.

The clients made very good improvement in their PTSD symptoms and were generally more positive and feeling more in control of their lives.

However, improvement and recovery are not the same--recovery needs to be measured against some relevant comparative group. When the clients' responses after treatment were compared to those of the nurses in the PENN and CORE control groups, it emerged that on some items they were not doing as well as the controls, but on other items they were showing enhanced performance relative to the controls. When these were analysed, on 20 of 26 PENN items the clients post-treatment scores were found to show no significant difference from the control group.

They were still struggling with intrusive bad memories and flashbacks of their recent workplace experience, and the persistence of these still kept them feeling a little bit different from others. These clients were choosing to complete counselling in spite of these ongoing problems. The difference from before counselling was that they now understood what was happening; they learned how to manage these symptoms and they improved their cognitive functioning and were less confused, disorientated or distracted. They felt able to cope on their own. They were not symptom free but in keeping with the educative orientation of Cognitive Behavioural Counselling, they took on the management of their own symptoms which were significantly reduced and were continuing to decline. There is a sense in which they were now normal people with an illness which they were learning to live with, instead of the illness totally assuming and consuming their identity as it had when they came for counselling.

The counsellor could therefore end treatment. Over the next 6 months 62.5% of the clients continued to make as much improvement on their own as during the treatment.

Homework is an important component of CBC, and they continued what they had learnt, at home, without the counsellor.

A slightly less positive reason which may contribute to the ending of counselling might be that, with their symptoms generally reduced, having to talk about their experiences and symptoms in counselling may have become more distressing than normal life, where they were now able to block most things out and get on with it. There is a decreasing cost (pain) benefit for the client in continuing treatment.

When the clients' post-treatment CORE scores were compared to controls, the clients showed no significant difference on only 9 items. Most of these items were connected to the Risk scale. On 24 items, the clients still had significantly ($p = <0.05$) higher scores. The strongest of these continuing problems were around PTSD symptoms of intrusive thoughts and images, difficulties putting problems aside, feeling overwhelmed by problems, heightened arousal, feeling isolated, general tension, fears or anxiety, not feeling able to cope and not being optimistic. It is not surprising that the clients still have not fully recovered on these items since they were among the highest scoring items before treatment.

The clients are not symptom free but have a continuing sub-syndromal PTSD; they are however no risk to themselves or others. They have a wide spread of other more general symptoms, but the mean difference from controls is small, under one grade on the rating scale. With no other major or specific outstanding issue to work on, it would be difficult to see how extending their treatment would bring any additional benefit. In fact, holding them on too long when they want to step out on their own may undermine their growing self confidence through indicating some lack of trust in them on the part of the counsellor.

On one single item on both the PENN and the CORE scale, the clients after treatment also showed an enhanced performance compared to controls: PENN item 3 and CORE item 3, which refer to enjoyment in being with others and having someone to turn to for support when needed. Taken together, these would seem to indicate an enhanced ability to connect with at least one other significant person in a two-way

relationship involving support and enjoyment. To have a normal level of this would seem very positive but to report a significantly higher degree of this than controls is not so easy to explain. One explanation might be that in the light of their traumatic experience, they have re-evaluated their priorities in life and are less work focused and learning to appreciate relationships and a life apart from work. Traumas do cause people to re-evaluate their priorities.

So with a better understanding of their condition, an improved sense of control, and a growing sense of connectedness, the clients feel ready to step out on their own.

**Ongoing Symptom Recovery**

A sample of 16 clients was followed up 6 months after completing treatment. 10 clients were identified, representing 62.5% of the sample, who made strong ongoing improvement. The CORE scale showed these10 clients improving almost as much, averaging 47% of their total, after completing treatment as they did during treatment. As a wrap up to the Symptoms section, the symptoms of these 10 ongoing improvers will be examined, and their final CORE scores compared to the control group.

On 27 of the 34 CORE items the 10 clients reported better, more pro-functional results than the control group at the six month follow up. This better performance was significant for 6 items ($p = <0.05$). One of these items was CORE item 3, discussed above, refers to feeling one has someone to turn to for support. A second item was CORE item 19, which had an enhanced score on completion of treatment but now is significant, referring to feeling warmth and affection for others. This confirms that they are sharing warm and supportive relationships with others. This is very reassuring for the author, because it was not clear when the clients completed their questionnaires at the end of counselling whether the positive statements the clients made then about sharing enjoyment and supportive relationships referred to the author or their own personal support systems. After 6 months with no contact with the author, these responses clearly refer to personal support systems. The other 4 items in

## 4.3—PTSD AND WORKPLACE VICTIMISATION

In this section, the discussion will focus on PTSD and workplace victimisation. As has been previously mentioned, the symptoms profiles of the 51 clients seemed to be classic PTSD, but, because not all the symptom criteria of DSM-IV are fulfilled, the clients are left with no way of identifying what has happened to them and no common concept or understanding of the kinds of symptoms they are experiencing. The greater community of employers, colleagues, family, and friends are similarly left with no explanation of these symptoms and are prone to dismiss them in an accusing or, at best, unhelpful manner. For this reason this study is pushing for a wider definition of PTSD, which would include workplace victimisation as a criterion.

### 4.3.1—The Event

If the 51 clients in the present study had an anxiety disorder or depression, then the diagnosis of their condition would depend on their symptoms alone. Based on their symptoms alone, the 51 clients in this study would be assessed as having PTSD. However, PTSD and Acute Stress Disorder are unique in that they have a non-symptom criterion in their DSM-IV diagnostic requirements.

This non-symptom criterion is that the person must have been exposed to a particular type of event, involving actual or threatened death or serious injury, or a threat to the physical integrity of self or others. Clearly such an event would be traumatic, in that it would be capable of causing an injury or deep emotional disturbance, which is the definition of a trauma. However, this is not an illustrative list of examples of the types of events that might be considered traumatic, but is a definitive list. There must be a dimension of physical threat in the event for it to be considered a trauma or capable of having a traumatic effect. Some childhood bullying could, if serious enough, meet this description; some forms violent bullying in the workplace could meet this description. But purely relational adult workplace bullying is a very sophisticated strategy which usually has no dimension of actual or threatened physical violence.

Whilst the word trauma signifies a physical wound or a deep emotional disturbance,

the official diagnostic criteria set out in the Diagnostic and Statistical Manual of Mental Disorders, Edition 4, (DSM-IV) (APA 1994) will only recognise an event as a trauma if it involves a physical component. Fundamentally, PTSD is an emotional or psychological wound, but its official definition only recognises physical means of wounding and not psychological means of wounding.

During the study the author has referred to clients having PTSD-like symptoms and meeting DSM-IV criteria B to F, recognising that the 51 clients in the study would have difficulty meeting Criterion A part 1 as it is currently worded and conceptualised in DSM-IV. But if a person's condition is not PTSD, there is no other disorder to describe their event focused, intrusive, avoidant and hyperarousal symptoms. They have not been physically threatened; the bullying and unfair discipline is not physical. Without a PTSD assessment, the clients are denied a common conceptualisation of their experience and are left as a random group of individuals with various mental health problems. Depending on other comorbid conditions and individual expressions of the condition, they might fulfill the diagnostic criteria for anxiety or depression or phobia or panic attacks or substance abuse or paranoia or a combination of these. Yet any one of these descriptions would only capture a subset of their total symptoms. The description that best matches the totality of their experience is PTSD.
The best name for the condition of the victims of bullying would be Prolonged Duress Stress Disorder (Scott & Stradlings1992), but this is not a recognised psychological disorder. If the victims of bullying were labelled as having Prolonged Duress Stress Disorder, those who experienced a single traumatic victimisation would not fit that description, and would require yet another label. This debate over names seems absurd. After in depth counselling and psychometric testing of victims, the author of the present study could find no fundamental difference in the psychological symptoms of either type of victim. Their condition is basically the same whatever it is called. Furthermore, from the author's past experience working with more classic trauma victims with a full clinical diagnosis of PTSD, there were no obvious observed

differences in symptoms between the clients in this study and classical cases of clinical PTSD. This however is the author's subjective impression. There was neither historical psychometric data available to verify this nor a clinical PTSD control group in the study.

A few minor differences were noted between victims of bullying and single traumatic victims. The author observed that some victims of bullying required more work on building self esteem, in addition to their trauma work. This may be an additional effect of the bullying apart from the PTSD, where prolonged criticism has created more negative and dysfunctional patterns of thinking and more negative concepts of themselves. Single traumatic victims were not subjected to the same mean period of 17 months of mental abuse experienced by the victims of bullying. The only objectively measured significant differences ($p = <0.05$) between victims of bullying and single traumatic victims was that single traumatic victims reported slightly more problems with flashbacks before treatment, and victims of bullying were reporting slightly more problems with self blame and feeling different after treatment. These differences were small and only identified on statistical analysis of the psychometric instruments: they were not observed during the counselling. This would suggest that the author's observations only pick up strong differences between groups, and the author's observed differences or non-differences between clients in this study and those with more classical causes of clinical PTSD should be interpreted in that light. These more subtle differences are probably related to the victim's event experiences, single traumatic victims have a more focused, sudden and intense event to be the focus of specific flashbacks. The raised feelings of self blame or feeling different from others have some resemblance to the wider PTSD-like symptom profile found in Diseases of Extreme Stress Not Otherwise Specified (DESNOS) (Herman 1993) or Associated Symtoms of PTSD (APA 1994). These are more common in situations of prolonged trauma such as abuse rather than short traumas.

Each of these observations, although small in itself adds increasing weight to the client's workplace experience of victimisation being the cause of their event-focused

PTSD-like disorder.

Having a diagnosis of clinical PTSD is important. Without it, the clients would be seen as having a stress exacerbated mental health problem which was probably there in the first case and was probably a major contributory factor to any problems they were encountering in work. Since mental health problems such as anxiety and depression are high in the community, the client's condition could more easily be attributed to non-work related sources. To be assessed with an event-focused psychological injury such as PTSD, which can be more specifically placed in terms of time and location and which is an uncommon condition in the general community, would be very useful in establishing a case for compensation for injuries and highlighting the psychological hazard of victimisation.

A PTSD diagnosis would mean they have been injured by a specific circumstance which their employer's duty of care should not have allowed to arise, but without a PTSD diagnosis they might be seen as mentally weak.

Rather than considering the intense fear, helplessness or horror as a reaction to an event, it might be more appropriate to consider it as an event, an internal, emotional and psychological event. It is no less a real event for being internal and psychological or for lacking a physical form; in fact, it has a physical representation in the body and the brain's chemistry and physiology. The experience of intense overwhelming fear, helplessness or terror would be the core event or pathway that leads to PTSD. This would more easily accommodate the idea that a number of different triggers could activate it. These could be a classic threat to life or a more everyday event in a sensitised person, or the last straw in a series of bullying which has systematically undermined the person's emotional and psychological coping ability and threatened their mental integrity rather than their physical integrity. Other forms of emotional or psychological abuse which can cause such an internal event and go on to produce PTSD would then find recognition, including bullying, solitary confinement, false imprisonment or rough justice.

### 4.3.2—Threat to Mental Integrity

An understanding of the traumatising effect of the experience of intense fear, helplessness or horror in the absence of a physical threat might have led to a quite different conceptualisation of Criterion A and PTSD in general, but this was not the case, and any change now will not make a difference for the 51 clients in this study. But if adult workplace bullying and its threat to mental integrity can be recognised as causing an effect identical to that caused by a threat to physical integrity, and be legitimised as a field of trauma study and research, it may contribute to the revisionist thinking about PTSD that has been generated by recent neurochemical and neurophysiological research.

When the physically violent behavioural form of abusive expression is curbed by norms and rules, as is the case in the workplace, other means of expression using verbal, mental or emotional cruelty are found which are just as damaging, and often much harder to monitor. Yet society seems to regard these as a less serious problem and has a less developed concept of the damaging effect of such psychological abuse.

### 4.3.3--Removing Criterion A1 for PTSD

If A1 criterion was removed from DSM-1V then definitions would certainly describe accurately the internal experience of the clients in repeated systematic bullying situations. They would similarly describe the internal experiences of someone finding themselves suddenly accused of a serious offence they didn't do, but finding those around taking the accusation seriously and being put through investigation and escalating disciplinary procedures. Clients would meet all DSM-IV criteria A2 to F.

Political pressure for the recognition of PTSD may have shaped the rather restricted and exact wording of Criterion A1. Those who wrote it must have had a specific purpose for the radical step of introducing a non symptom diagnostic criterion. Many of the PTSD symptoms are common to other disorders which is not unusual for many

medical and psychiatric conditions. Those with disorders such as general anxiety disorder or depression, especially if combined together, could be mistaken for mild PTSD, if it were not for the requirement to have some sort of fairly severe event experience. It is also much easier to objectively verify if such an event has taken place than it is to determine if the client had an internal, A2 experience of intense fear, helplessness or horror. It is a simple tool which would be relatively effective in a large proportion of what would have been considered PTSD cases at the time the disorder was originally formulated. The association of the disorder with particular types of events also raised an awareness among clinicians to consider trauma as a possible condition in patients with a particular history.

The strong positive correlation between PTSD, as represented by the PENN score, and general psychiatric problems, as represented by the CORE score would suggest that those with PTSD have a basic foundation of general psychiatric problems plus the additional unique features of PTSD. When the PTSD features are mild, they may be masked by the more general problems, and only the history of a recent extreme event preceding onset of symptoms alerts to the possibility of traumatisation. Those with the most severe PTSD symptoms may in turn be mistaken for some of the less common disorders such as Borderline Personality Disorder BPD which shares some of the more unique features of PTSD. Again, the event associated with onset of symptoms helps distinguish between PTSD and BPD which will have been a more longstanding condition whose symptoms pre-existed the more recent extreme experience. The idea of some sort of event associated with onset of symptoms, therefore, is useful in both alerting to the possibility of a PTSD diagnosis and differentiating PTSD from some other disorders. To get rid of it would not be helpful: the main difficulty would seem to be the wording of the current event description, being solely focused on physical integrity.

The Helsinki Declaration 1983 on Biomedical Research, and those who campaign

against torture, link violations of physical and mental integrity together as one concept. The growing literature on humiliation as a cause of PTSD emphasises the effect of a non violent attack on the persona as traumatising (Lindner 2001). One can be mentally assaulted by being brainwashed, having one's will broken or being mentally tortured by solitary confinement. Why do we put people in solitary confinement for punishment or use sensory deprivation in interrogation if these are not powerful psychological weapons? Enforced isolation can cause more fear and terror than physical torture. Non violent relational bullying uses such techniques in sending people to Coventry, by ostracising them and by exclusion. Psychological violence is neither new nor rare, and there needs to be some accommodation of threat to mental integrity into the event description for PTSD.

### 4.3.4—The Importance of a PTSD Diagnosis

For the author it is important to validate the assessment made of the client's condition, and to demonstrate that the treatment approach being taken based on that conceptualisation is correct and appropriate for the present study clients and for those who will be seen in the future. Both a best practice approach needs to be adhered to as well as the delivery of a satisfactory outcome.

Strict application of DSM-IV diagnostic criteria for PTSD would not assess the 51 clients with PTSD within this study. If a test subject were to report that their husband has hit them several times when drunk, the counsellor could assess the client's condition as PTSD, say the PTSD was due to her husband's assault, and describe the workplace bullying as another form of bullying to which the client was having an associated response, and justify a trauma counselling approach. But if the client's only experiences were workplace bullying or false accusation in work, the counsellor could not strictly justify a PTSD assessment or a trauma counselling approach.

Yet the most obvious cause of their problems is their current workplace bullying or Single Traumatic Victimisation. The original concept of PTSD laid out in DSM-IV is being challenged (Yehuda 1999c, Bowman 1999). Many individual susceptibility

factors and individual sensitisation may result in particular individuals being traumatised by events other than disasters.

Most studies associate bullying with severe stress effects and comment on PTSD-like symptoms. This study will contribute to the laying of a research foundation for the connection between PTSD and non-physical triggering event like psychological bullying or serious false accusation.

A PTSD diagnosis is also important for the victims. Being recognised with a mental injury rather than a mental illness refutes allegations that subjects are at fault for not being able to work, and protects their reputation. It would buy them time in court action, justifying why they did not file a complaint immediately on the grounds of incapability to do so. With their symptoms, it is very difficult to instigate legal action within the normal time limits.

Currently the time limit on filing a complaint on sexual harassment, for example, is 3 months since the last incident.

A recognised work injury would also improve the employer's attitude to rehabilitating the clients. Some were good but not all, since early termination of their contracts would ultimately have to be paid for in a court settlement for lost earnings and most test subjects simply wanted to get back to work. They were not seeking compensation, but equally they didn't want penalised for something that was not their fault but the fault ultimately of their employer.

The discussion will now move on to look at some of the personality factors which contribute to bullying and victimisation, and then some of the forms the victimisation takes.

**4.3.5—Stress, Bullies, Victims and PTSD**

The dynamic Horney describes as hypercompetitiveness (see section 1.4.6) is a useful idea: it is a survival mode brought on by early life stress and low self esteem, and

could include subclinical antisocial or narcissistic behaviour and what is described as Machiavellianism. It also links in the victim role of compliance. We should not dismiss those who are apparently quiet and not actively competing. Horney (1945) described a third neurotic type, detached, which is just as much a game plan but aimed at never being influenced or obligated. We should then consider compliant, defiant, passive aggressive, deceptive or controlling behaviour all as survival power plays of hypercompetitiveness. Hypercompetitiveness is a non-violent system of abuse or neglect that self propagates itself in the form of hypercompetitive non-violent bullies and victims.

It is not so much their type that is important as the difference between them and those they engage with. A normal middle of the road person could find themselves being bullied by a very hypercompetitive person: the other person might fit Field's (1996) description of the sociopathic bully. Equally, a normal middle of the road person could easily walk all over a very compliant person, take them for granted, abuse their good nature and bully them. Or a normal person may become very frustrated by the defiant or passive aggressive response of someone and erupt.

The extreme archetypes are rare, but moderately hypercompetitive and moderately compliant people would be more common. The most common form of bullying then might be a situation where a well adjusted person with a moderate aggressive hypercompetitive trend engages with a well adjusted person with a moderate compliant or detached hypercompetitive trend, the key factor being the difference between them in approach. To an onlooker, what may appear to happen is someone who most people have no problem getting on with and someone most people see as quite capable and able to take care of themselves, suddenly get locked into psychological warfare. That would be a good description of some forms of adult workplace bullying and could even explain the targeting factor, why it only happens between certain people and to certain people.

In this study of bullying, it becomes clear that it is not one dynamic but an umbrella

term under which a number of different dynamics are gathered. The dynamic outlined above may be just one of them, but it has important implications. It suggests that bullies should also be considered vulnerable individuals who may themselves have an increased risk of traumatisation. In light of the findings in this study with respect to the traumatising affects of exaggerated accusation or excessive disciplinary procedures, it is vital that we develop alternate non-discipline approaches to resolving individual cases of bullying. Disciplinary procedures will nevertheless remain the final arbiter if mediation or conflict resolution approaches fail. But much greater care is needed in general investigation and disciplinary processes to treat those accused fairly and to minimise the stress caused by these processes.

**4.3.6--Understanding Bullies**

The desire to see bullying recognised as a cause of PTSD is to legitimise the experience of the clients and not to demonise bullies. The author is not in the camp of those who want to witch hunt or crucify the bully, and could not support them being sacked for being mentally ill. It could be argued that their own line manager is culpable in not adequately supervising them and noting what was going on.

Ever-growing numbers of children are being diagnosed with disorders such as Attention Deficit/Hyperactivity Disorder (ADHD): such people are undoubtedly to be found in the workforce and maybe labelled bullies. There is remarkably little written on the problems of working with mentally ill colleagues, those with mild sub-syndromal conditions or more recently recognised syndromes and the effect this has on colleagues. Also it might be pertinent to ask what happens if two such people with different or similar problems come to work together and how it affects each of them. Other bullies may be characterised as having what is referred to as an extreme personality; but there is a growing counter argument that those being labelled ADD or ADHD are simply a normal personality type, but one that does not fit in the traditional education approach: they may not learn best by sitting down listening to lessons.

The MBTI approach (Myers 1962, 1992 and 2000) does not consider any of its 16 personality profiles dysfunctional. Each brings a unique and complimentary approach to organising, prioritising, decision making and relating. They also each have particular needs in terms of the sort of situations they require to learn best and to perform best. Society and organisations need these people who might be considered different or even odd by those who do not share the same profile and have not learnt to appreciate diversity but expect everyone else to be like them. Most may philosophically assent to such an idea, but at a more practical level, the approach would be "But not in our team / organisation". One person's difference of approach may be disruptive and difficult for others to work with, and that may be part of what bullies or victims may find difficult in the other person.

The strong association between high stress environments and high incidence of bullying further suggests that factors outside the control of either the bully or the victim play a significant role and points more to what Field (1996) called situational bullies, normal people under extreme stress behaving in uncharacteristic ways. Nursing is a high stress profession but the present study found that clients who had experienced bullying worked in units (micro-environments) within the profession experiencing twice as many general stressors, such as change in manager, change in working practice, and excessive work demands, as those who experienced a single traumatic victimisation. Myers (1995) in reference to MBTI types suggest that people under stress at first become more rigid and inflexible in their personality type and under more extreme stress begin to behave uncharacteristically.

From the author's experience working with victims of workplace bullying and despite the distressing events which clients report have been done to them, the author's sensing is that the bullies in nursing are usually not Field's (1996) sociopaths but instead could be situational bullies or maybe over stretched managers.

Later the personality types of nurses will be examined. The personality type that makes someone a good nurse has a shadow side which may come out under extreme

stress and contribute to bullying. It is an inseparable part of the very thing that makes them a good nurse, the problem is the extremes stress they are sometimes put under. The causes and effects of bullying need to be better understood in order to see improvement in the prevention and management of its harmful effects.

In the next two sections, the dynamics of victimisation will be examined. Single traumatic victimisation will be discussed first. As it is not usually linked to bullying, some time will be spent examining the phenomenon and issues surrounding it, including the difficulties of including it in a definition of bullying and linking it to PTSD.

### 4.3.7—Single Traumatic Victimisations (STV)

During the pilot study it was recognised that there were two broad types of experiences among those selected for the study with PTSD like symptoms: bullying and a single incident of victimisation involving some sort of formal false accusation and consequential disciplinary action. The term Single Traumatic Victimisation (STV) was created in this study to describe the second of these, experienced by 15 (29%) of the 51 clients.

This study did not select its clients by first asking if they had been bullied and then going on to study those who were. It asked first if they had the symptoms of PTSD and whether its onset related to a workplace experience, and then went on to study those clients and their workplace experience. If the study had made a more upfront selection of victims of bullying based on criteria of repeated weekly or daily experiences over 6 months, these individuals might have been missed.

A single verbal threat of violence or the menace of violence through an extreme temper tantrum by a manager might be more generally accepted as bullying, rather than false accusation, and is presumably what some researchers are referring to as severe single incidents, but even these would be left outside the definition of bullying weekly to daily for 6 months proposed by some researchers. It is rare, in the author's experience of counselling, to hear of single acts in nursing where actual violence is

threatened or of single acts of intense anger which might have a menace of violence or might be feared could spill over into violence.

Because this is not a random incidence study and because, unlike with bullying, the general background incidence of unproven accusation in nursing is not known, the relative incidence of single traumatic victimisation to bullying cannot be determined. The sample is probably more representative of nurses on long term sick leave with a serious psychological disorder following a distressing incident or series of incidents in the workplace. On that basis it could be said that single traumatic victimisations are almost as common a cause of work-related PTSD as bullying.

Where attempts are being made to curb workplace bullying, there is a present danger of repeating mistakes from the past by defining workplace bullying too specifically and only addressing one particular form, the persistent repeated verbal insult and criticism form, rather than dealing with the real issue: the underlying dynamic of the abuse of power in the workplace. The fundamental abuse of power in bullying to control, subjugate, relegate or expel (forms of humiliation, Lindner 2001) can be seen as the underlying dynamic behind all forms of discrimination.

Under present discrimination legislation and corresponding company policies, a single clear act of racial or sexual prejudice or harassment may result in the offender being cautioned or worse, if the act is serious enough or repeated again. But in emerging definitions of bullying, the offence must be repeated or persistent, and frequencies of weekly to daily over 6 months are being considered necessary to call it bullying. That would translate as 24 to 125 acts of verbal criticism, insult or threats or acts of unjust treatment or exclusion. This is somewhat different to the position taken if such behaviour contained an implicit or explicit racial, religious or sexual component. Anti-bullying legislation based on such a definition of bullying would only address another facet of workplace discrimination, harassment and aggression and not the underlying dynamic of abuse of power.

However, an authoritative definition of bullying would be welcomed. In the absence of an authoritative definition of bullying and a very narrow concept and definition of PTSD which only recognises events with a component of threat to physical integrity, it is difficult to establish a causal link between bullying or STV and PTSD.

The MSF Union (MSF 1995c) definition of bullying does include unfair use of sanctions, but as part of an overall strategy of harassment against one individual not a one-off incident. Field (1996) describes a growing campaign of bullying escalating into a disciplinary action aimed at finally expelling the victim from the organisation, particularly when the victim stops absorbing the treatment and begins to challenge or make complaints about their treatment.

Single Traumatic Victimisation (STV) typically does not occur in such a context, yet is an attack on the person's reputation, on their occupational standing, and affects their health as bullying does. It puts the victim in the same position as bullying does: difficulty in defending themselves, eliciting the same feelings of upset, feeling threatened and vulnerable, having confidence undermined and experiencing stress. The effects of STV are like the effects of bullying, but the triggering experiences don't fit the description of bullying. This parallels the argument this author is also making in respect of PTSD, that the client's response to their experiences is identical to PTSD, but the description of their precipitating event does not match the classic definition of a traumatic event.

Thus a more fundamental rethinking of PTSD is necessary rather than simply expanding its definition to include bullying. If the PTSD criteria were simply expanded to include both a threat to one's physical integrity, and mental integrity through prolonged psychological abuse, an argument that has some justification, the single traumatic victims in the present study would still be left out. It would be difficult to argue such a case for single traumatic victims.

The only theme the author can find to bring bullying and STV together would be the concept of humiliation proposed by Lindner (2001); both are acts of humiliation, or bringing one low, and threatening one's standing or even continued existence in a

hierarchy.

Workplace bullying typically involves putting down, destroying reputation, stealing credit, blaming, over supervision, excluding, rendering powerless by attacking in front of others. STV could be seen as a humiliation process which involves false accusation, dismissal, suspension, a prejudicial attitude, a concerted effort to find fault or undermine standing and reputation, and excessive discipline for minor offences including down grading. In this case any revision of the concept of PTSD would need to recognise a threat to mental integrity and recognise that severe humiliation was a threat to mental integrity.

The incidents of Single Traumatic Victimisation (STV) mostly came without warning, although in 40% of cases there had been a few differences of opinion or frictions with the accuser before the incident, but the nature and intensity of this was different from a systematic campaign of bullying.

Through in depth counselling interviewing, it was established that these previous incidents were isolated, would not have been exceptional problems, and would be quite common events occurring among any group of people working together. In most cases where there had been some previous incident, the victim thought it was resolved and had no reason to believe the other person would hold any form of animosity against them or would have any reason to want to accuse them.

The main component of the traumatic incident was a formal allegation against the test subject, followed by the client's line or senior management with formal investigation and disciplinary procedures. Sometimes the line manager was both accuser and active agent in initiating the discipline, or someone else made the accusation and the line manager followed through. In some incidents, the line manager reported the individual to a more senior manager who then followed through on the disciplinary action. In most cases there was someone else involved, a manager, a senior manager or personnel officer, who should have brought some sort of check or balance to what was happening, but usually they followed through on the accusation without ensuring that everything had been properly processed and all the details double checked.

The allegations were very serious ones, these included incompetence, fraud, wilful misconduct and mistreatment of patients or other staff.

Those who believe they are behaving properly should have no fear of threats of disciplinary action. In fact, they should welcome that the matter is to be fairly arbitrated by an independent person, especially if there is some sort of dispute over something between a nurse and her manager. However, the fact that threats of disciplinary procedures are effectively used to control and intimidate shows that the disciplinary process is flawed, handing out random injustice with no penalty for those wasting the time of the disciplinary system by initiating unfounded cases.

The flawed process produced a great fear in the accused, making it difficult enough for them to explain themselves or tell their story, but often they were given no opportunity to sort out any misunderstandings, because management went straight into investigation and formal procedures. The experience was of things happening and decisions and actions being taken that directly and profoundly affected the client, but they had no control over it. They experienced shock, intense fear, helplessness and dread, all the DSM-IV Criterion A2 responses to the event.

Where bullying could be understood in terms of a mounting pressure and an eroding of self confidence, STV is a sudden catastrophic collapse of self confidence and functioning. The key event components are criticism, rejection and finding that others could so readily believe or think that the subject could do such a thing. The rejection and presumption of guilt was reinforced by 1 being dismissed on the spot and 7 (41%) being suspended pending enquiry.

Suspension or immediate dismissal immediately labelled them as unfit and cut them off from their primary support networks and friends in the workplace. Although they knew they were not guilty as charged, everything had gone against them and was beyond their power to stop so far, and so their expectations were that the findings would go against them too.

These situations are repeatedly referred to here as false accusations, inappropriate discipline and rough justice. This is not just the counsellor's perspective or the

client's claims. There were10 formal investigations among the 15 victims of STV; one of these was an industrial tribunal. In 7 (70%) of the 10 formal cases including the immediate dismissal case, the clients won their cases and were cleared. By any standards, that is a very poor success rate for those mounting formal enquiries and indicates an excessive and totally inappropriate use of disciplinary systems, especially since the management only has to prove their case on a balance of probabilities not beyond any reasonable doubt as in a court of law. Most cases should never have been processed this far.

In the other 3 formal investigations, one was downgraded, another was dismissed and the other left their post first because they felt they were going to be a scapegoat, to be made an example of for others.

Among the remaining 5 cases not formally investigated, 4 had informal investigations at unit level and 2 of these clients cleared their name and 2 received writtten or verbal warnings. The final client cleared their name without any sort of informal investigation but still had a PTSD reaction to the whole experience

In the formally and informally investigated cases which did find some fault with the accused, it is worth noting that what was considered proven against them was a much lesser case than what they had been originally accused of, often a quite minor technicality to save the face of those taking the action. The scale of the discipline given to them relative to the seriousness of what was actually proven was excessive in all cases, suggesting that the unproven serious allegation was allowed to unduly influence the determination of the penalty for the minor proven offence. This reinforces the view that one is marked from the time one is accused and that the system will punish you severely if they can find even one single fault, whether it is related to the original charge or not. None of these proven cases were on matters serious enough to merit reporting to the UKCC, in stark contrast to what they had originally been accused of. Therefore it can be stated that the original accusation was not upheld in any of the situations, with the possible exception of the one case that

was not completed because the client resigned first: this case was untested.
Despite the seriousness of the original charges being sufficient in themselves to investigate anyone on, these other minor accusations are usually added later in the process almost as a fall back option in case the original case cannot be proven.
The actual experiences of these 15 clients, with the justice system in nursing, explains why so many nurses fear the experience of formal investigation and why some may have such an adverse trauma response to the experience.

It was noted that there were three points in this accusation and investigation process at which the test subject may begin to show signs of traumatisation.

1. If the victim is brought into the manager's office and forcefully confronted with an accusation that they have done something and are perhaps immediately suspended, they may develop PTSD symptoms right away.
2. On the other hand if they are only informed that a complaint has been made and an investigation is going to take place, they are able to handle the situation more logically, hope that the system will sort it out, and usually do not have a trauma response at that point. But as they see the investigation develop and see the attitude or approach of those investigating, they may then lose confidence and develop PTSD.
3. The final point where traumatisation may occur is after having been cleared on the main charge they find themselves excessively disciplined on a minor point which they had not given much previous attention to because they did not see it as a significant problem in relation to the main accusation. It was a minor issue and so they thought it would be dealt with in a minor way.

The first type of traumatisation where the client is suddenly confronted and suspended or dismissed on the spot is like a classic trauma, sudden, unexpected, forceful confrontation and accusation. The third type of traumatisation is more like the final straw in bullying where a client, emotionally drained and exhausted by the process, is

finally taken off guard and overwhelmed and by an unexpected event of less seriousness.

The author found that most of the STV involved a denial of due process, a denial of natural justice, or a denial of human rights. If investigation begins to struggle to find substantive evidence, it tends to expand into an investigation of the person and all aspects of their work. If anyone had their work examined in great detail there is almost certainly some minor point that they could be faulted on, but they would not expect a serious punishment for a minor fault.

Such incidents are difficult to characterise. On the face of it, the case of nurse F (see section 3.9.3), accused of bullying and then found guilty of data protection mistakes, does not fit the emerging definitions of bullying, yet one would like to label it as institutionalised bullying. On first examination it would appear that the accuser is not acting as a bully apart from maintaining and backing up with either verbal repetition or statements, a malicious or offensive attack on the accused. Those taking the case forward are initially not acting as a bully but carrying out their duties of management to investigate and to protect the apparent victim (accuser).

However, when the investigation widens out into other areas and seeks to generally find fault rather than impartially investigate the complaint, a fine dividing line is crossed. What was appropriate scrutiny begins to become excessive scrutiny or excessive supervision, which is recognised as a strategy in bullying. The accuser claims fault in the accused, and the investigators begin to get drawn into finding fault instead of investigating a specific accusation. In this way they could be seen as possibly acting as supporters of the bully (accuser), inappropriately adding an extra dimension of aggression against the victim by treating them unjustly.

In the case of nurse F, the accuser had not been in the hospital very long, had come from some distance away and was unknown to the local staff. Subsequently they went on to another hospital and repeated a similar pattern of behaviour accusing a more senior colleague of bullying, and it was later found that they had previously made similar complaints about colleagues in other hospitals. They were a serial accuser.

There is another similarity in this case to bullying: the onlookers who witness what happened to nurse F are themselves victimised. They develop a very legitimate fear of the investigation and disciplinary procedures of their organisation, so that if they are ever in the position of being accused of something, they will feel they are presumed guilty, will feel helpless and will fear the worst possible outcome.

There needs to be an alternative to discipline for dealing with interpersonal and other workplace problems.

Disciplinary procedures with their strict rules are not appropriate to deal with many problems. For example, the nurse described in Section 3.9.4 was being bullied by their manager, who could take it no more and lost their cool and yelled at the manager. The manager reported them for yelling at them, but the disciplinary process only wanted to look at this yelling behaviour and would not take the bullying background and build-up to the incident into consideration.

The author works with many nurses who have had various complaints made against them, with and without trauma. They are usually all shocked, and most feel they have been falsely accused and cannot understand why such a complaint should be made. Through counselling, the author is usually able to help them identify aspects of their character and behaviour that may not be appreciated or understood by others. There can be genuine reasons for many complaints. Part of the counselling work is to help the person honestly and realistically explore the substance of any complaint made against them.

In the case of STV the event does not fit the definition of bullying, and the event would not on first examination fit the conceptualisation of a threat to mental integrity which could be used to explain how bullying might cause PTSD. The only explanation of these clients' PTSD would be in terms of either extreme sensitivity to high stress events or that the event had some powerful significance for the client. None of the clients had been through similar disciplinary procedures before which

might have sensitised them. Similarly neither they nor their families had had past histories of experiences with the police or legal processes.

This event would hold a very great significance for any nurse and be a very serious threat to their self identity. Nevertheless there has to be some other element of sensitisation to explain the client's extreme reaction to the event, sufficient to result in PTSD. Again Horney's compliant neurotics and their need for approval and extreme reaction to criticism or rejection seem to fit the situation, neuroticism being recognised as a risk factor for PTSD (Bowman 1999).

Horney's description of these compliant types sees them as liking to be controlled, a contained life within restricted borders, and being protected and guided. They seek approval through pleasing or serving others, are self effacing and submissive. If they have this overly sensitive and vigorous dysregulated stress hormone response, which Yehuda (1999c) and Teicher (2002) suggest exists in those susceptible to developing PTSD, they may select a lifestyle and career which is unlikely to trigger it too often. They will seek out work and social relationships which are stable, structured, methodical, maybe hierarchic where they know their place, clear rules, procedures and guidelines. They have a few close friends but not lots of friends and excitement. They regulate their reactive internal homeostasis by building themselves into a regulated world and environment. Nursing would certainly fit this description and seem an ideal career, so perhaps there are more of these types of people in nursing, explaining why this is being observed in this study and not being commented on anywhere else.

The author is not saying these clients are the extreme neurotic archetypes or fit the popular concept of a neurotic. They are socialised, adapted, balanced individuals. It is just that their balance is a little more easily destabilised under high stress situations. But particularly if the key element in maintaining their stability, their vocation, is under threat, this could be a very traumatic experience for them. This is a hypothetical idea trying to link together certain facts into a coherent story that gives meaning and sense to them, but, as in counselling, there may be another equally plausible story that

can be drawn around these details.

In summary, these 15 clients were confronted with an attack that was a serious threat to their continuing role and identity as a nurse. They became victims, powerless to protect themselves as evidenced by the failure of their explanations to avert formal proceedings. Their intense fear was heightened by the fact these allegations were being believed and backed by others in power and authority over them. The event clearly had special significance for the clients. They perceived it as a threat to their security, their relationships, their self esteem and their self actualisation or vocation. They experienced an extreme reaction of intense fear, helplessness and horror, because the central component to their identity and stability was under threat.
Those traumatised by STV may be a particular at risk group who may be disproportionately attracted to traditional, stable, regulated, procedure-driven careers such as nursing. They will be more easily disturbed by stress and will be more easily traumatised by extreme stressors.

**4.3.8—The Dynamics of Bullying**

The study identified 24 clients who had experienced a prolonged period of mainly verbal criticism and fault finding along with being left out, not informed of things to the last minute, or not being consulted about things that related to them and their work. In over 50% of situations, the clients would have said they had a good relationship with the significant other before this began.
There was usually no apparent reason for this period of harassment beginning or significant event in either the bully's or the victim's lives, apart from the 48% of situations in which the bullying line manager or colleague was a relatively new member to the team. Even in the case of new team members who went on to bully, the victims often reported getting on well with them at the start.
The first incidents did not particularly stand out and were some time ago, so it was difficult to identify whether they were totally unfounded or not. The victim usually

absorbed the impact and got on with their work a little surprised by the event and annoyed. The incidents typically started slowly and intermittently but gradually increased as the victim became aware that they were being watched, checked up on, disapproved of, not trusted, even if not always being actively criticised. Anxiety around their job performance grew, and they wondered if others were being asked about them. Their increasing sensitivity to others' looks or comments lead to a growing sense of isolation. Rising anxiety and concern began to affect their concentration, memory and focus, and lead to minor mistakes. Most of these mistakes they discovered themselves because nurses carry out a high degree of self monitoring and double checking, but there was great concern that these might have been noticed or noted for future reference. They were also concerned that they may not catch their own mistakes and someone else might find them.

Even simple mistakes like knocking something over but with no harm done became concerning. Although nothing was said to them at the time, there was no sense of closure that the incident was over and done with. There was the fear it might, and often was, brought up to reinforce a later criticism. The criticism was chiefly centred on their work performance and attitude but sometimes would become more personal.

The more sudden onset for Nurse B (see Section 3.9.4) was probably because a bullying regime was already well established in the unit, and she walked into the middle of it. But even then, although she was immediately exposed to a serious level of bullying, she did not recognise it as such and actually took it as being supportive. It was only when what seemed healthy support and close supervision failed to fade away, as it ought to with growing competence, that it became more unpleasant and began to deskill and diminish her self confidence. Even though she did not like it, she did not recognise what it was until others put in a complaint.

Often the person actually appears genuinely helpful, and then the nature of the interactions begins to change. The incidents become less helpful, and more intrusive and violating. There can be a similarity to what in child abuse is called grooming,

where an abuser first is nice and wins the trust and confidence of the victim, and then begins to change, gradually over stepping appropriate boundaries. The initial trust and apparent friendship holds the person there in the face of emerging treatment which they would otherwise have fled from if faced with it on the first day of the relationship. By the time the victim decides there is something not right, they are entrapped and cannot get away, feeling there is something wrong with them.

Incidents of bullying typically start slowly and insidiously. At first they seem hardly worth making a fuss about, but by the time the victim realises there is a recurring pattern, their confidence is so greatly reduced it is difficult to do anything about it. By over scrutinising and over supervising the bully has often either caught them out on some minor items or precipitated some mistake of concentration or memory. The victims genuinely believe that there must be some fault in them and fear making a fuss in case they are found out.

There is something about the person who bullies that creates great turmoil in the victim, a feeling of helplessness, and an inability to respond in their presence, especially when the bully is putting the victim's own behaviour and performance under scrutiny and criticism. The victim might be able to challenge them in other settings on a work related technical or philosophical point, but not when they themselves are the subject of debate. The bully always seems to be able to out flank them, wrong foot them, confuse them, strike and escape before they realised what was happening.

Because of the great discomfort and distress experienced by the victim during the incident, they did not want to go back and revisit the issues, even when they had gathered their thoughts and could refute or challenge what was said. The alternative was to absorb the emotional impact and get on in the hope that the other would stop. Sometimes in the confusion of the incident they may have said things that made matters worse, digging a bigger hole, and feared that happening again.

However from the bully's perspective, not to be challenged on their assessment of the

item of criticism and to get no adequate explanation, only confusing and even incriminating responses, simply reinforces their negative opinion of the victim. The effect is to increase all their suspicions and grounds for over supervising, watching, pointing out even small things in case they escalate. The victim's non-response increases the likelihood of the bullying behaviour being repeated, not reduced. The repeating of the bullying increases the likelihood of the victim's confidence, self esteem and performance being diminished, and the cycle repeats itself.

If the new boss in the first week took an instant dislike to them, criticised them, took away responsibilities, made major changes without involving them, then blamed them when things didn't work, threatened them with discipline for not achieving impossible tasks, ostracised them, and on Friday started formal procedures to dismiss them, their reaction would not be to just put up with it and get on with their work. Instead it took place over a mean of 17 months for 24 bullied clients in this study and, although by the end of that time it was happening every day, they had lost the ability to react until something in the last straw critical incident caused them to react, something happens which destabilises this domination and that is the point where they are traumatised and develop PTSD.

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Work place bullying in nursing creates an unusual situation of psychological warfare where the subject is physically safe but every other part of their being is threatened and destroyed a bit at a time. There is the additional element similar to some forms of child abuse of dependency on the abuser, since a bully in an authority position represents the employer and provider of salary and position and of grace, favour, good off duty, easier jobs. This creates very mixed and conflicting emotions. The typical critical incident was some clear but minor injustice which in the victim's mind represented all the wrong that has been done to them and became the focus of all the emotional distress from the events that have gone before. It is an event that was very significant for the test subject but, looked at on its own and objectively, would not

appear that extreme to others.

However in 8 (33%) of bullying cases, there was an escalation in the exclusion strategy towards the end with an attempt to use disciplinary procedures to get rid of the victim or prepare grounds for getting rid of them. This attempt at disciplinary action was the critical incident in these cases.

Bullying comes in many forms and patterns, some very crude and blatant, some extremely sophisticated, some maintains the victim in a trapped state over many years, some builds towards expulsion of the person from the workplace. It is an umbrella term covering many behaviours, which in turn are expressions of many underlying psychologies.

One aspect of the psychology of bullies and victims is the concept of transference which may explain why some of the responses in these situations seem almost predictable and are so difficult to change. This will be taken up in the next section.

### 4.3.9--Transference

Through extensive interviewing, some of the author's clients who were bullied came to realise one of the reasons they felt inhibited in responding appropriately when the other person started to over step what was appropriate was that the other person intimidated them, intimidated in the sense they reminded the victim of someone who previously had a dominant influence over them. The client almost stepped back into that previous role and relationship.

From a counsellors' perspective this is a classic example of what would be called a transference reaction, where something about the other person, which could be as simple as a physical resemblance, reminds the subject at an unconscious level of a previous bad experience or unresolved conflict.

Adams (1992) describes a series of incidents happening to a teacher called Bill. Bill, later reflecting on his experiences, comments on a similarity between the bully and his very critical mother which seemed to cause him to freeze and feel extreme dread in her presence. He just could not defend himself.

It does not mean that the other person in the present is actually like the original person, but the subject begins to transfer all the negative expectations, emotions and hurts from the previous situation to the present relationship. This may include feelings of futility in being able to change things and revert to a previous mode and pattern of coping. The subject begins to react in the same defensive manners as they did previously but to the present other. The present other who thinks they only asked a simple question are met with perhaps a hostile, defensive or defiant response, or even the subject bursting into tears, and they begin to countertransfer, responding to the subject's defensiveness.

The subject's defensiveness evokes in the present other a reaction not dissimilar to the original other's behaviour, reinforcing the subject's unconscious worst fears about this new person. Both go away from the encounter with a completely wrong impression of the other and in their next encounter will start off from the completely wrong place.

These dynamics can get very messy and complicated, especially if the present other also has unresolved past conflicts and does their own transferring onto the subject. What can result is a very enmeshed, intense, explosive relationship from which neither party is actually able to extract themselves.

Another pattern of transference the author has observed in the present study is that a nurse who has been experiencing bullying in one post moves and begins to experience victimisation in the new post. She is not very happy with her previous job but probably doesn't see it as bullying, just as being treated badly. The incidents in the previous post started slowly and insidiously, and she was numbed and paralysed from reacting to them. In the new post, she thinks she is safe, her defences are down, and something simple and totally innocent is said to her like "Could you come into my office" and she gets hit with full blown panic.

There is absolutely no problem with the present manager: something in the tone or words takes the victim back to the previous manager, and whilst previously they had endured bullying every day, now that they are away from it, they experience a

hypersensitive reaction to even the slightest resemblance to the previous situation.

From the author's experience, transference in some form or other and in either party plays some role in approximately half of the bullying cases. It can take many forms including transference of feelings onto some authority figure brought in to try and resolve a complaint.
Those experiencing a Single Traumatic Victimisation in this study were checked for any previous bullying history to see if their extreme reaction to a single accusation (criticism) might have been as a result of such hypersensitive response because of transference, but no evidence for this was found.

Another dynamic in bullying and victimisation is the role that change induced stress plays. The next section will look at this in more detail.

**4.3.10—Change as a Trigger**

In this study, 48% of bullying victims reported a recent new manager prior to onset of bullying. Other events, all coming under the label change, can break a pattern of bullying and precipitate PTSD. These events, whether something major like change of post, or minor, like being off work for awhile, can cause the victim to relax. Their continuous absorption and repression of the emotional effects of bullying lets up, thoughts and feelings rise to the surface, and may be expressed in various conscious or unconscious behaviours, or may bring on PTSD.

Some of the clients in the study had recently moved jobs and had suddenly developed unexplained illnesses and behavioural problems shortly after moving post, and were having difficulty fitting into the new job. Nurse E came for counselling because she was having problems controlling her anger at home and in work. She had only been in her new job for three months and, although she enjoyed the job, she found herself getting angry about delegation and organisational structure. She was snapping,

criticising, and accusing staff if she felt something was unfair: she wanted justice all the time. At home she was worse. She realised she had changed from an easy going person to a monster and wanted to kill everyone when her anger was triggered. She now feared she could be accused of being a bully herself and came to counselling to learn anger management. Fortunately E was self aware enough to realise something was wrong and to seek the appropriate kind of help.

What emerged was that she had been bullied for 4 years in her previous job. She challenged her treatment at first but became quieter hoping they would go away and leave her alone. It was only witnessing another colleague, whom she respected, being put down that brought her to her senses and she decided to act. Several nurses complained and there was an investigation. She had no anger during the investigation, was emotionally numb and just relieved when it was over. She did not want to leave her job, but felt she needed to and was angry about having to leave. But the intensity of her anger towards others in her new post shocked her.

Nurse E in fact had PTSD. Most of her symptoms were relatively mild and she was able to control them to a large extent by herself, but the one thing she could not control was her intense anger. The DSM-IV criterion D2 refers to irritability and outbursts of anger, but the examples cited acknowledge shouting or throwing things and stop short of aggression against others.

The stories of some victims would indicate that for those who have been bullied for a prolonged period, simply moving post, without counselling, may bring on an emotional backlash. To date, none of the 8 victims of bullying in this study who moved to other employment in nursing after counselling have returned with new problems in new posts. From the exit and follow up assessment of clients, the counsellor would be confident that the counselling has extinguished their traumatisation reactions.

Moving without reporting victimisation may leave a vacant post which another unsuspecting nurse walks into and becomes the next victim. The victim's new post may have been vacated by a previous victim, since high bullying units have a high

turnover and a lot of vacancies. Those who move appear to be much more vulnerable to psychological problems in the new unit than under the constant drip feed of humiliation in the previous unit. They may find themselves sensitised and vulnerable to revictimisation, or, like nurse E above, may have the potential to victimise others. In the light of this, reports of an association between victimisation and the bully or victim recently moving post need to be re-evaluated in a wider context than just the current dysfunctional relationship.

Those who endure prolonged bullying and then move can also experience unusual illnesses as illustrated by another client, nurse D. She was experiencing medical problems, but medical tests and brain scans could find no physical problems, so she came for counselling. She was in danger of being declared unfit to work. What emerged in counselling was that she had been bullied in her previous job and had moved to escape it, but was now having nightmares in which her previous boss was harming her. She went on to tell of times she was having intrusive thoughts, memories and flashbacks of scenes of her old boss yelling at her in front of others or behind closed doors, saying she was stupid and telling her "I have power to sack you".

This current study observed that in 48% of bullying cases there had been a recent change of manager. A change in manager could be seen in several ways: as an additional stressor since any change is stressful (Holmes & Rahe 1967), or the introduction of a new personality into the unit, creating potential transference opportunities as discussed in the last chapter.

The identification of a serial accuser in the case studies shows a victim moving to escape victimisation only to find themselves in a situation where they had become very sensitised to anything resembling bullying. They were angry, intolerant and in danger of acting in a bullying manner towards others. The cause of any current problem, one person accused of bullying another, may not necessarily lie within the current situation but may in some cases be linked to a previous situation in the past

employment history of either the alleged victim or alleged bully. A very thorough case history needs to be taken from all parties involved, in a non-accusatory environment, if another layer of injustice is not to be added to what they have previously experienced. All too easily, investigation of complaints can get focused on finding out who did something wrong and not in understanding what is going on.

When something changes, such as the victim or bully moving jobs or one of them is off work with an injury or someone else begins speaking out, that change brings home the full realisation of what has happened. They experience the full emotional impact: like an emotional dam which has built up, it only takes a trigger to make a small break in the dam. The resulting emotional rush can completely overwhelm the person themselves or to burst out onto others around them.

**4.3.11—Costs**

In the study most of the clients were off sick, with an average of 6 months on full pay since they were fulltime permanent contract staff, and because they were fairly senior grades this was a substantial bill of £603,000. But with 42% of clients moving post or leaving nursing through early retirement or ill health, there was a large cost for covering and replacing their post, and to the wider health service in having to train 6 (12%) replacement nurses just to stand still. This brought the total actual costs to the Health Service for the 51 clients just short of £1M. or approximately £19,300 per client. Because of the higher proportion of those bullied moving post the actual cost for each of the victims of bullying was £20,700.

The costs of their counselling enhanced recovery was borne by RCN, and estimated at a total of £24,000 for all 51 clients or £500 each. If even one nurse who might otherwise leave the service is enabled to recover, then the full cost benefit of the counselling provided to the 51 clients is recovered. Several clients intended giving up nursing but, as the result of counselling, returned to nursing, so on that consideration alone counselling has been shown to be cost effective. Six months sick leave is a

serious illness, to lose only 6 (12%) nurses who have had a mean of 6 months sick leave is a good outcome.

Most clients were relieved to clear their name in formal investigations or just to get back to nursing, but the numbers taking matters further is growing.

In the pilot study only 7% took legal action and in the second phase of the study, 25% are taking legal action. The cases are not complete but so far they have all been successful with constructive dismissal claims which will encourage others facing the same situations now to follow their example. For the 51 clients, the employers and ultimately the NHS are exposed to an additional potential compensation and legal bill of £1.5 mostly in respect of bullying cases, bringing the average weighted cost for each bullying case to a total £ 81,000. Because they are not all claiming the actual mean, cost for each victim of bullying in this study will be closer to £ 40,000.

Despite this serious cost incurred by the bullies, no substantive action was taken against any bully connected to this study and no action was taken against the managers who pursued unnecessary formal disciplinary procedures and an unfair dismissal.

This section has examined various difficulties victims of bullying and false accusation have in claiming PTSD, and has discussed ways this might be changed in the future. An in depth look was taken at bullying and victimisation from various angles to try to describe it, understand how some people might be drawn into such a relationship. And finally a quick overview was given of how costly this problem is, not only in personal terms, but in actual financial costs to the employers and the health service.

The discussion will now look at the effects personality factors and personality profiles can have in the workplace and how these might lead to bullying and victimisation.

## 4.4 PERSONALITY

Clients often tell of complaining to more senior managers about being bullied, only to find their claim ignored, and managers explaining the situation away in terms of a difference or conflict of personality. In only 50% of the bullying cases in this study, which are among the most serious cases in terms of impact on the victims, was there any form of investigation carried out in the workplace.

Since such complaints are pushed aside so quickly, with no formal or professional assessment, the terms "personality differences" or "personality conflict" can be seen as a dismissive label used to minimise the seriousness of the complaint. Such a label relegates the matter to the personal zone between the two individuals and as such, there is no need for management to get involved. To call it bullying would mean taking action, provided that there is a policy in place.

The author's experience in conflict resolution situations in nursing, and from counselling nurses with a range of inter-personal relationship problems, once a problem is considered personal between two people, then the one in the more powerful organisational position tends to be supported by management and the other has to adapt or go. That is how a hierarchic system works and is the likely outcome from such an assessment of the situation where management makes no substantive objective investigation of the complaint.

On the other hand, there is a common sensing that personality is involved somewhere but no clear consensus. Field (1996), an anti-bullying campaigner, portrays bullies as mentally ill and suffering from various personality disorders, including Antisocial Personality Disorder or Narcissistic Personality Disorder. Others associate personality traits such as psychoticism and neuroticism with bullying (Ramirez 2001, Mynard & Joseph 1997). Neuroticism and other personality traits have also been associated with victims (Connolly & O'Moore in press, Mynard & Joseph 1997, Coyne, Seigne & Randall 2000).

Personality might not only contribute to bullying, but those most severely affected by it, who develop chronic PTSD, may also undergo profound personality changes. Such

a chronically traumatised victim could go on to be quite dysfunctional in social relationships and potentially repeat the cycle of victimisation by bullying someone else. The role of personality needs to be more fully understood in relation to the collection of behaviours referred to as bullying.

This study therefore sought to examine the personality of the clients to see if an explanation could be found for their susceptibility to being victimised or to having an adverse response to their victimisation leading to PTSD. The Myers Briggs Type Indicator (MBTI) was used to profile a sample of the clients (see section 1.4.7). Unfortunately it was not possible to directly profile any of the bullies associated with this study or to get a sample of individuals accused of bullying for profiling, but a general profile was compiled from the accounts of the victims.

### 4.4.1—The Significant Other

The significant other is the other person or persons involved in the incident of accusation or the series of incidents of bullying. Generally, it was a single individual. No one in the study suffered a series of unconnected mishaps with different people. In 2/3 of the cases when the significant other was a colleague or subordinate, it was two or three individuals acting together. In 65% of bullying cases and 73% of single traumatic victimisations the bully or accuser was in a managerial position of power relative to the victim.

Other significant players were often non participating colleagues who had witnessed the bullying, but did not intervene or support the victim. With the single traumatic victimisations, the incident was often over before anyone knew, and colleagues only found out later what was happening. But afterwards, when some clients were taking a case, colleagues often refused to make statements or show support for fear of their own position, and their vulnerability in working in the unit with the bully. They had seen senior management move victims, leaving the perpetrator to continue unchecked. None of the bullies in the 24 cases of bullying identified in this study were moved. In

one case, management offered the victim an internal move, commenting that there was no point doing anything with the bully, because they were not going to change. In this way the significant others in the whole dynamic can be seen not just the protagonists who accuse or bully, but also those who see the bullying and do nothing. In this sense, bullying is not a simple one-to-one dynamic, but a group, social and organisational phenomenon, and these passive witnesses are also part of it.

Although this study did not have access to those accused of bullying, the clients gave the following details. Where the perpetrators were nurses, they ranged from grades E to I. Since 60% of the victims were nursing grades G and above, and 70% of their bullies or accusers were line or senior management, they were mostly grades G and above. One might expect bullying from senior nurses to the most junior nurses, but this was among mid to senior management: contemporaries in different positions of power.

**4.4.2—Profile of the Bully**

From the stories of the clients in this study, a certain profile emerged, indicating that bullies are forceful, determined to get what they want, and capable of being ruthless if necessary. They like to be in control. They are competitive and usually play win/lose rather than win/win strategies. They are adept at changing their tactics or even the entire game being played if they are not winning. They can't be beaten or beaten off--they just keep coming back again and again. They are quick, plausible story tellers, good at spinning and putting themselves in a good light, even if that puts others in a lesser light. They are good at telling everyone around them things they want to hear and are often thought well of by those not directly experiencing their bullying. They think on their feet, making hasty decisions without reflection or all the facts, and are unprepared to reconsider or change their mind. They don't like being challenged or questioned or to have to revisit an issue once they consider it settled.

They have an ability to engage with a person in a way that makes the other person feel apprehensive, caught on the hop, wrong-footed. This puts the other person on the defensive, and reinforces the bully's control.

Some of the bully's behaviour may be considered 'operational' in that it is purposefully directed towards getting what they want and not done for malicious intent of hurting or harming. They may not want to share power because they consider that they know best, so why listen to others' ideas or open oneself to other suggestions which are seen as a criticism of their own ideas. They don't want ideas or suggestions or challenge, only approval of their own ideas. Rather than being good at delegating, sharing or developing leadership in others, they seem to resent others with initiative, drive and vision of their own, who by definition are not investing their full time and energies into serving and advancing the bully's agenda.
This general description contains certain narcissistic, Machiavellian or antisocial traits but not enough to merit a diagnostic label. They appear to be overly competitive and are prepared to shape situations to maximise their own comfort and get the most advantage for themselves. They seem to be unembarrassed to behave in this way and have little concern for how others may feel in these situations. The description that would most closely describe them would be Machiavellian.

There would appear to be an association between high bullying and high stress organisations Hoel and Cooper (2000). It is often difficult to tell whether the bullying causes the stress or the stress triggers the bullying. In this study, we were able to compare the reported level of excessive workload and changes of work practice between nurses reporting single traumatic victimisation and nurses reporting bullying. Those experiencing bullying were twice as likely as those experiencing a single traumatic victimisation to report excessive workload or changes in work practice in their workplace. These non-interpersonal stressors were twice as high in the units of those reporting bullying.

**4.4.3—Victims**

The clients were all nurses, mostly nurse managers. As nurses or nurse managers, aged 30 - 50, working full time, tertiary level education, socio-economic group II,

salary £20,000+, they are members of one of the most stressed groups in the UK workforce (Smith, Brice, Collins, Matthews & McNamara 2000).

Myers Briggs Type Indicator (MBTI) profiles were obtained from a sample of 19 clients, representing 50% of the phase II participants. For the comparative management control group this study took a well functioning nursing management team of eighteen senior nurse managers from a single Health Care Trust as a representative control group.

The sample size of 16 in the study was too small to do much in depth statistical analysis. Only more general level analysis was possible, which nevertheless points towards some interesting areas for future investigation (see section 1.4.7 and Appendix D).

Identifying a meaningful comparative control group was difficult. There are no local or UK-wide surveys of MBTI profiles in nursing. What work has been done is American and Canadian based. Longitudinal studies by Myers (McCauley 1977) confirmed that ESFJs and ISFJs had the lowest drop out rates in nursing. Each victim might potentially need their own relevant control group to determine if there was a marked difference between them and the group from which they were singled out, but this would need to be studied further.

Of the clients profiled in this study, 58% had the trait combination SF indicating a Sensing and Feeling preference. According to Myers and Myers (1980), 44% of nurses demonstrated this combination of traits, while 34% were NFs (iNtuitive Feelers). There were no NFs (iNtuitive Feelers) among the victim group. By contrast NTs, (iNtuitive Thinking) made up 32% of the client group which Myers and Myers (1980) found in only 7% of nurses. NFs appear under-represented among the clients experiencing problems in their workplace, while NTs appear over represented.

At the same time, no NTs were found in the comparative nursing management team. This compares with an expected proportion in nurses of 7% and an expected general population proportion of 9.5 (UK) and 16.7 (IRL) (Killen and McKenna 2000).

Although over represented among the victims they were not associated with any one problem, some were bullied, some victimised, and some had complex situations.

The proportion of SFs, 58%, in the victim group is around what might be expected for a random sample of nurses, but to find no NFs among the victims suggests they may be less likely to be selected for bullying or victimisation or better able to cope with the effects of it. NFs prefer possibilities to facts and are usually very successful in understanding and communicating with people, so perhaps they can resolve interpersonal difficulties early. There were 11% NFs in the comparative nurse management team.

The clients fell into just 5 of the 16 possible personality types in the MBTI. Two personality types ESFJs and ISFJs made up 58% of the clients. The United States Department of the Interior regards these as most suitable profiles for nursing career selection (USDOI 2001).

In the management team 33% were ESTJs, but none of the victims were ESTJ. In fact, STs comprised 50% of the management team compared to 10% of the victims. The expected frequency of STs in nursing is 15% (Myers & Myers 1980), so there are more STs in the management team than the expected average, but this is not surprising since they are managerial types and more would be expected higher in the organisation.

The most striking aspect of both the management team and the victim team is the complete absence of Perceivers (Ps), whose expected frequency in UK and Ireland is around 42%. The author's experience using the MBTI both in therapy and in training counsellors is that the proportion of Ps in the Northern Ireland population is very low, somewhere in the region of 10-15%. There are no specific population profiles for Northern Ireland, but there is no reason to expect them to be very different from the UK or Ireland figures, yet Ps appear to be rare among both clients and controls.

**4.4.4--iNtuitive Thinkers (NTs)**

The NTs, who are over represented in the victim sample (32%), fit two profiles: INTJ

and ENTJ. They are usually academic, creative visionaries, possibility thinkers. In a problem solving situation, NTs would be the ones expected to combine the logical implications (T) and the big picture (N) to create a range of logical options to be decided on.

Yet there were no NTs in the management team, which would present difficulties in coming up with logical options for courses of action. The result might be that when the first option was eventually generated by the management team, it would be immediately latched onto as the 'one right way' and immediately moved forward to implementation by all the Judgers (Js) who want to make a decision. If more options had been quickly generated by giving NTs a voice, weighed up and evaluated, a much better solution that would suit all involved might have been arrived at.

INTJs are only a small proportion of any population 2 - 4% but they are academic high fliers. In an American study they comprised 8.8% of National Merit Finalists and 11.3% of Rhodes scholars but comprised only 0.4% of the pupils in the equivalent to our secondary school. They tend to select careers in science, engineering, creative arts, and educational administration (Myers and Myers 1980). These people are valuable assets in any organisation, because of their ability to solve complex challenges, global thinking, visionary goals, sharp insight, and, above all, the ability to translate their creativity into good plans. To have such people choose nursing as a career is good for nursing, but despite 15 to 30 years in nursing these clients were only grades E to G.

There are several problems which INTJs may encounter in nursing. The most common nursing types, ISFJs and ESFJs, are very practical and task centred, considering those who want to develop ideas as wasting time. INTJs are not very good at relating to others or engaging in social forms of conversation, so developing relationships at work may be difficult, leaving them isolated from their colleagues. People therefore tend to experience them as hard to know, private or even aloof. Others may see INTJs as opinionated, which surprises them because they are very willing to change views if new evidence emerges. They promote their ideas but not

themselves, and probably work best as part of a management team rather than a single manager or the lead manager. There is probably a glass ceiling for them beyond which they find it difficult to progress despite their capability. Unless they find a niche in the organisation where they are appreciated and valued, they will not be able to give a full contribution.

ENTJs are high achievers, creative and visionary like INTJs but are much more up front. They therefore make it through the ceiling. Although they had been in the profession for similar amounts of time to the INTJs, they were on higher grades, grades G to I. ENTJs are natural leaders, strategic visionaries, adept at planning for future needs of the organisation; they often challenge other people's behaviour or statements, expecting them to defend and engage in mutual learning. They are comfortable with conflict as a way of resolving problems, verbally fluent, decisive and self confident. For their managers, ENTJs, unlike INTJs, are very much in their face with ideas, suggestions and challenges.

ISFJs and ESFJs, the most common nursing types, are very practical, task focused and will consider ENTJs off the point and wasting time, and will find their critical, confrontational style difficult. ENTJs and INTJs may therefore find a distance between themselves and the most common nursing types ISFJs and ESFJs, who will feel threatened and overpowered by them. This isolation or distancing may leave them less supported or protected if singled out for bullying.

Referring back to the profile of the bully in section 4.4.2, who doesn't like being questioned or having their ideas criticised, it is easy to see how conflict could arise between such a bully and an ENTJ, and yet the victim not get much support from other nurses who would also find them difficult.

There were no NTs in the profiled management team. There were 6 ESTJs in the management team but none of these in the victim group. Both ESTJs and ENTJs are extraverted thinkers and would have a similar logical, directing, analytical critical approach and be comfortable in leadership roles. They value competence, recognition for their accomplishments, and would value being respected more than being liked.

Why then are ENTJs at 16% among those experiencing difficulty in the organisation while ESTJs at 33% appear to be ascendant in management? The main differences between them are that ESTJs are more traditional in their approach to solving problems, applying and adapting past experiences rather than devising new solutions, and perhaps failing to recognise the need for changes and to introduce them. This may make them more like ESFJs and ISFJs who share this same traditional approach, preferring to stick to the tried and tested, and disliking change. Therefore ESTJs, ESFJs, ISFJs would share a more traditional attitude and would regard NTs as a disruptive or disturbing element. NTs however are not being disruptive for its own sake or in any negative sense; they are simply bringing their innovative ideas and the challenge to change.

A number of bullying victims report having ideas stolen, not being given credit for things they have set up and developed, having projects on which they had substantial work done taken away and given to others, or sensing jealousy from their managers. A conflict situation could easily be created where an NT comes up against the bully described in Section 4.4.2, a competitive manager who lets a creative subordinate do the innovative work and steals the credit to promote themselves.

One NT client left nursing, one retired through illness, one was down graded. For a relatively rare group in the population and in nursing to be disproportionately experiencing this amount of attrition and downward and outward pressure is not good for the future development of nursing, especially because of the vital role NTs play in the creative development of novel logical options and in problem solving for service or treatment development.

The types of problems experienced by these NTs in their workplace were quite diverse, each on their own might be dismissed or explained away due to some particular circumstance. But together, as 32% of the victim sample, they suggest a pattern of personality or intellectual discrimination.

Much more work needs done on this area which will require a large scale sampling and profiling of the local background community, nursing students, nursing career

leavers, nursing career grades, and nurse management teams to determine if forces in the organisation are driving particular types out.

**4.4.5—Perceivers (Ps)**

Another feature noted in the study was the complete lack of Ps among any of the 37 managers and victims profiled. The expected rate of Ps in UK and Ireland is approximately 42% (Killen and McKenna 2000), but the author, having used the MBTI profiling over a number of years in both therapeutic and counsellor training applications, has only found at most 10-15% Ps among over 500 profiles. Among nurses coming for counselling, the author has found only 1 P in approximately 150 profiles although this could be a sampling distortion.

But consider the impact on an organisation of having virtually all Judgers (Js). Js use either/or thinking, Ps use both/and thinking. Js want closure and things settled, even without all the facts and even if they have to tell others what they should be thinking. The Ps go round inquisitively asking why and seeking to understand, and don't come to a conclusion until they must and perhaps not even then. Js solve, Ps hope to solve by understanding better.

The high rate of Js is particularly relevant in the context of this study to those experiencing a Single Traumatic Victimisation (STV). Those who have experienced STVs were wrongfully accused by others, yet found management making decisions and acting without hearing both sides or getting all the facts. They faced an uphill struggle to get them to reverse the original unsound decision. Yet the findings of this study speak for themselves in the number of people, 70%, who subsequently cleared. These experiences with the organisational hierarchy would suggest a strongly J organisational personality within Northern Ireland nursing.

The overabundance of Js is not the only problem--the shortage of Ps can also have a profound effect on the character of the organisation or profession. The main role of Ps is to bring balance to the Js. They need to be there in reasonable numbers. Ps make teamwork possible, leading by promoting group work, including and encouraging

others, creating a facilitative atmosphere, working for consensus, blending interests, using quiet authority, evaluating before acting, and allowing others to lead whenever possible. This involving approach is different from logistical co-ordination; it is much more person centred than task centred. This is the opposite of the destructive behaviours of bullying: exclusion, expedient decision making, inflexibility, overpowering leadership and rivalry. Many of these items are also recognised as potent stressors so the P approach can equally be seen as an antidote to stress.
Without the full balance of types, an organisation or team may get by under normal circumstances, but when under pressure, it becomes a very dangerous and unsafe work environment for those less psychologically equipped for such a jungle.
Individuals could be more exposed to excessive or unfair discipline, bullying behaviour, and vulnerability to stress. An organisational style that is extremely J might merit the label of Institutionalised Bullying.

### 4.4.6—Feeler / Thinker Conflicts

Of the 11 bullying victims profiled, 72% were Feelers, compared to 50% Fs in the management team and approximately 55 % in the UK and Ireland populations.
If the NTs are removed from the calculation because their marginalisation can be explained in terms of discrimination against their innovative approach, then of the remaining 9 unexplained bullying cases, 89% are Fs. A significant number of these are likely to be working for a Thinking line manager.
The higher proportion of Fs among bullying victims may suggest that for some of them, their problem is associated with a Feeler / Thinker incompatibility with their line manager. Fs tend to avoid conflict; two Fs will focus on areas of agreement, valuing each others views and, if conflict does occur, it is unlikely to be openly expressed.
Two Ts will focus on areas of disagreement, spend time finding flaws in each others' arguments, appear heated to observers, but just feel they are debating. They do not take it personally and both will be reasonably happy with the conduct of the

encounter.

In both of these above situations there is a match in the rules of engagement.

A Thinker / Feeler relationship will not include open conflict or argument: the T will express criticism, generating conflict; the F will make efforts to overcome the conflict by absorbing it, taking the blame, saying nothing. However both will feel dissatisfied afterwards: the T will consider the discussion of issues inadequate, and the F may take the criticism personally, wonder how the other could be so critical of them, and then continue in the relationship as if nothing had happened.

The number of Extroverts in management (61%) and Introverts who were victims (63%) magnifies the situation. A series of unproductive encounters for the Extroverted Thinking (ET) manager ensue and a series of hurtful encounters for the Introverted Feeling (IF) recipient ensue. A Thinker/Feeler incompatibility with the T in the dominant power position could be the trigger that leads on to a bullying relationship.

**4.4.7—Profiles of**

**Extroverted Sensing Thinking Judging (ESTJ)**

**Extroverted Sensing Feeling Judging (ESFJ) &**

**Introverted Sensing Feeling Judging (ISFJ)**

Just three MBTI profiles ESTJ, ESFJ and ISFJ represent 65% of the combined management team and victim sample profiles. These three profiles would represent the majority of nurses (Myers & Myers 1980), and are worth exploring in more detail. They will be looked at in terms of how they may interact with each other and the implications if they have not fully developed their preferences.

For the purpose of this study, the author is focusing on the aspects of these profiles which may cause relational problems or conflicts with others. The MBTI emphasises heavily the very strong positive qualities of every type and their contribution to teams and organisations, but each profile comes with an accompanying "Achilles Heel".

Under-development in either Thinking or Sensing, even in normal situations, may result in quick decisions based on bias and prejudice rather than an evaluation of the facts, resulting in harsh and inconsistent decisions. Such a person may lack an internal check on their J decision maker. With few balancing Ps in the organisation, this weakness may be exaggerated in its effect, perhaps contributing to either bullying or unfair penal sanctions.

These three types, ESTJ, ESFJ and ISFJ have characteristic responses if they are feeling unappreciated and left out, or if struggling to find their place. These responses include imagining criticism, increased sensitivity to criticism and being judgmental and critical of others. In this study 48% of bullying victims reported a recent change of manager prior to the onset of their victimisation. Difficulty fitting in may trigger something in either the victim or the bully, making one more vulnerable to victimisation and one more prone to victimise others.

A new ESTJ manager, struggling to establish themselves, may become rigid, critical, judgmental, distrusting of others, overpowering, intrusive, dogmatic and sensitive to criticism, all descriptions applied to bullies. If such behaviour is directed at their new colleagues or supervisees, this could be the start of a pattern of bullying. It could also isolate them from collegial support and comradeship, further reinforcing this pattern of behaviour and leaving them perhaps vulnerable to being bullied themselves.

Both ESFJs and ISFJs are sensitive to the effects of criticism, exclusion or rejection, which are common behaviours of bullies. Such treatment is very destabilising for them. They rapidly lose confidence, become worried, guilty, and sensitive to comments, have difficulty trusting others, bury themselves in their work, become rigid by the book and critical of others. These reactions can escalate the situation.

ESTJs are more expressive of criticism in normal situations and more comfortable with conflict as a means of resolving problems, which may create a problem between them and ESFJs and ISFJs. In one way ESTJs look like potential bullies among the ESFJs and ISFJs who dislike conflict, but both ESFJs and ISFJs under stress can react back very irrationally with great criticism, and an ESTJ in a subordinate position

could equally end up as a victim.

ESFJs and ISFJs in particular share a common discomfort with conflict of any kind, including change, ambiguity, and uncertainty. Apart from being more comfortable with interpersonal conflict, the ESTJs share this same love for things ordered, controlled, organised, structured, planned, traditional, and with a clear hierarchy. They are all very much at home in nursing. The structures are designed to provide the stable working environment they prefer, which includes keeping disorder, confusion, chaos or conflict out, and rapidly squashing or expelling any sources of these within. Single traumatic victimisations and bullying could be seen respectively as formal and informal means of squashing or expelling sources of general conflict from the organisation, a means of getting rid of uncomfortable people or messy situations and relationships that have been mishandled and turned sour. That may be why these practices are tolerated at an organisational level, especially one that may be short on creative ideas for dealing with new situations.

The problem could be that some managers are abusing the system and their positions of power and trust, in order to drive out good nurses with whom they have a personal difficulty, but who are no threat or danger to the organisation. For example, the manager may have shown unfair favouritism to one nurse and now the other nurse is complaining and challenging, putting them in an awkward situation. Or this nurse does not say yes to the manager's every suggestion, pointing out weaknesses in their ideas, or may even suggest their own new ideas among the other staff. The manager may have stolen an idea or taken credit for something the nurse did, and that nurse is unhappy about it.

Each of these scenarios is a possibility of the abuse of power combined with conflicts caused by personality differences, differences which arise simply from the preferences of the individual personality profiles.

The discussion will now look at a further aspect of personality which can cause even more problems in the workplace: the shadow side which emerges under extreme

stress.

**4.4.8—Shadow Side**

This suggestion may sound extreme to even suggest but it is a useful introduction to what Carl Jung called the Shadow of our nature: the unadapted, unconscious parts of our psyche where we hide, through repression, the experiences, impulses and desires which we, our parents or society consider unacceptable or not fitting to our ego.

> "The other in us always seems alien and unacceptable but if we let ourselves be aggrieved, the feeling sinks in, and we are the richer for this little bit of self knowledge" Carl Jung (1964).

The idea of the shadow was incorporated into Jung's personality typology in the form not only unique to the individual and one's life experience, but of the inferior, less preferred functions of our personality type. Naomi Quenk (1996) has developed it through to the MBTI framework.

We prefer our dominant functions and have conscious control over them. Our inferior functions are in the unconscious. ESFJs have dominant Extraverted Feeling, relating to the outer world primarily through their feelings. Their inferior function is the opposite Introverted Thinking: they relate to their inner world through their thinking. If our dominant function is Feeling, our inferior function is Thinking.

The unconscious shadow function remains dormant as long as the dominant conscious function is operational. It is still part of our personality and typically emerges, sometimes dramatically, during times of stress, fatigue, illness, under the influence of alcohol or mind altering drugs, or when we experience particular triggers which are specific to each personality type, causing us to act in a way that seems quite out of character. A familiar example of the shadow might be where a quiet person may become the heart and soul of the party when drunk while another may become aggressive or abusive. Those are real feelings deep inside them which they hold pushed down and repressed, often for fear of what others might think or say, fearing rejection or sanction by others.

An ISFJ may lead a very controlled, sensible, safe life, but they also have the unused ability in their shadow side to be unconventional, take risks or be adventurous. Some get in touch with and learn to express those other abilities through free time activities, and are psychologically healthier for it. Others may be the sensible, caring ones all the time, just as particular at home as in their nursing. This second group is more at risk under extreme stress for this impulsive side to emerge. Because it is less integrated and used, it will not be expressed as flexibility, adaptability and sensible risk taking, but will come out as impulsiveness and irresponsible risk taking. It is this non-integrated eruption of the shadow under extreme stress, or at lower stress levels in response to certain triggers, that will be explored below in relation to the common nursing profiles.

ESTJs and ENTJs are both Extraverted Thinking types.

Their shadow may be provoked by a disregard for their deeply held values. They usually only invest their feeling in a few concerns, but if one of these is violated they will react disproportionately. Another trigger is strong emotion being expressed by others which they cannot deal with in their normal logical direct way. The third trigger is regret, self criticism, and blame for being harsh or insensitive to others. Such self recrimination can bring out a shadow response.

When this shadow response erupts, they may become categorical, make unfounded negative pronouncements, lose their ability to think and act logically. They may flit from task to task, may be unable to come to conclusions, and have outbursts of anger. It will be difficult for them to express any of what they are feeling for fear of losing control and, although they may appear in control, they will be struggling inside and be very shaky and doubt their own emotional stability. Such shadow experiences are relatively infrequent and short lived for these types, and they appear in control most of the time. However it is just under the surface at other times, and people will readily sense their anger, disapproval, touchiness and be generally wary of them. They would be seen as someone you should not get on the wrong side of.

When this person's shadow erupts, they could act in a bullying way. If the other

person in this encounter were in a higher position of power or authority to them, rather than a subordinate, they could equally take on a victim role.

ESFJs and ENFJs are both Extroverted Feeling types.
Their shadow may be triggered by not being trusted: for example, if their intentions are misunderstood or if they are not listened to and taken seriously. They need to be given due regard that what they do and think matters, and not be taken for granted. They will react to being pressured to conform or having something imposed on them which they can't agree with or which they do not understand or have not been involved with and taken ownership of. They have difficulty when outer requirements conflict with their inner values. Another common trigger of the shadow is interpersonal conflict. What is particularly difficult for them in conflict is being unable to or being prevented from discussing and resolving the situation. They may react in particular to more personal attacks or disagreement with their point of view or opinion, rather than more logical disagreements over ideas.

The shadow side of the ESFJ expresses excessive criticism and fault finding of almost everything, becoming particularly intolerant of the incompetence of others. They may make sweeping condemnations of others and express frustration by yelling, slamming, saying cruel things and using inappropriate humour to shock. Some describe themselves as Jekyl and Hyde. This outward expression eventually turns inward, to depression and withdrawal, accompanied by feelings of overwhelming inadequacy.
In this study it would appear that victims can act in a victimising way towards others either in situations of great stress or when struggling with mental health problems such as anxiety or depression. This sounds very like a shadow type reaction expressed outwardly at the situation, but then eventually turning in on itself as depression, and then turning out again as they come out of depression.
Another expression of their shadow side is convoluted or distorted logic, very rigid

black and white thinking based on irrelevant data and therefore impractical but very hard to reason with. They may imagine conspiracies or very complicated explanations for events rather than the more simple and obvious explanations. They will be perfectionist and angry and try to organise more. Other expression of their shadow may include a compulsive search for the truth and answers to validate their experience, a pessimistic outlook or ignoring other's feelings.
They could be a victim finally overwhelmed by depression and feelings of inadequacy, or they could act in quite expressly bullying ways to others while under pressure or even while being bullied themselves.

ISTJ & ISFJ are Introverted Sensing types.
Their shadow may be triggered by any approach which denies facts or reality, which could include the illogical pronouncements of a stressed ESFJ or the visionary ideas of INTJs and ENTJs. Their response to the unknown or any future change, unless it is well planned and they have time to adjust to it, may be extremely harsh and negative. They will react with fear and horror, seeing dire possibilities and anticipating what could go wrong in an unsafe, threatening world. Reassuring them, especially in the midst of a disaster that everything will be okay, will be met by a strong reaction. Again they may seem outwardly unperturbed by their situations but inside there is a lack of focus, confusion, as well as anxiety and panic.
Another trigger for these types, and which may be common in nursing because of the contingencies of the service, is having to overdo their type: doing too much of what are normally satisfying jobs which they usually thrive on, long hours, doing other peoples' work and being unappreciated or taken for granted. This is where an over extended care giver role at home in addition to work may have an impact.
In the grip of their shadow side ISFJs can lose control over facts and details. They have difficulty discerning what is relevant and arriving at rational conclusions and may loose trust in their ability to sense, or think about, situations. Their internal system for classifying and organising facts breaks down and they experience

overwhelming confusion.

Another aspect of their shadow is that they may be impulsive and uncharacteristically spontaneous, but not the guided spontaneity of dominant intuition, but the inferior function of intuition that is thoughtless and later reviewed as irresponsible.

The three shadow side response patterns described above, ESTJ/ENTJ extroverted thinkers, ESFJ/ENFJ extroverted feelers and ISTJ/ISFJ introverted sensers, cover 33 (92%) of the 19 clients and 18 management team subjects profiled in this study. They reflect the typical triggers, responses and interactions that may occur in middle to senior nursing management under extreme stress. Many expressions of the shadow side would match behaviours labelled as bullying. Equally many of these expressions of the shadow side describe how those subjected to bullying may respond to such treatment.

Some of the difficulties which victims of bullying experience with cognitive function such as concentration, memory, focus and achieving goals, prior to the final collapse of coping may in fact not be the simple effects of stress, but expressions of their shadow side behaviour which is expressed under conditions of extreme stress. If trauma is thought of as being brought on by exhaustion of conscious energy through prolonged duress or extreme stress then it is not surprising that these unconscious shadow phenomena are a common part of the PTSD symptom profile.

**4.4.9—The Shadow and Sporadic Bullying**

Shadow side reactions under high stress environments may account for the large number of people in surveys who report low frequencies of bullying. In the Working Well Survey (RCN 2002), 85% of those reporting bullying only experienced incidents twice a month or less often, and accounted for 43 % of the total of 11,000 incidents of bullying reported in the study. Nearly half the incidents of bullying reported to the Working Well Survey could potentially be classified as isolated incidents of casual bullying.

Nurses, trying to cope with highly stressful conditions and interpersonal friction, express shadow side reactions of criticism and intolerance to others or hyper-sensitivity. This could show up in surveys as sporadic bullying, and may explain the common idea that this kind of behaviour is exceptional and due to extenuating circumstances.

This form of sporadic bullying adds to the general stress of already over stressed units and teams, increasing the chance it will be repeated. It undermines trust and confidence in fellow staff and isolates individuals from each other.

The solution would be a managerial one of reducing overall stress and organisational practices which cause the most distress for the common nursing personality types. This would involve the way change is managed at the macro level and at the individual level, such as the induction and integration of new staff. It would include a less directing, commanding, deciding type of management and a more inclusive, responding, open, interactive style.

The first step is to recognise the problem and the need to change. It won't come about by edict from above or putting in a director from industry. It must come about from a change of culture, ethos and attitude from within, the catalyst for this being education. The key area for training will be nurses understanding the needs, strengths, and weaknesses of themselves and others, and developing an appreciation of personality types.

**4.4.10—Association of Stress Bullying and Personality**

A general connection appears to exist between high levels of bullying and the caring professions, but the connection to administrative professions and the police is not so immediately clear apart from them all being service careers. Teaching, nursing, public service administration and security also appear among the highest stress industries (Smith et al 2000, Jones, Hodgson, Clegg & Elliott 1998).

Myers & Myers (1980) reporting on some of the early calibration work with the

MBTI reported the most common types in police and school administration as ESTJ, ISTJ, ESFJ and ISFJ. No figures for teachers or nurses were given, but the US Department of Interior (USDOI 2000) suggests elementary teaching and nursing as among suitable career choices for ESFJ and ISFJ. In the present study, ISFJ, ESFJ, ISTJ and ESTJ accounted for 78% of the 39 nursing managers and clients profiled. These professions all appear to have an over representation of the same four personality profiles, showing a possible association between them, and the high stress and high bullying reported.

The findings of this study would suggest that these particular personality types may be more susceptible to the effects of stress and/or may react to stress in a way that increases inter-personal conflict and sensitivity to criticism, an increase in inter-personal aggression and an increased vulnerability to victimisation. Because such aggressive feelings towards others or feelings of not being able to cope are so contrary to their nursing identity as the caring and capable ones, they deny and suppress them, only to see them erupt in other ways through lack of care, support and protection for fellow nurses and as strong attack on anyone who does something that appears to be wrong.

**4.4.11—The Enemy Within**

The results of this study indicate that nursing is a profession with a higher proportion of potential victims than many other professions: factors for this include high background stress levels, a culture of making one's own needs subservient to the needs of others to the point of self sacrifice, a hierarchic power structure, and a distance or isolation between individuals. A high proportion of personality types in nursing react to stress with criticism of others and sensitivity to criticism. This creates the sort of environment in which someone with antisocial, narcissistic or Machiavellian traits will be freer to operate, and in which there may be a high level of sporadic interpersonal strife.

The use of such labels as antisocial, narcissistic or Machiavellian suggests there is

something wrong with bullies, but Kritek (2002) suggests people exercising dominant power without challenge to the legitimacy of it become accustomed to viewing themselves as excelling in the arena where they exercise this power. Who then created this narcissistic monster? By not confronting the bullies, might nurses share a collective responsibility? Challenging those in authority may be frightening, but if individual incidents of bad behaviour are not challenged by victims or witnesses, and if people don't talk and share about what is being done to them, both speaking out and talking to each other, bullying will thrive.

We as nurses have created these situational bullies. We are just as much players of the game of manipulation but play the strategy of short term expediency: not challenging, only telling people what they want to hear, being co-opted, enjoying the inner circle, playing stupid when we know what's going on. We create and feed the monsters: we know their little ways and foibles, when to duck, when to yield, when to pass. However miserably, we do survive; yet we lose so much of ourselves, hiding things, being on guard, losing our sense of humour and fun, our playfulness, our vulnerability, our sensitivity, our comradeship with our fellow colleagues. But we go on, and usually the axe falls on some relative newcomer or the person with the fanciful ideas or the uncomfortable, challenging person.

Bullies may simply start out as someone who is more comfortable with their shadow side than others. The shadow contains all the things we have been taught are unacceptable, which for nurses may include their masculine side, their ability to be assertive and competitive. The feminist writer and psychologist Phyllis Chesler in 'Women's Inhumanity to Women' (Chesler 2001) suggests that women need to acknowledge their own aggression and competitiveness, devising rules of engagement to fight fair and have dinner afterwards as men do. Some are afraid of it, in themselves and in others, and have no response for it, while other women use it for power and control over others. Women, she says, are more comfortable with women leaders who are humble, maternal, patient, and give the entire group a sense that we are all in this together. They find it difficult to relate to a female boss who is in touch

with a side of themselves which the employee may not be in touch with and cannot respond to appropriately in such a boss.

There is nothing wrong with being assertive and competitive, but such people must have good internal control, good boundaries, high standards of behaviour and the ability to empathise with others, because the typical nursing manager and subordinate nurse, with whom they will be working, will probably not be able to draw those boundaries for them. Without the balance that good supervision or challenging subordinates bring, they will become a monster.

It is not that they are a monster but they become one, and everyone, from their manager to peers to subordinates and including themselves, owns a part in this. Others share a part too: those who were mentoring them during their career development, every manager they ever had who wrote glowing references, the appointment panels who selected them. Some of the stories the study clients told, suggest their bullies had a complete lack of any recognisable moral code or compassion, especially those bullying multiple people at the same time. But the author cannot explain such a person choosing a career in nursing in the first place or rising to a prominent position in nursing if they were like that from the beginning.

Something may have changed or happened to them along the way. Perhaps they were bullied themselves and been traumatised by it but struggled on, as some nurses did in this study. Without proper help and counselling, this could have become chronic PTSD which does have a particular change in personality, notably emotional and relational difficulties, criticism of others, looking for threats, and suspicion. The cycle of adult bullying through the mechanism of traumatisation and chronic PTSD is potentially a self sustaining one, creating both victims and potential new victimisers.

Reports on work with adolescents suggest that good reciprocated peer relationships with at least one other person in their class (group) could reduce peer victimisation rates (Boulton, Trueman, Whitehand, Amatya 1999). Most of the bullying in this study was hierarchic with only 29% of cases involving a peer acting on their own. While better peer relationships might not impact hierarchic bullying, something that

might help in even 29% of cases is worth exploring. Building good relationships did appear to speed and assist ongoing recovery in all the study's clients, so such relationships may have both protective and therapeutic value. An area for future study might be the quality of relationships nurses at all levels in the organisation have, both in work and outside, and how this compares with those who are victimised. If the quality of friendships diminishes as they move up the ranks, take on more work responsibilities, as family responsibilities grow, both children and caring for sick partners or parents, it might explain why so many of the clients in this study were in senior grades and aged between 31 and 50.

Thus there is a need to work with those who actually have been adult workplace bullies and work with both parties in such a dynamic in conflict resolution. The details must be determined of what is happening inside each individual and what is happening between them in a series of bullying incidents in order to properly address the issue.

## 4.5—CONCLUSION

The aims and objectives of the study included studying the effects of counselling on the recovery from PTSD symptoms of a group of nurses traumatised by workplace victimisation, studying and using the PENN inventory and the CORE system to quantify the PTSD and general psychiatric problems in the victims and their recovery, and to compare the two instruments, and to study the role of personality in victimisation and situational bullying. In the conclusion section, this study would like to make some final observations to tie ideas and results together and venture some recommendations for change. This will follow the same major groupings as the discussion: clients and therapy, PTSD and bullying, and finally, the role of personality in the dynamics of bullying and victimisation.

### CLIENTS AND THERAPY

Over a three year period the study identified a group of 51 nurses attending the RCN Counselling Service in Belfast who had symptoms of PTSD as the result of a single or a series of incidents in work. Their condition was assessed against the DSM-IV Diagnostic Criteria for PTSD and the PENN Inventory, a PTSD assessment instrument validated with both military and civilian populations. They were assessed by both methods as having a sufficient range and severity of PTSD symptoms to meet the symptom criteria for PTSD.

Their level of general psychiatric problems was also assessed using the CORE clinical audit system for counselling and psychotherapy. They were found to be severely clinical in respect of indicators of general psychiatric problems.

The study later raised the clinical threshold on the PENN Inventory to 42.5 to confidently exclude those with general psychiatric problems, since nursing has a very high background rate of general mental health problems. 75% of clients were still assessed as PTSD by both DSM-IV criteria for PTSD and the stricter PENN threshold. Those dropped out by this raising of thresholds were mostly early onset PTSD cases who had not yet developed the full symptom profile and clients who had

previously had more severe symptoms but had made some recovery on their own. The incidents which had traumatised the clients fell into two main groups, 24 (47%) had been bullied on a daily to weekly basis, mostly criticism and exclusion for at least 6 months but some had endured this for several years; the mean period of bullying was 17 months. A smaller subgroup of 5 (10%) had experienced discriminatory bullying. The second main group of 15 (30%) experienced a single incident or short series of linked incidents, of false accusation followed up by excessive prosecution and/or excessive punishment. These were named as Single Traumatic Victimisations in the study since their experiences did not fit the study's definition of bullying nor the generally accepted frequency and duration criteria widely used for bullying. The other 7 (13%) clients had complex victimisation.

Because this was a counselling-based study, the victims were interviewed at length and in depth, and no other current or historical, work or personal, cause of traumatisation could be found in these individuals apart from the workplace incident/s. By checking the timing of onset of symptoms and looking at previous mental health problems, the study verified that the onset of trauma symptoms were coincident with either the sudden accusation and disciplinary processes or a last straw event in a series of bullying incidents.

Based on extensive experience working with classically traumatised PTSD cases, including sexual assault, accidents and terrorist attacks, during interviewing, the author noted that clients reacted to the bullying or their accusation experience in exactly the same way as a more classically traumatised person reacts and relates to their traumatic event. They had difficulty remembering parts of it, were extremely distressed recalling it and memories, thoughts and images of the event/s would intrude into their dreams as nightmares and into their waking as flashbacks. They had an event focused disorder and their intrusive and avoidant symptoms were focused on their workplace experience.

Taking a trauma based Cognitive Behavioural Counselling approach and focusing on the clients' reported workplace problems as a trauma event was very effective with

over 90% recovery from PTSD during counselling and 69% recovery from general psychiatric and mental health problems by 6 months after completion of treatment. The question of recovery is one that could be called into question, as the clients' recovery from PTSD was strong, yet they continued to show psychiatric problems. However, the clients who were followed up showed continued improvement up to six months later, and 69% had shown improvement enough to be labelled as recovered from general psychiatric and mental health problems as well. This raises the question of whether clients can be assessed as recovered if the presenting symptoms of the special problem they came for counselling for have been dealt with but other areas also affected but not falling in the specific disorder have not been significantly reduced. Have they recovered or not, if, for example, their PTSD symptoms are mostly gone, but they still fight with symptoms of depression or anxiety that came about as a result of the trauma?

As a compromise the author suggests a concept of 'full recovery', whereby recovery is measured in terms of a cross tabulation between two scales, a specific scale which measures the main presenting condition of the client (in this case the PENN inventory) and a more general scale that measures a broad spectrum of indicators of general psychiatric problems (here the CORE system was used). Full recovery is when a client shows Reliable and Clinically Significant Change on both scales.

This study has shown that trauma based CBC therapeutic counselling is successful for treating victims of workplace bullying and victimisation with PTSD-like symptoms. But having heard the stories of what the clients were subjected to in their victimisation, having witnessed the effect it had upon them and having shared with them part of their journey on the way to recovery, the author would emphasise that prevention is the approach of choice.

Those with the condition need to be recognised much sooner and referred for appropriate treatment, and not spend on average 4 to 5 months on sick leave before counselling. Earlier intervention will prevent the fragmentation of their support

systems and the risk of permanent damage to themselves, their family, their social life and their work life. This research and its preliminary findings have already raised awareness among RCN Officers, and the counsellor is seeing more people referred earlier in their condition. Hopefully wider publication among primary health carers including GPs and Occupational Health Departments and within the nursing profession itself will improve this further. However this is still not good enough.

Prevention is the key, and as such, much depends upon education. If, as has been suggested, the responsibility for the high incidence of victimisation in nursing is within the profession itself, there must be a concerted effort in several areas to prevent it, all requiring more conscious education by the profession and the institutions which train nurses.

First would be to raise a ground level awareness of personality types and the contributions each type has in a team, in an effort to overcome the most fundamental differences between workers in each unit. When each worker has a basic framework to relate to others with, to know what to expect from others in a normal situation, a stressful time, and problem-solving scenario, perhaps many misunderstandings could be prevented and better relationships based on appreciation for one another could be built.

A second area for education and implementation would be better supervision and mentoring of managers and their management style. Those who are in higher management positions would need to make supervising and mentoring managers a higher priority and perhaps get more training in that area. This could help competitive managers, who are driving to get the job done, establish better boundaries for themselves as they work with their staff, and develop more empathetic relationships with them.

The third area that could improve through education would be assertiveness training for staff, to enable challenging bullying behaviour when it arises, rather than just taking it and going on with work as if nothing happened. If those in authority are not

confronted when they lose their temper or overstep boundaries into unacceptable management style, they begin to feel that it is acceptable to do so. But if the staff challenge them, that helps managers know how to relate to their staff in constructive ways. Much stress caused, sporadic bullying could be dealt with successfully in this way and perhaps consistently malicious bullies could begin to be hindered as well.

When challenging fails, or there is a major disagreement and the relationship cannot be resolved within the unit, mediation should be a more called upon alternative. Mediation or conflict resolution is not a pipe dream. Barbara Martin (MSF anti bullying conference, 18/2/98) said that no case is ever black and white; there is usually an 80:20 split of responsibility in the breakdown which is the opening to mediation and negotiation work. Since 65% of harassment victims approach their union representative first with the problem, unions and staff representative bodies such as RCN are in the ideal place to be involved in mediation work, especially since both parties are often members.

It is of paramount importance to develop and research the possible rehabilitation of the bullies, just as it is to develop the treatment and rehabilitation of the victims. Nothing is to be gained from promoting a witch hunt in which people may be accused, severely punished or dismissed. As this study has shown, the antagonists if treated in this manner may end up in counselling for PTSD themselves.

**PTSD and BULLYING**

At present, adult workplace bullying and victimisation are outside the PTSD umbrella and would not be included as a major area of PTSD study. If we were to go back to 1980, before the defining of PTSD, knowing what we do now about bullying and its effects, bullying would be seen as another potential cause of psychological traumatisation. It might be one of the key areas of study in the field of psychological trauma, because it offers a unique opportunity to study the role of the emotional

response of fear, helplessness and horror in isolation from threats to life or physical integrity. Adult workplace bullying within a professional setting is a highly ritualised behaviour with a very muted physical threat component.

Seeing the conceptualisation of PTSD in the context of Vietnam War veterans explains why the wording of DSM-IV Criterion A1 is so heavily constructed around the concept of physical threat. Those who wrote it were faced with a very specific and mounting scientific, social and political challenge that they could no longer deny, but in conceding the argument, they only addressed the issues of war veterans and other forms of physical violence.

Strong lobbies and large scale disasters, where many go through similar experiences at the same time, have disproportionately shaped the study and the concept of psychological trauma around a physical threat. A lot of forms of trauma have been able to attach themselves to the PTSD banner because they have been able to argue some dimension of physical threat such as in child abuse or rape. This has bolstered the physical threat position and has meant very little work has been done on the separate role of threat to mental integrity in triggering trauma, even though threat to mental integrity rather than physical integrity is arguably a major component of these experiences. People experiencing individual traumas on their own, with no lobby group, have in common the symptoms of trauma but, like war veterans, abused children and raped women before them, they have not been recognised and have been blamed instead for having problems: 'its just you', 'there's something wrong with you', 'why can't you just get over it?' .

War veterans were traumatised before PTSD gave it recognition. A number of victims of bullying and single traumatic victims, as shown by this study, are traumatised by their experiences even though the American Psychiatric Association will not give it that name.

Vocal lobbying groups have pushed through legislation against discrimination or harassment on grounds of gender, race, religion or political affiliation. But we have

no legislation to protect people from bullying, the fundamental abuse of power or position, which is the common dynamic which underlies all other forms of abuse, harassment or discrimination. Establishing that bullying causes PTSD may be as much a social and political endeavour for the victims as a matter of scientific argument.

The author of this study would recommend that those who are working towards enlarging the criteria to be met for PTSD assessment look at the larger, overall picture of the cause of trauma rather than tweaking the definition of "event" or twisting and contorting the conceptualisation of bullying to make it fit the present PTSD criterion. Either of these approaches would be yet another quick fix which will need to be changed again later. A better approach would be to incorporate an in depth, well researched understanding of the effects of abuse of power and humiliation as a threat to mental integrity which can act as a trigger in bringing on PTSD. Humiliation has been suggested as the link between the various forms of victimisation discussed in this study as well as other forms of discrimination and abuse.

Such an approach would cover not only those individuals whose experiences of bullying brought about PTSD, but also those who experienced a Single Traumatic Victimisation through false accusation and unjust punishment, rather than prolonged abuse at the hands of the bully. Both kinds of experiences caused PTSD and both would clearly fit a description of abuse of power and humiliation.

There are many reasons why such a change is needed. Knowing that a client has PTSD can lead the counsellor to select a therapeutic approach which is appropriate and more likely successful. It helps the client and client's family and friends understand what is happening to them and why, as well as alleviate fears they may have that they are going mad. It can help management know how to work with the client and get them back into the workplace more quickly. If there are grounds for legal action, this will give the victim legal authority make a claim and, if appropriate, to be compensated. This is not just a textbook issue: it has far-reaching implications for all concerned. One issue which came out several times in the interviews was the

abuse of the disciplinary system of the profession or the institution the client was working for. For the victims of Single Traumatic Victimisations, this meant the accuser taking a false accusation through the system to see the victim pushed out of their job, downgraded, or harshly disciplined in a likewise humiliating way. The speed with which the system over reacted and meted out unjust punishment became an example to the other nurses in the organisation of how the system could be used against them, reinforcing their mistrust and fear of the system.

Bullies can take advantage of this fear and abuse subordinates with threats of reporting mistakes to management, of initiating investigations or disciplinary processes, or sending reports to the UKCC. Such threats can be used to blackmail or control individuals, turning what should give confidence to well disciplined nurses into an instrument of fear. The perception which nurses at ward level have of the whole disciplinary procedure is heavily coloured by their experience of justice at unit level which is often very poor. Because they have seen harsh, inappropriate discipline handed out, their understanding of upper levels of the justice system in health care is distorted into something even more draconian.

The threats included accusations which, if reported to the nursing state registration board of the United Kingdom Central Council for Nursing and Midwifery (UKCC), could result in them being struck off the register and losing their professional career. In nursing, unlike many other professions, the registration body has teeth and uses them. The author's impression in the instances of working with the UKCC and individuals who were reported to them is that it very fair. The perception among nurses, however, is that it is strict, lays down a lot of very exacting rules which it applies strictly. It also interprets and applies quite widely some less specific rules such as bringing the profession into disrepute. The UKCC may see itself differently, but this is the general perception, which is what is important when trying to understand the reaction of these nurses.

It will take concerted effort on the part of management throughout the whole health care system to reverse this perception and reinstate trust in the system.

## PERSONALITY

More detailed personality profiling of both groups of victims and of a comparative nursing management team using the Myers Briggs Type Indicator (MBTI) identified a number of interesting patterns which merit future exploration. There is a general consensus that workplaces are not fully heterogeneous in respect of personality types, that certain types of people select certain careers, but getting detailed profiling of professional groups is difficult. Using the MBTI it was noted that the typical nurse and nurse manager profiles, Introverted Sensing Feeling Judging (ISFJ), Extroverted Sensing Feeling Judging (ESFJ) and Extroverted Sensing Thinking Judging (ESTJ) made up 65% of the clients and management team. These personality types make excellent nurses: caring, thorough, detail oriented, responsible, conscientious, and self sacrificing in meeting the needs of others. But the ISFJ nurse is very similar in many ways to Coyne et al's (2000) description of a typical victim of bullying, and for this reason nurses may be more susceptible to bullying and perhaps other forms of victimisation.

This study has discussed the shadow side of these personality types at some length believing that it brings more light onto the subject. These types are susceptible, under high stress, or under certain triggering conditions including unexpected change, imposition of unrealistic plans and excessive overdoing of their normal roles, to becoming extremely critical of others and be particularly sensitive to criticism themselves. A lot of sporadic or casual bullying in nursing may be due to the shadow side effect since nurses, and particularly the main age bands in the study group, are one of the most stressed groups in the general workforce. They also experience on a regular basis the specific trigger situations which they are most susceptible to, including excessive workload and unrealistic organisational changes. This may result in low grade inter-personal conflict which could be seen as a type of casual bullying, and this background of casual bullying may trigger more serious bullying, or may create a tolerance of bullying which allows more systematic bullying to go unchallenged.

In the study an association was noted between a potential for victimisation and/or bullying and particular MBTI personality profiles. Other researchers have already noted associations between high stress workplaces and bullying, and between caring professions and bullying. High stress, high bullying and caring professions seem to be associated, but several groups which would not fit under the description of caring professions also had high stress and high bullying, such as public administration and the police.

In the background study to this research, it was noted that some relatively old work done when the MBTI was first being calibrated noted an over representation of the personality types ISFJ, ESFJ and ESTJ with a number of professions. These three profiles are high in nursing, teaching, caring professions, public admin and police. This suggests that high stress, high bullying, service/care sectors and a raised proportion of certain MBTI profiles are coincident with one another. Some of these industries have changed greatly over recent years and this personality profiling needs updated and carried out on a local basis.

However it suggests certain types of personality are more common in bullying environments. Whether this indicates more victims, or whether high stress and shadow may make them swing both ways needs further study.

Several other observations were made about personality types but need to be followed up with a larger group and some more in depth profiling of the local community and nursing. The management group and victims were all Judgers (Js), and consequently there were no Perceivers (Ps). Js are decision makers: they make decisions, often with minimal investigation or consultation, don't like going back and changing decisions. If nursing is high in Js, it would explain the often inadequate initial investigation of accusations and rapid forwarding to action which is producing so many cases of traumatisation by single traumatic victimisation.

Another pattern noted was the over representation of Introverted iNtuitive Thinking Judgers (INTJ) and Extroverted iNtuitive Thinking Judgers (ENTJ) types in the client group, who were experiencing a variety of forms of workplace victimisation. These

are the creative innovative types and are quite different from the more common nurse types, ISFJs, ESFJs and ESTJs, who tend to be slow to change, very practical and traditional. This raises the question of whether some personality types are experiencing downward and outward pressure within nursing. Many forms of differences like this can be the basis of interpersonal conflict and consequent victimisation.

As has been mentioned earlier, an awareness must be raised within the nursing profession of personality types and the strengths each type brings to the workplace in order to build a working environment of mutual support and appreciation. Staff also must learn about the shadow side of their type as well as that of their colleagues in order to be able to better deal with the Jekyll and Hyde that each of us can be in times of extreme stress.

While this study was limited in the number of people taking the Keirsey Type Indicator to base these observations on, it is the desire of the author that more research be done in the work place to verify these patterns and perhaps develop programs to combat more effectively the phenomenon of victimisation in the workplace.

In the author's experience throughout the research, the earlier people came after the disclosure of the incidents, the speedier their recovery.

The goal of the counselling was that the clients overcome the symptoms of PTSD, enhance relationship skills, return to their jobs, and gain a sense of normalcy as they would define it. These goals were generally achieved. In addition to this, the evidence in the study was that people learned about their trauma and, became more aware of their own personality and their ways of interrelating. They actually improved their closer relationships, re-prioritised their lives, and learned better coping skills for stress and inter-personal relationships in the workplace. Some benefited in various aspects of life through assertiveness training. The Health Service and general public benefited because well-trained, experienced nurses returned to work rather than leaving the health care profession.

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## APPENDIX A

Diagnostic and Statistical Manual of Mental Disorders, 4th edition.(DSM-IV)

Criteria for Post Traumatic Stress Disorder (APA 1994)

The diagnostic criteria for PTSD are defined in DSM-IV as follows:

A. The person experiences a traumatic event in which both of the following were present:

1. the person experienced or witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others;

2. the person's response involved intense fear, helplessness, or horror.

B. The traumatic event is persistently re-experienced in one or more of the following ways:

1. recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions;

2. recurrent distressing dreams of the event;

3. acting or feeling as if the traumatic event were recurring (e.g. reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those on wakening or when intoxicated);

4. intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event;

5. physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma) as indicated by at least three of the following:

1. efforts to avoid thoughts, feelings or conversations associated with the trauma;

2. efforts to avoid activities, places or people that arouse recollections of this trauma;

3. inability to recall an important aspect of the trauma;

4. markedly diminished interest or participation in significant activities;

5. feeling of detachment or estrangement from others;

6. restricted range of affect (e.g. unable to have loving feelings);

7. sense of a foreshortened future (e.g. does not expect to have a career, marriage, children or a normal life span).

D. Persistent symptoms of increased arousal (not present before the trauma) as indicated by at least two of the following:

1. difficulty falling or staying asleep;
2. irritability or outbursts of anger;
3. difficulty concentrating;
4. hypervigilance;
5. exaggerated startle response.

E. The symptoms on Criteria B, C and D last for more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

## APPENDIX B

Hammarberg's PENN Inventory (Hammarberg 1992)

Background Information and Questionnaire

**PENN Inventory**

Allen (1994) recommends a multi-modal approach for the assessment of Post Traumatic Stress Disorder. That was one reason why the PENN Inventory was included in addition to clinical assessment against DSM-IV criteria for PTSD. Another major reason for using the PENN Inventory was to enable a scaling of the severity of the condition and to quantify recovery.

The use of Hammarberg's (1992) PENN Inventory a self report, 26 item, questionnaire enabled a numeric value (0 to 72) to be given to the level of trauma symptoms experienced by the subjects. The collection of such quantitative data allows for the "manipulation of numerical data through statistical procedures for the purpose of describing phenomena or assessing the magnitude and reliability of relationships between them." (Pollit & Hungler 1995)

The PENN Inventory is a Likert scale involving the scoring and summation of client selected responses to a series of sets of closed ended cafeteria questions.

Hammarberg's PENN Inventory

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the statement in each group which best describes the way you have been feeling during the PAST WEEK, INCLUDING TODAY! Circle the number beside the statement you picked. Be sure to read all the statements in each group before making your choice.

| | | |
|---|---|---|
| 1 | 0 | I don't feel much different from most other people my age. |
| | 1 | I feel somewhat different from most people my age. |
| | 2 | I feel so different from most people my age that I choose pretty carefully who I'll be with and when. |
| | 3 | I feel so totally alien to most other people my age that I stay away from all of them at all costs. |

| | | |
|---|---|---|
| 2 | 0 | I care as much about the consequences of what I'm doing as most other people |
| | 1 | I care less about the consequences of what I'm doing than most other people. |
| | 2 | I care much less about the consequences of what I'm doing than most other people. |
| | 3 | Often I think "Let the consequences be damned!" because I don't care about them at all. |

| | | |
|---|---|---|
| 3 | 0 | When I want to do something for enjoyment I can find someone to join me if I want to. |
| | 1 | I'm able to do something for enjoyment even if I can't find someone to join me. |
| | 2 | I lose interest in doing things for enjoyment when there's no one to join me. |
| | 3 | I have no interest in doing anything for enjoyment when there's no one to join me. |
| 4 | 0 | I rarely feel jumpy or uptight. |
| | 1 | I sometimes feel jumpy or uptight. |
| | 2 | I often feel jumpy or uptight. |
| | 3 | I feel jumpy or uptight all the time. |
| 5 | 0 | I know someone nearby who really understands me. |
| | 1 | I'm not sure there's anyone nearby who really understands me. |
| | 2 | I'm worried because no one nearby really seems to understand me. |
| | 3 | I'm extremely disturbed that one nearby really seems to understand me. |
| 6 | 0 | I'm not afraid to show my anger because it no worse or better than anyone else's. |
| | 1 | I'm afraid to show my anger because it goes up quicker than other people's. |
| | 2 | I'm often afraid to show my anger because it might turn to violence |
| | 3 | I'm so afraid of becoming violent that I never allow myself to show any anger at all. |

| | | |
|---|---|---|
| 7 | 0 | I don't have any past traumas to feel overly anxious about |
| | 1 | When something reminds me of my past traumas I feel anxious but can tolerate it. |
| | 2 | When something reminds me of my past traumas I feel very anxious but can use special ways to tolerate it. |
| | 3 | When something reminds me of my past traumas I feel so anxious I can hardly stand it and have no ways to tolerate it. |
| 8 | 0 | I have not re-experienced a flashback to a trauma event "as if I were there again". |
| | 1 | I have re-experienced a flashback to a trauma event "as if I were there again" for a few minutes or less. |
| | 2 | My re-experiencing of a flashback to a trauma event sometimes lasts the better part of an hour. |
| | 3 | My re-experiencing of a flashback to a trauma event often lasts an hour or more. |
| 9 | 0 | I am less easily distracted than ever. |
| | 1 | I am as easily distracted as ever. |
| | 2 | I am more easily distracted than ever. |
| | 3 | I feel distracted all the time. |
| 10 | 0 | My spiritual life provides more meaning than it used to. |
| | 1 | My spiritual life provides as much meaning as it used to. |
| | 2 | My spiritual life provides less meaning than it used to. |
| | 3 | I don't care about my spiritual life. |

| | | |
|---|---|---|
| 11 | 0 | I can concentrate better than ever. |
| | 1 | I can concentrate about as well as ever. |
| | 2 | I can't concentrate as well as I used to. |
| | 3 | I can't concentrate at all. |
| 12 | 0 | I've told a friend or family member about the important parts of my most traumatic experiences. |
| | 1 | I've had to be careful in choosing the parts of my traumatic experiences to tell friends or family members. |
| | 2 | Some parts of my traumatic experiences are so hard to understand that I've said almost nothing about them to anyone. |
| | 3 | No one could possibly understand the traumatic experiences I've had to live with. |
| 13 | 0 | I generally don't have nightmares. |
| | 1 | My nightmares are less troubling than they were. |
| | 2 | My nightmares are just as troubling as they were. |
| | 3 | My nightmares are more troubling than they were. |
| 14 | 0 | I don't feel confused about my life. |
| | 1 | I feel less confused about my life than I used to. |
| | 2 | I feel just as confused about my life as I used to. |
| | 3 | I feel more confused about my life than I used to. |

15 0 I know myself better than I used to.

1 I know myself about as well as I used to.

2 I don't know myself as well as I used to.

3 I feel like I don't know who I am at all.

16 0 I know more ways to control or reduce my anger than most people.

1 I know about as many ways to control or reduce my anger as most people.

2 I know fewer ways to control or reduce my anger than most people.

3 I know no ways to control or reduce my anger.

17 0 I have not experienced a major trauma in my life.

1 I have experienced one or more traumas of limited intensity.

2 I have experienced very intense and upsetting traumas.

3 The traumas I have experienced are so intense that memories of them intrude on my mind without warning.

18 0 I've been able to shape things towards attaining many of my goals.

1 I've been able to shape things towards attaining some of my goals.

2 My goals aren't clear.

3 I don't know how to shape things towards my goals.

| | | |
|---|---|---|
| 19 | 0 | I am able to focus my mind and concentrate on the task at hand regardless of unwanted thoughts. |
| | 1 | When unwanted thoughts intrude on my mind I'm able to recognise them briefly and then refocus my mind on the task at hand. |
| | 2 | I'm having a hard time coping with unwanted thoughts and don't know how to refocus my mind on the task at hand. |
| | 3 | I'll never be able to cope with unwanted thoughts. |
| 20 | 0 | I am achieving most of the things I want. |
| | 1 | I am achieving many of the things I want. |
| | 2 | I am achieving some of the things I want. |
| | 3 | I am achieving few of the things I want. |
| 21 | 0 | I sleep as well as usual. |
| | 1 | I don't sleep as well as usual. |
| | 2 | I wake up more frequently or earlier than usual and have difficulty getting back to sleep. |
| | 3 | I often have nightmares or wake up several hours earlier than usual and cannot get back to sleep. |
| 22 | 0 | I don't have trouble remembering things I should know. |
| | 1 | I have less trouble than I used to remembering the things I should know. |
| | 2 | I have about the same trouble as I used to remembering things I should know. |
| | 3 | I have more trouble than I used to remembering things I should know. |

23 0 My goals are clearer than they were.

1 My goals are as clear as they were.

2 My goals are not as clear as they were.

3 I don't know what my goals are.

24 0 I'm usually able to let bad memories fade from my mind.

1 Sometimes a bad memory comes back to me, but I can modify it, replace it, or set it aside.

2 When bad memories intrude on my mind I can't seem to get them out.

3 I worry that I am going crazy because bad memories keep intruding on my mind.

25 0 Usually I feel understood by others.

1 Sometimes I don't feel understood by others.

2 Most of the Time I don't feel understood by others.

3 No one understands me at all.

26 0 I have not lost anything or anyone dear to me.

1 I have grieved for those I have lost and can now go on.

2 I haven't finished grieving for those I've lost.

3 The pain of my loss is so great that I can't grieve and don't know how to get started.

## APPENDIX C

CORE Clinical Outcomes in Routine Evaluation (CORE System Group 1998a)

CORE Outcome Measure Questionnaire and

Extracts from the CORE System User's Manual (CORE System Group 1998b)

# Clinical Outcomes in Routine Evaluation

## SECTION A: INTRODUCTION to THE CORE SYSTEM

### The CORE System: A Summary

The CORE System Group [CSG] developed, piloted and implemented a co-ordinated quality evaluation, audit and outcome benchmarking system for psychological therapy services. This has involved working closely with a range of stakeholders groups representing psychiatry, psychotherapy, clinical psychology, and counselling. The CORE System comprises three components, which act as the standardised 'hub', which can be complemented by either methodological or domain/population/diagnostic-specific 'spokes'.

#### CORE Administration Checklist

One of the consistent challenges to traditional service evaluation has been the collection of comprehensive and representative datasets. For a variety of reasons, many evaluations to-date have suffered from considerable data attrition. The CORE Administration Checklist has been designed to audit CORE System Data administration and collection. This helps to not only co-ordinate the day-to-day administration of the CORE System, but also collect information on data representativeness and associated problems.

### CORE Assessment & End of Therapy Forms

Traditional evaluation methodologies are largely reliant on service administrators and practitioners ensuring that clients/patients (hereafter termed clients) receive questionnaires to complete throughout various stages of their contact with the service. The experience of CSG members is that services report considerable resource constraints in attempting to efficiently and effectively administer, process and utilise self-report questionnaires which lead to problems securing data which is representative of service provision. Consequently the CSG has worked closely with practitioners from health, education and voluntary sector services to devise two pragmatic practitioner-completed data capture forms which can be used for both treatment evaluation and service audit purposes. The CSG believes such an approach has several advantages over client/patient-reliant methodologies:

- Completed for every client by every practitioner, the forms help assure *comprehensive profiling* of service throughput
- The forms collect data on routine *audit items* (e.g. waiting times, appropriateness of referral, non-attendance rates) to help inform and enhance service efficiency
- The forms collect data on *presenting and emerging problems/concerns* via a categorisation framework complemented by an international classificatory system (ICD 10) to help profile service populations
- The forms collect data on *the benefits of therapy* to help profile outcomes for those clients coming to unplanned endings
- The forms collect data on *therapy descriptors* (e.g. therapy type, duration and frequency) to help profile services and contextualise client self-report and practitioner-rated outcomes
- Methodologically, the forms offer the opportunity to focus client-collected data specifically on therapy issues, which enhance assessment, therapy planning and discharge.

## CORE Outcome Measure

The CORE Outcome Measure has been designed to be suitable for use across a wide variety of service types; the measure taps into a pan-theoretical 'core' of clients' distress, including subjective well-being, commonly experienced problems or symptoms, and life/social functioning. In addition, items on risk to self and to others are included.

The CORE Outcome Measure addresses global distress and is therefore suitable for use as an initial screening tool and outcome measure; like most self report measures, it cannot be used to gain a diagnosis of a specific disorder. The mean of all 34 items can be used as a global index of distress, the main design intention. However, mean item scores for the dimensions of well-being, problems/symptoms, life functioning, and risk can also be used separately where that distinction may be desired. The risk items should not be regarded as a scale but as clinical flags and some services may wish to use them to trigger more discussion of risk at assessment.

The measure has been extensively piloted and resultant data (in press) suggest: the measure (1) has considerable clinical face value; (2) has supportive validity and reliability; and, (3) distinguishes between clinical and non-clinical or general populations. The CSG believe the CORE Outcome Measure has the following advantages over the range of client-completed protocols utilised in existing measurement practice:

- As the measure is both very *brief* (2-sided) *& user-friendly* (measured reading ease), client compliance appears high
- The content of the measure addresses those *patient aspects* identified by practitioners as routine assessment domains
- As the measure can be *practitioner-scored*, subjective well-being, symptom, functioning and risk profiles are pragmatic for assisting assessment and discharge
- Practitioners utilising the measure are able to compare individual scores with supplied *normative data* for clinical and non-clinical populations allowing clinically significant change to be determined
- As the CSG are committed to the national implementation and support of the measure, our aim is to help it become both widely used and durable, quickly growing a substantial dataset of *comparative outcome data* to complement research efficacy data
- As the measure is designed to have *generic applicability* across all levels of service delivery, resultant data should be highly useful for comparing presentations and outcomes at different levels of service provision

**Other Advantages of the CORE System**

- As the CORE System is standardised, highly efficient *automated reporting* is possible. This offers the potential for a range of reports which can include individual practitioner feedback, practice feedback, service feedback, domain feedback and symptom group feedback
- Because the CORE System is standardised, service delivery and outcome data for a range of provision domains (i.e. primary, secondary and specialist care) and across a range of provider affiliations (i.e. counselling, clinical psychology, psychotherapy, art therapy) service can compare themselves on a 'like with like' basis

## STRUCTURE

The 34 items of the measure cover three dimensions:

1. *subjective well-being* (4 items),
2. *problems/symptoms* (12 items),
3. *life functioning* (12 items).

These should be compatible with the phase-model of change which suggests a sequential impact on (remoralising) subjective well-being early in therapy, progressing to (remediating) symptoms, and then to (rehabilitating) aspects of life functioning for many therapies (Howard, Lueger *et al*, 1993). In addition, it contains:

4. *risk/harm* (6 items).

These items should be used as clinical indicators of the patient being 'at risk' to themselves or others. Features of the measure include high and low intensity items to increase sensitivity and 25% of the items are 'positively' framed. The items are presented in Table 1.

### Table 1. Dimensional breakdown of the CORE Outcome Measure

| Dimension | Item<br>(Pos) = Positively phrased scoring | Severity/ Intensity | Item N° |
|---|---|---|---|
| ***Subjective Well Being*** | I have felt O.K. about myself (Pos) | Lo | 4 |
| ***Subjective Well Being*** | I have felt like crying | Hi | 14 |
| ***Subjective Well Being*** | I have felt optimistic about my future (Pos) | Lo | 17 |
| ***Subjective Well Being*** | I have felt overwhelmed by my problems | Hi | 31 |
| ***Symptoms - anxiety*** | I have felt tense, anxious or nervous | Lo | 2 |
| ***Symptoms - anxiety*** | Tension and anxiety have prevented me doing important things | Hi | 11 |
| ***Symptoms - anxiety*** | I have felt panic or terror | Hi | 15 |
| ***Symptoms - anxiety*** | My problems have been impossible to put to one side | Lo | 20 |
| ***Symptoms - depression*** | I have felt totally lacking in energy and enthusiasm | Hi | 5 |
| ***Symptoms - depression*** | I have felt despairing or hopeless | Hi | 23 |
| ***Symptoms - depression*** | I have felt unhappy | Lo | 27 |
| ***Symptoms - depression*** | I have thought I am to blame for my problems and difficulties | Lo | 30 |
| ***Symptoms - physical*** | I have been troubled by aches, pains or other physical problems | Lo | 8 |
| ***Symptoms - physical*** | I have difficulty getting to sleep or staying asleep | Lo | 18 |
| ***Symptoms - trauma*** | I have been disturbed by unwanted thoughts and feelings | Hi | 13 |
| ***Symptoms - trauma*** | Unwanted images or memories have been distressing me | Hi | 28 |
| ***Functioning - general*** | I have felt able to cope when things go wrong (Pos) | Hi | 7 |
| ***Functioning - general*** | I have been happy with the things I have done (Pos) | Lo | 12 |
| ***Functioning - general*** | I have been able to do most things I needed to (Pos) | Lo | 21 |
| ***Functioning - general*** | I have achieved the things I wanted to (Pos) | Hi | 32 |
| ***Functioning - close rel.*** | I have felt terribly alone and isolated | Hi | 1 |
| ***Functioning - close rel.*** | I have felt I have someone to turn to for support when needed (Pos) | Lo | 3 |
| ***Functioning - close rel.*** | I have felt warmth and affection for someone (Pos) | Lo | 19 |
| ***Functioning - close rel.*** | I have thought I have no friends | Hi | 26 |
| ***Functioning - social rel.*** | Talking to people has felt too much for me | Hi | 10 |
| ***Functioning - social rel.*** | I have felt criticised by other people | Lo | 25 |
| ***Functioning - social rel.*** | I have been irritable when with other people | Lo | 29 |
| ***Functioning - social rel*** | I have felt humiliated or shamed by other people | Hi | 33 |
| ***Risk/Harm to self*** | I have thought of hurting myself | Lo | 9 |
| ***Risk/Harm to self*** | I have hurt myself physically or taken dangerous risks with my health | Hi | 34 |
| ***Risk/Harm to self*** | I made plans to end my life | Hi | 16 |
| ***Risk/Harm to self*** | I have thought it would be better if I were dead | Lo | 24 |
| ***Risk/Harm to others*** | I have been physically violent to others | Hi | 6 |
| ***Risk/Harm to others*** | I have threatened or intimidated another person | Hi | 22 |

**Total Score and Total Mean Score**

Key points in the scoring of the CORE Outcome Measure are as follows:

- Each item within the CORE Outcome Measure is scored on a 5-point scale ranging from 0 (not at all) to 4 (most or all the time).
- The **total score** is calculated by adding the response values of all 34 items.
- The minimum score that can be achieved is 0 and the maximum 136.
- The **total mean score** is calculated by dividing the total score by the number of *completed* item responses (normally 34).

However, in the case of **missing data**, the mean score can be calculated for the non-missing items. For example, if two items have not been responded to, the total score is divided by 32 (see below). We do not recommend e-scaling the total or non-risk scores if more than three items have been missed. Similarly we do not recommend re-scaling dimension scores if more than one item is missing from a dimension.

The measure is problem scored, that is, the higher the score the more problems the individual is reporting and/or the more distressed they are. This makes scores on the "well-being" dimension a bit counter-intuitive but they are kept this way for consistency with the other dimensions.

**Dimension Scores**

The four dimensions of the CORE Outcome Measure can be identified by the letter adjacent to the column of boxes labelled "office use only" at the far right hand side of the measure. These are shown in Table 2 below. These boxes are for immediate hand scoring if required. Thus to gain a total score for the "Well-being" dimension, first write the values of the responses in the allocated boxes, then total the scores of the four boxes marked 'W' and write this score in the box marked "W" at the foot of the measure. The **mean scores for each dimension** are calculated by dividing the total scores by the number of *completed* item responses for each dimension; for "Well-being" the score would normally be divided by four, if one 'well being' item has been omitted, score should be divided by three.

**Risk Items**

These items cover suicidal ideation and harm to self and others. Where an individual scores more than '0' on any item marked 'R' (Risk), this should be flagged for further attention by the clinician. To calculate the mean total score minus risk items ('All minus R') first calculate the total score, minus the risk score, and then calculate the mean score by dividing this score by the number of completed item responses marked 'W', 'P' or 'F' (normally 28).

Table 2 - Identifiers and score ranges for dimensions of the CORE Outcome Measure

| Identifier | Dimension | No of items | Total Score Range | Mean Score Range |
|---|---|---|---|---|
| ***W*** | Well Being | 4 items | 0 - 16 | 0 - 4 |
| ***P*** | Problems or Symptoms | 12 items | 0 - 48 | 0 - 4 |
| ***F*** | Functioning | 12 items | 0 - 48 | 0 - 4 |
| ***R*** | Risk | 6 items | 0 - 24 | 0 - 4 |
| | ***Total Score*** | 34 items | 0 - 136 | 0 - 4 |

## NORMATIVE DATA

In work to date, data have been collected on samples from two groups:

- A non-clinical population of students from two different universities on a variety of different courses, and a sample of convenience of both staff and their friends and relatives (total $n$ = 1,106) and
- a clinical population comprising users waiting for or receiving a wide variety of psychological interventions in a wide variety of settings throughout Britain (total $n$ = 890).

The **non-clinical data** came from the three samples. The first was of 691 respondents from a university. It comprised 304 (44%) women, 381 (55%) men with gender not given by 6 (1%). The age range for this sample was 17 to 43 with quartiles at 19, 20 and 23. The second sample was of data from 55 students at another university participating in a test-retest reliability study. Eight (15%) were men, 46 (84%) were women, and one not state their gender. Their ages ranged from 20 to 45 but the quartiles were 20, 21 and 22 years of age illustrating how 75% were 22 or younger. The last non-clinical sample was a sample of convenience, $n$ = 360, of therapists, researchers and their other colleagues, friends and relatives. This comprised 251 (70%) women and 109 (30%) men with no missing data for gender. The age range in this sample was from 14 to 45 with two missing ages and again the age range is a young one with quartiles 18, 20 and 23.

The **clinical data** came from 21 sites. The majority were within the NHS but they included one university student counselling service and one staff support service. One service was employed by a general practice, another was entirely focused on primary care, others had wider spans of referrals. Service leadership and membership varied including medical psychotherapists, clinical psychologists, counselling psychologists, counsellors and psychotherapists. Theoretical orientation also varied with few pure behavioural or cognitive-behavioural services but many eclectic services, some with strong psychodynamic orientations. The data used were the first data from each individual provided that this came from pre-treatment or from the first treatment session. The numbers from each site varied from 10 to 196 (mean 42). Gender was recorded for 874 of the 890 (98%), 530 (61%) were women, 344 (39%) men. Age was recorded for 850 and ranged from 16 to 78 with mean 36, median 34 and quartiles at 26, 34 and 45.

### Differences between clinical and non-clinical samples

The primary requirement of any clinical measure of distress is that it should show differences between the clinical populations for which it has been designed and non-clinical samples. Table 3 illustrates that the differences between the clinical and non-clinical populations are large and highly significant on all dimensions ($p \leq .0005$), i.e. less than a 5 in 10,000 chance differences as big as this occurred by chance.

*Table 3 - Means and standard deviations for clinical and non-clinical samples*

| | Non-clinical (n = 1084) | | Clinical (n = 863) | | Difference | |
|---|---|---|---|---|---|---|
| **Dimension** | **Mean** | **S.D.** | **Mean** | **S.D.** | **95% C.I.** | **p*** |
| Well-being | 0.91 | 0.83 | 2.37 | 0.96 | 1.38 to 1.53 | <.0005 |
| Problems | 0.90 | 0.72 | 2.31 | 0.88 | 1.33 to 1.48 | <.0005 |
| Functioning | 0.85 | 0.65 | 1.86 | 0.84 | 0.95 to 1.09 | <.0005 |
| Risk | 0.20 | 0.45 | 0.63 | 0.75 | 0.38 to 0.49 | <.0005 |
| All non-risk items | 0.88 | 0.66 | 2.12 | 0.81 | 1.18 to 1.31 | <.0005 |
| All items | 0.76 | 0.59 | 1.86 | 0.75 | 1.04 to 1.16 | <.0005 |

*p values for Mann-Whitney test

## Gender Differences

There were statistically significant but not very large differences between men and women in our non-clinical samples. The differences in the clinical samples were generally non-significant or significant but small. These results suggest that gender should be taken into account when relating individual scores to clinical or normative distribution data but that effects of gender are small compared with effects of clinical *versus* non-clinical status.

*Table 4 - Gender differences in CORE Outcome Measure scores for clinical and non-clinical samples*

**Non-Clinical Population**

| | Male ($n$ = 471) | | Female ($n$ = 576) | | Difference | |
|---|---|---|---|---|---|---|
| **Dimension** | **Mean** | **S.D.** | **Mean** | **S.D.** | **95% C.I.** | **p*** |
| Well-being | 0.68 | 0.71 | 1.10 | 0.87 | -.51 to -.32 | <.0005 |
| Problems | 0.78 | 0.64 | 1.00 | 0.76 | -.30 to -.13 | <.0005 |
| Functioning | 0.83 | 0.62 | 0.86 | 0.67 | -.11 to .05 | .65 |
| Risk | 0.23 | 0.47 | 0.15 | 0.40 | .03 to .14 | <.0005 |
| All non-risk items | 0.79 | 0.59 | 0.95 | 0.70 | -.25 to -.09 | <.0005 |
| All items | 0.69 | 0.53 | 0.81 | 0.61 | -.19 to -.04 | .004 |

**Clinical Population**

| | Male ($n$ = 338) | | Female ($n$ = 515) | | Difference | |
|---|---|---|---|---|---|---|
| **Dimension** | **Mean** | **S.D.** | **Mean** | **S.D.** | **95% C.I.** | **p*** |
| Well-being | 2.22 | 0.98 | 2.41 | 0.97 | -.33 to -.06 | .004 |
| Problems | 2.32 | 0.92 | 2.28 | 0.87 | -.08 to .17 | .270 |
| Functioning | 1.92 | 0.87 | 1.84 | 0.85 | -.04 to .20 | .184 |
| Risk | 0.69 | 0.75 | 0.61 | 0.77 | -.02 to .19 | .030 |
| All non-risk items | 2.13 | 0.84 | 2.11 | 0.82 | -.09 to .14 | .522 |
| All items | 1.88 | 0.78 | 1.85 | 0.77 | -.07 to .14 | .380 |

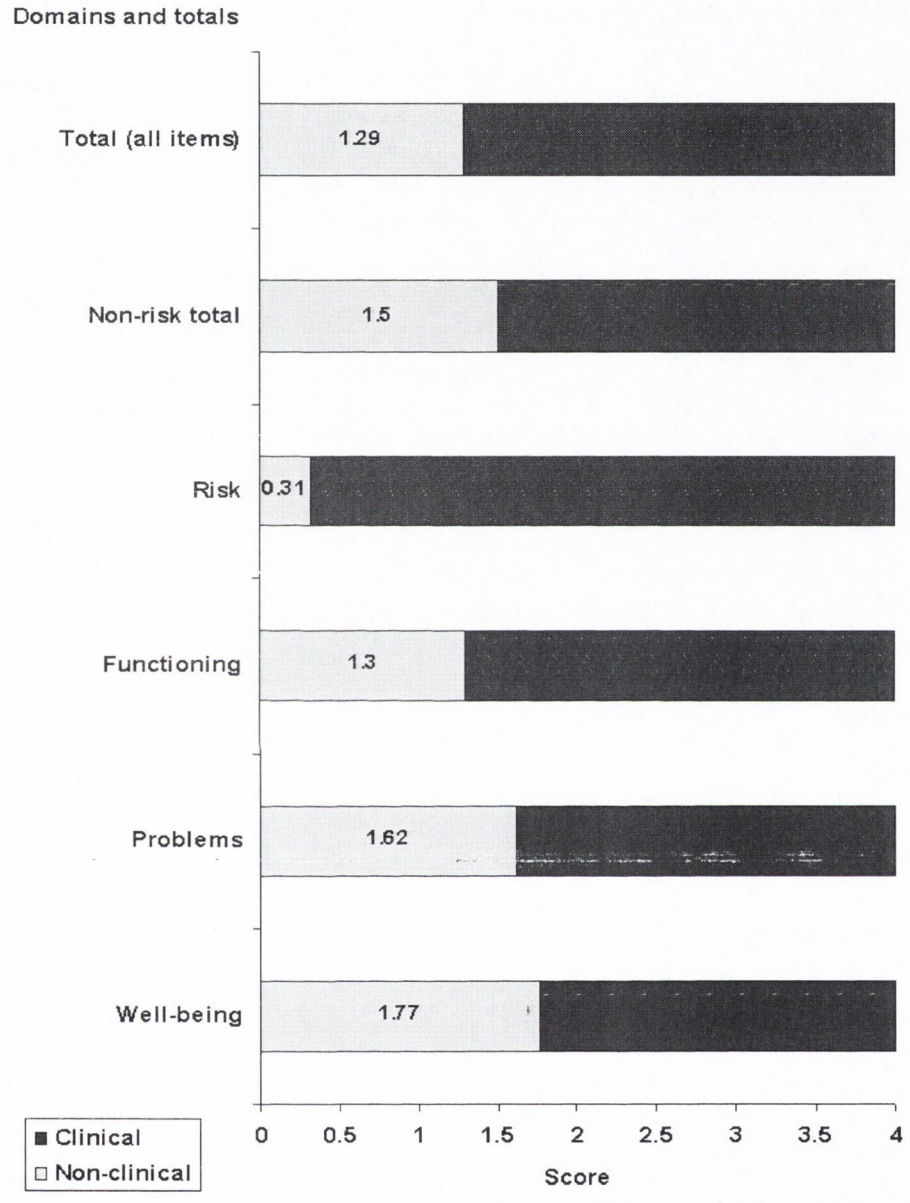
## CUT-OFF POINTS FOR RELIABLE AND CLINICALLY SIGNIFICANT CHANGE

Jacobson and colleagues (Jacobson et al., 1988) have suggested methods for determining reliable and clinically significant change. Reliable change is that which is unlikely to have arisen just by the unreliability of measurement of the instrument. Clinically significant change is sufficient improvement to have moved the client to a score more representative of the general population than a clinical population. There are several methods of calculating both the criterion for reliable change and for clinically significant change. These are well summarised by Jacobson & Truax, 1991; Evans, Margison & Barkham, 1998; and within the CORE System Handbook (CORE System Group, 1998). Practitioners interested in determining the clinical significance of change scores from the CORE Outcome Measure can use the values from the large samples reported in the following Table 5 and the graphs overleaf.

*Table 5 - Male and Female cut-off scores between clinical and non-clinical populations*

| Dimension | Male | Female |
|---|---|---|
| *Well-being* | 1.37 | 1.77 |
| *Problems* | 1.44 | 1.62 |
| *Functioning* | 1.29 | 1.30 |
| *Risk* | 0.43 | 0.31 |
| *All non-risk items* | 1.36 | 1.50 |
| ***All items*** | 1.19 | 1.29 |

## CORE Outcome Measure Cut-off scores: FEMALES - Non-clinical and clinical populations




Information to ClientsIn compliance with the Data Protection Act of 1998, it is necessary that clients give their explicit consent to the collection and processing of any identifiable data of a personal nature. They should also be informed of the reasons they are being asked to complete questionnaires, how the data will be used, who has access to the questionnaires, and whether or not this will affect their therapy. Clients also need to be assured that completing the questionnaires is voluntary, and that the information they give is confidential.

It is therefore required that clients sign an appropriate consent form, and be presented with an information sheet about the evaluation system when being asked to take part. Overleaf, you will find examples of an information sheet and consent form which will give you some guidelines as to what you should include. You may wish to alter these to be compatible with the details of your therapy/service, including an address for clients to contact if necessary.

## Client Information Sheet

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This practice uses a standard evaluation system, which has been developed to help providers of counselling and other psychological therapies to deliver and develop the best possible services to clients seeking help for their difficulties and concerns. As part of the system, all patients are asked to complete a brief questionnaire before and after their contact with the service. These questionnaires assist us in understanding your problems, and ultimately, the degree to which we help you with those problems. We hope you will agree to complete the questionnaires, but would like to emphasise that participation is entirely voluntary and declining to complete them will not affect your counselling/therapy in any way.

### About our evaluation:

- We would like you to complete a brief questionnaire before and after your contact with the therapy service. Your counsellor/therapist may also complete simple record forms relating to your therapy.
- Completing the questionnaires is entirely voluntary and you are free to choose whether you wish to complete them or not. **If you decide not to complete the forms this will not affect your counselling/therapy in any way, nor will anything you put on the questionnaire.** However, the more people who complete questionnaires, the more comprehensive the information is for improving the service for future clients.
- Your responses to the questionnaires help us understand more about the problems that counselling/therapy is required to address, the problems which counselling/therapy is most effective in helping, and the way in which our services can be improved.
- The information from the questionnaires will be treated as strictly confidential, no names are used on any questionnaires, and no one other than the researchers and ourselves will have access to your responses.

***The pre-completed information in the top right-hand shaded box of the questionnaire is for administration purposes only***

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### CLIENT CONSENT FORM

I have read the information sheet provided and I agree to the fair and lawful processing of personal information for the purposes of analysis and research in line with the Data Protection Act 1998.

I understand that the researchers using data collected will not have access to any personal data provided (eg name, address, date of birth) which makes the information identifiable to me and that I will not be identified in any way in anything that is written or reported about the research.

Signature .....

Name (block capitals) .....

Date .....

# SAMPLE

**C**LINICAL
**O**UTCOMES in
**R**OUTINE
**E**VALUATION

**OUTCOME MEASURE**

Site ID

letters only | numbers only

Client ID

Therapist ID | numbers only (1) | numbers only (2)

Sub codes

Date form given (D D / M M / Y Y Y Y)

Age

Male

Female

Stage Completed

S Screening
R Referral
A Assessment
F First Therapy Session
P Pre-therapy (unspecified)
D During Therapy
L Last therapy session
X Follow up 1
Y Follow up 2

Stage

Episode

**IMPORTANT - PLEASE READ THIS FIRST**

This form has 34 statements about how you have been OVER THE LAST WEEK.
Please read each statement and think how often you felt that way last week.
Then tick the box which is closest to this.
*Please use a dark pen (not pencil) and tick clearly within the boxes.*

| | Over the last week | Not at all | Only Occasionally | Sometimes | Often | Most or all the time | OFFICE USE ONLY |
|---|---|---|---|---|---|---|---|
| 1 | I have felt terribly alone and isolated | 0 | 1 | 2 | 3 | 4 | F |
| 2 | I have felt tense, anxious or nervous | 0 | 1 | 2 | 3 | 4 | P |
| 3 | I have felt I have someone to turn to for support when needed | 4 | 3 | 2 | 1 | 0 | F |
| 4 | I have felt O.K. about myself | 4 | 3 | 2 | 1 | 0 | W |
| 5 | I have felt totally lacking in energy and enthusiasm | 0 | 1 | 2 | 3 | 4 | P |
| 6 | I have been physically violent to others | 0 | 1 | 2 | 3 | 4 | R |
| 7 | I have felt able to cope when things go wrong | 4 | 3 | 2 | 1 | 0 | F |
| 8 | I have been troubled by aches, pains or other physical problems | 0 | 1 | 2 | 3 | 4 | P |
| 9 | I have thought of hurting myself | 0 | 1 | 2 | 3 | 4 | R |
| 10 | Talking to people has felt too much for me | 0 | 1 | 2 | 3 | 4 | F |
| 11 | Tension and anxiety have prevented me doing important things | 0 | 1 | 2 | 3 | 4 | P |
| 12 | I have been happy with the things I have done. | 4 | 3 | 2 | 1 | 0 | F |
| 13 | I have been disturbed by unwanted thoughts and feelings | 0 | 1 | 2 | 3 | 4 | P |
| 14 | I have felt like crying | 0 | 1 | 2 | 3 | 4 | W |

Please turn over



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# SAMPLE

## Over the last week

| | Not at all | Only Occasionally | Sometimes | Often | Most or all the time | OFFICE USE ONLY |
|---|---|---|---|---|---|---|
| I have felt panic or terror | 0 | 1 | 2 | 3 | 4 | P |
| I made plans to end my life | 0 | 1 | 2 | 3 | 4 | R |
| I have felt overwhelmed by my problems | 0 | 1 | 2 | 3 | 4 | W |
| I have had difficulty getting to sleep or staying asleep | 0 | 1 | 2 | 3 | 4 | P |
| I have felt warmth or affection for someone | 4 | 3 | 2 | 1 | 0 | F |
| My problems have been impossible to put to one side | 0 | 1 | 2 | 3 | 4 | P |
| I have been able to do most things I needed to | 4 | 3 | 2 | 1 | 0 | F |
| I have threatened or intimidated another person | 0 | 1 | 2 | 3 | 4 | R |
| I have felt despairing or hopeless | 0 | 1 | 2 | 3 | 4 | P |
| I have thought it would be better if I were dead | 0 | 1 | 2 | 3 | 4 | R |
| I have felt criticised by other people | 0 | 1 | 2 | 3 | 4 | F |
| I have thought I have no friends | 0 | 1 | 2 | 3 | 4 | F |
| I have felt unhappy | 0 | 1 | 2 | 3 | 4 | P |
| Unwanted images or memories have been distressing me | 0 | 1 | 2 | 3 | 4 | P |
| I have been irritable when with other people | 0 | 1 | 2 | 3 | 4 | F |
| I have thought I am to blame for my problems and difficulties | 0 | 1 | 2 | 3 | 4 | P |
| I have felt optimistic about my future | 4 | 3 | 2 | 1 | 0 | W |
| I have achieved the things I wanted to | 4 | 3 | 2 | 1 | 0 | F |
| I have felt humiliated or shamed by other people | 0 | 1 | 2 | 3 | 4 | F |
| I have hurt myself physically or taken dangerous risks with my health | 0 | 1 | 2 | 3 | 4 | R |

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

al Scores

ın Scores
score for each dimension divided by
er of items completed in that dimension)

| (W) | (P) | (F) | (R) | All items | All minus R |
|---|---|---|---|---|---|
| | | | | | |

Survey : 151

Page : 2

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## APPENDIX D

Overview of the 16 Myers Briggs Types (Myers & McCauley 1985)
Kiersey Sorter Questionnaire and Scoring Sheet (Kiersey 1998b)

# Kiersey Sorter for Myers Briggs

## Characteristics frequently Associated with each type

| Sensing | types | Intuitive | types | |
|---|---|---|---|---|
| **ISTJ**<br>Serious, quiet, earn success by concentration and thoroughness. Practical, orderly, matter-of-fact, logical, realistic and dependable. See to it that everything is well organized. Take responsibility. Make up their own minds as to what should be accomplished and work toward it steadily, regardless of protests or distractions. | **ISFJ**<br>Quiet, friendly, responsible and conscientious. Work devotedly to meet their obligations. Lend stability to any project or group. Thorough, painstaking, accurate. Their interests are usually not technical. Can be patient with necessary details. Loyal, considerate, perceptive, concerned with how other people feel. | **INFJ**<br>Succeed by perseverance, originality, and desire to do whatever is needed or wanted. Put their best efforts into their work. Quietly forceful, conscientious, concerned for others. Respected for their firm principles. Likely to be honored and followed for their clear convictions as to how best to serve the common good. | **INTJ**<br>Usually have original mindsand great drive for their own ideas and purposes. In fields that appeal to them, they have a fine power to organize a job and carry it through with or without help. Skeptical, critical, independent, determined, sometimes stubborn. Must learn to yield less important points in order to win the most important. | Introvert |
| **ISTP**<br>Cool onlookers—quiet, reserved, observing and analyzing life with detached curiosity and unexpected flashes of original humor. Usually interested in cause and effect, how and why mechanical things work, and in organizing facts using principles. | **ISFP**<br>Retiring, quietly friendly, sensitive, kind, modest about their abilities. Shun disagreements, do not force their opinions or values on others. Usually do not care to lead but are often loyal followers. Often relaxed about getting things done, because they enjoy the present moment and do not want to spoil it by undue haste or exertion. | **INFP**<br>Full of enthusiasms and loyalties, but seldom talk of these until they know you well. Care about learning, ideas, language, and independent projects of their own. Tend to undertake too much then somehow get it done. Friendly, but often too absorbed in what they are doing to be sociable. Little concerned with possessions or physical surroundings. | **INTP**<br>Quiet and reserved. Especially enjoy theoretical or scientific pursuits. Like solving problems with logic and analysis. Usually interested mainly in ideas, with little liking for parties or small talk. Tend to have sharply defined interests. Need careers where some strong interest can be used and useful. | types |
| **ESTP**<br>Good at on-the-spot problem solving. Do not worry, enjoy whatever comes along. Tend to like mechanical things and sports, with friends on the side. Adaptable, tolerant, generally conservative in values. Dislike long explanations. Are best with real things that can be worked, handled, taken apart, or put together. | **ESFP**<br>Outgoing, easygoing, accepting, friendly, enjoy everything and make things more fun for others by their enjoyment. Like sports and making things happen. Know what's going on and join in eagerly. Find remembering facts easier than mastering theories. Are best in situations that need sound common sense and practical ability with people as well as things. | **ENFP**<br>Warmly enthusiastic, high spirited, ingenious, imaginative. Able to do almost anything that interests them. Quick with a solution for any difficulty and ready to help anyone with a problem. Often rely on their ability to improvise instead of preparing in advance. Can usually find compelling reasons for whatever they want. | **ENTP**<br>Quick, ingenious, good at many things. Stimulating company, alert and outspoken. May argue for fun on either side of a question. Resourceful in solving new and challenging problems, but may neglect routine assignments. Apt to turn to one new interest after another. Skillful in finding logical reasons for what they want. | Extrovert |
| **ESTJ**<br>Practical, realistic, matter of fact, with a natural head for business or mechanics. Not interested in subjects they see no use for, but can apply themselves when necessary. Like to organize and run activities. May make good administrators, especially if they remember to consider other's feelings and points of view. | **ESFJ**<br>Warm-hearted, talkative, popular, conscientious, born cooperators, active committee members. Need harmony and may be good at creating it. Always doing something nice for someone. Work best with encouragement and praise. Main interest is in things that directly and visibly affect people's lives. | **ENFJ**<br>Responsive and responsible. Generally feel real concern for what others thing or want, and try to handle things with due regard for other person's feelings. Can present a proposal or lead a discussion group with ease and tact. Sociable, popular, sympathetic. Responsive to praise and criticism. | **ENTJ**<br>Hearty, frank, decisive, leaders in activities. Usually good in anything that requires reasoning and intelligent talk, such as public speaking. Are usually well informed and enjoy adding to their fund of knowledge. May sometimes appear more positive and confident than their experience in an area warrants. | types |

# Kiersey Sorter

1. At a party do you
 a) interact with many, including strangers
 b) interact with a few, known to you

2. Are you more
 a) realistic than speculative
 b) speculative than realistic

3. Is it worse to
 a) have your "head in the clouds"
 b) be "in a rut"

4. Are you more impressed by
 a) Principle b) emotions

5. Are you drawn towards
 a) Convincing b) touching

6. Do you prefer to work
 a) to deadlines b) just whenever

7. Do you tend to choose
 a) rather carefully
 b) somewhat impulsively

8. At parties do you
 a)stay late, with increasing energy
 b)leave early with decreased energy

9. Are you more attracted to
 a) sensible people
 b) imaginative people

10. Are you more interested in
 a) what is actual b) what is possible

11. In judging others are you more swayed by
a) laws than circumstance
b) circumstance than laws

12. In approaching others is your inclination to be somewhat
 a) objective b) personal

13. Are you more
 a) punctual b) leisurely

14 Does it bother you more to have things
 a) incomplete b) complete

15. In your social group do you
 a) keep abreast of others' happenings
 b) get behind with the news

16. In doing ordinary things are you more likely to
a) do it the usual way b) do it your way

17. Writers should
 a)"say what they mean and mean what they say"
 b)express things more by use of analogy

18 What appeals to you more, are you more impressed by
 a) consistency of thought
 b) harmonious human relationships

19. What are you more comfortable in making
 a) logical judgments
 b) b) value judgments

20. Do you want things
 a) settled and decided
 b) unsettled and undecided

21. Would you say you are more
 a) serious and determined
 b) easy going

22. In phoning do you
 a)rarely question that it will all be said
 b)rehearse what you'll say

23. Facts
 a) "speak for themselves"
 b) illustrate principles

24. Visionaries are
a) somewhat annoying
b) rather fascinating

25. Are you more often
 a) a cool-headed person
 b) a warm-hearted person

26. Is it worse to be
 a) unjust b) merciless

27. Should one usually let events occur
 a) by careful selection and choice
 b) randomly and by chance

28. Do you feel better about
 a) having purchased
 b) having the option to buy

29. In company do you
 a) Initiate conversation
 b) wait to be approached

30. Common sense is
 a) rarely questionable
 b) frequently questionable

31. Children often do not
 a) make themselves useful enough
 b) exercise their fantasy enough

32. In making decisions do you feel more comfortable with
 a) standards b) feelings

33. Are you more
 a) firm than gentle b) gentle than firm

34. Which is more admirable
 a) the ability to organize and be methodical
 b) the ability to adapt and make do

35. Do you put more value on
 a) definite b) open-ended

36. Does new and non-routine interaction with others
 a) stimulate and energize you
 b) tax your reserves

37. Are you more frequently
 a) a practical sort of person
 b) a fanciful sort of person

38. Are you more likely to
 a) see how others are useful
 b) see how others see

39. Which is more satisfying
 a) to discuss an issue thoroughly
 b) to arrive at an agreement on an issue

40. Which rules you more
 a) your head b) your heart

41. Are you more comfortable with work that is
 a) contracted
 b) b) done on a casual basis

42. Do you tend to look for
 a) the orderly b) whatever turns up

43. Do you prefer
 a) many friends with brief contact
 b)a few friends with more lengthy contact

44. Do you go more by
 a) facts b) principles

45. Are you more interested in
 a) production and distribution
 b) design and research

46. Which is more of a compliment
 a) "there is a very logical person"
 b) "there is a very sentimental person"

47. Do you value in yourself more that you are
a) unwavering b) devoted

48. Do you more often prefer the
a) final and unalterable statement
b) the tentative and preliminary statement

49. Are you more comfortable
a) after a decision
b) before a decision

50. Do you
a) speak easily and at length with strangers
b) find little to say to strangers

51. Are you more likely to trust your
a) experience b) hunch

52. Do you feel
a) more practical than ingenious
b) more ingenious than practical

53. Which person is more to be complimented: one of
a) clear reason
b) strong feeling

54. Are you more inclined to be
a) fair-minded
b) sympathetic

55. Is it preferable mostly to
a) make sure things are arranged
b) just let them happen

56 In relationships should most things be
a) renegotiable
b) random and circumstantial

57. When the phone rings do you
a) hasten to get to it first
b) hope someone else will answer

58. Do you prize more in yourself
a) a strong sense of reality
b) a vivid imagination

59. Are you drawn more to
a) fundamentals
b) overtones

60. Which seems the greater error
a) to be too passionate
b) to be too objective

61. Do you see yourself as basically
a) hard hearted
b) soft hearted

62. Which situation appeals to you more
a) the structured and scheduled
b) the unstructured and unscheduled

63. Are you a person who is more
a) routinized than whimsical
b) whimsical than routinized

64. Are you more inclined to be
a) easy to approach
b) somewhat reserved

65. In writings do you prefer
a) the more literal
b) the figurative

66. Is it harder for you to
a) identify with others
b) utilize others

67. Which do you prefer for yourself
a) clarity of reason
b) strength of compassion

68. Which is the greater fault
a) being indiscriminate
b) being critical

69. Do you prefer
a) a planned event
b) an unplanned event

70. Do you tend to be more
a) deliberate than spontaneous
b) spontaneous than deliberate

| | A | B |
|---|---|---|
| 1 | | |
| 8 | | |
| 15 | | |
| 22 | | |
| 29 | | |
| 36 | | |
| 43 | | |
| 50 | | |
| 57 | | |
| 64 | | |

E I

| | A | B | | A | B |
|---|---|---|---|---|---|
| 2 | | | 3 | | |
| 9 | | | 10 | | |
| 16 | | | 17 | | |
| 23 | | | 24 | | |
| 30 | | | 31 | | |
| 37 | | | 38 | | |
| 44 | | | 45 | | |
| 51 | | | 52 | | |
| 58 | | | 59 | | |
| 65 | | | 66 | | |
| | > | > | | | |

S N

| | A | B | | A | B |
|---|---|---|---|---|---|
| 4 | | | 5 | | |
| 11 | | | 12 | | |
| 18 | | | 19 | | |
| 25 | | | 26 | | |
| 32 | | | 33 | | |
| 39 | | | 40 | | |
| 46 | | | 47 | | |
| 53 | | | 54 | | |
| 60 | | | 61 | | |
| 67 | | | 68 | | |
| | > | > | | | |

T F

| | A | B | | A | B |
|---|---|---|---|---|---|
| 6 | | | 7 | | |
| 13 | | | 14 | | |
| 20 | | | 21 | | |
| 27 | | | 28 | | |
| 34 | | | 35 | | |
| 41 | | | 42 | | |
| 48 | | | 49 | | |
| 55 | | | 56 | | |
| 62 | | | 63 | | |
| 69 | | | 70 | | |
| | > | > | | | |

J P

## APPENDIX E

Social Readjustment Rating Scale of Holmes & Rahe (1967)

**Social Readjustment Rating Scale**

| | EVENTS | SCALE OF IMPACT |
|---|---|---|
| 1. | Death of spouse | 100 |
| 2. | Divorce | 73 |
| 3. | Marital separation | 65 |
| 4. | Jail term | 63 |
| 5. | Death of close family member | 63 |
| 6. | Personal injury or illness | 53 |
| 7. | Marriage | 50 |
| 8. | Fired at work | 47 |
| 9. | Marital reconciliation | 45 |
| 10. | Retirement | 46 |
| 11. | Change in health of family member | 44 |
| 12. | Pregnancy | 40 |
| 13. | Sex difficulties | 39 |
| 14. | Gain of new family member | 39 |
| 15. | Business readjustment | 39 |
| 16. | Change in financial state | 38 |
| 17. | Death of a close friend | 37 |
| 18. | Change of a different line of work | 36 |
| 19. | Change in number of arguments with spouse | 35 |
| 20. | Large mortgage | 31 |
| 21. | Foreclosure of mortgage or loan | 30 |
| 22. | Change in responsibilities at work | 29 |
| 23. | Son or daughter leaving home | 29 |
| 24. | Trouble with in-laws | 29 |
| 25. | Outstanding personal achievement | 28 |
| 26. | Wife begins or stops work | 26 |
| 27. | Begin or end school | 26 |
| 28. | Change in living conditions | 25 |
| 29. | Revision of personal habits | 24 |
| 30. | Trouble with boss | 23 |
| 31. | Change in work hours or conditions | 20 |
| 32. | Change in residence | 20 |
| 33. | Change in school | 20 |
| 34. | Change in recreation | 19 |
| 35. | Change in church activities | 19 |
| 36. | Change in social activities | 18 |
| 37. | Small mortgage or loan | 17 |
| 38. | Change in sleeping habits | 16 |
| 39. | Change in number of family get-togethers | 15 |
| 40. | Change in eating habits | 15 |
| 41. | Vacation | 13 |
| 42. | Christmas | 12 |
| 43. | Minor violations of the law | 11 |

## APPENDIX F

Demographic Data Encryption Criteria

**All data were handled using Lotus 123 Spreadsheet and Statistical Analysis was by SPSS version 9.0**

**Subjects** were referred to by a number 1 to 51

**Timesick** number of months on sick as a result of current issue before counselling

**Timesus** number of months suspended or dismissed as a result of current issue before counselling

**Sympdur** number of weeks subject has experienced Post Traumatic stress Disorder symptoms before counselling

**Crittime** number of weeks from critical incident until starting counselling

**Duration** number of months interpersonal conflict has existed between subject and significant other

**Session** number of 1 hr. counselling sessions the subject received

**Span** number of weeks between starting and finishing counselling

**Grade** nursing grade of subject

| Grade | Encryption Code |
|---|---|
| D | 0 |
| E | 1 |
| F | 2 |
| G | 3 |
| H | 4 |

**Age Band**

| Age Band | Encryption Code |
|---|---|
| 21 - 30 years | 0 |
| 31 - 40 years | 1 |
| 41 - 50 years | 2 |
| 51 - 60 years | 3 |
| 60 + years | 4 |

**Incident**

| Incident | Encryption Code |
|---|---|
| denied a just request | 0 |
| threat of discipline | 1 |
| falsely accussed | 2 |
| threat of or actual agression | 3 |
| suspended or dismissed as a result of accusation | 4 |

nature of critical incident reported by subject to be the cause of present condition

**SOstatus**

| SOstatus | Encryption Code |
|---|---|
| subordinate | 1 |
| colleague | 2 |
| colleagues & line manager | 3 |
| line manager | 4 |
| senior management | 5 |

position of significant other, bully, accuser, discriminator, in the critical incident relative to subject

**DSM IV**

| DSM IV | Encryption Code |
|---|---|
| shock | 0 |
| anger | 1 |
| PTSD symptoms | 2 |
| other | 3 |

counsellors initial assessment of subjects symptoms

**Cause**

| Cause | Encryption Code |
|---|---|
| simple stress | 0 |
| formal discipline | 1 |
| discrimination | 2 |
| bullying | 3 |
| other | 4 |

counsellors final assessment of underlying dynamics of subject's condition

**Outcome**

| Outcome | Encryption Code |
|---|---|
| won case or cleared name | 1 |
| internal move | 2 |
| internal discipline | 3 |
| external discipline | 4 |
| dismissed | 5 |
| left post | 6 |
| left nursing | 7 |
| long term sick | 8 |

final outcome for subject 9 - 12 months after critical incident

**Interpersonal Conflict**

| Conflict | Encryption code |
|---|---|
| no | 0 |
| yes | 1 |

a period of prolonged interpersonal conflict with the significant other in the 18 months prior to the critical incident

**Formal**

| Formal | Encryption Code |
|---|---|
| no | 0 |
| yes | 1 |

Formal disciplinary proceedings initiated against subject

**Group**

| Group | Encryption Code |
|---|---|
| no | 0 |
| yes | 1 |

did the significant other act alone

**History**

| History | Encryption Code |
|---|---|
| no | 0 |
| yes | 1 |

was there a prolonged period of interpersonal conflict with the significant other in previous 18 months

**Isolated**

| Isolated | Encryption Code |
|---|---|
| no | 0 |
| yes | 1 |

were there isolated incidents of interpersonal conflict with the significant other in previous 18 months

**UKCC**

| UKCC | Encryption Code |
|---|---|
| no | 0 |
| yes | 1 |

was significant other a registered nurse

**Gender**

| Gender | Encryption Code |
|---|---|
| female | 0 |
| male | 1 |

gender of significant other

**Employer**

| Employer | Encryption Code |
|---|---|
| private | 0 |
| NHS | 1 |

employment sector where critical incident occurred

**Serial**

| Serial | Encryption Code |
|---|---|
| no | 0 |
| yes | 1 |

has the significant other previously done this or similar to others

**Manager**

| Manager | Encryption Code |
|---|---|
| no | 0 |
| yes | 1 |

has there been a change of manager in 18 months prior to critical incident

**Practice**

| Practice | Encryption Code |
|---|---|
| no | 0 |
| yes | 1 |

has there been major changes in work practices in 18 months prior to critical incident.

**Demands**

| Demands | Encryption Code |
|---|---|
| no | 0 |
| yes | 1 |

have there been numerous excessive or unrealistic demands been put on subject in the 18 months prior to critical incident, by the significant other.

**Threat**

| Threat | Encryption Code |
|---|---|
| no | 0 |
| yes | 1 |

have several serious threats of revenge or discipline been made to the subject in the 18 months prior to critical incident, by the significant other.

**Injustice**

| Injustice | Encryption Code |
|---|---|
| no | 0 |
| yes | 1 |

does the subject feel strongly that they have been treated very unjustly in the critical incident

**Criticism**

| Critiscism | Encryption Code |
|---|---|
| no | 0 |
| yes | 1 |

has the subject been singled out on a number of occasions for undue criticism or blame.

**Exclude**

| Exclude | Encryption Code |
|---|---|
| no | 0 |
| yes | 1 |

was a serious effort made to exclude the subject from involvement in areas of special responsibility, decision making or socially, in the 18 months prior to critical incident, by the significant other.

**Whistle**

| Whistle | Encryption Code |
|---|---|
| no | 0 |
| yes | 1 |

has the test subject been involved in any whistleblowing activities

**Medication**

| Medication | Encryption Code |
|---|---|
| no | 0 |
| yes | 1 |

is the subject on medication from doctor

**Friends**

| Friends | Encryption Code |
|---|---|
| no | 0 |
| yes | 1 |

did the subject have a good or close relationship with significant other before incidents began

**Assert**

| Assert | Encryption Code |
|---|---|
| no | 0 |
| yes | 1 |

would the subject benefit from assertiveness training

**OtKnew**

| OtKnew | Encryption Code |
|---|---|
| no | 0 |
| yes | 1 |

did other colleagues know what was happening

**Dgrade**

| Dgrade | Encryption Code |
|---|---|
| no | 0 |
| yes | 1 |

did subject take a downgrade move to get out of situation

**Damages**

| Damages | Encryption Code |
|---|---|
| no | 0 |
| yes | 1 |

is subject taking own legal action for damages

## APPENDIX G

Covering Letter to Prospective Study Subjects

**Covering Letter Given to Prospective Subjects in Study**

Karen Doherty

PTSD & Bullying Survey

RCN Counselling Service, Belfast

Dear

I am currently doing Doctorate Research with Trinity College Dublin.

I am researching the causes of workplace trauma in nurses and the effectiveness of counselling for those who have experienced bullying, accusation or other harassment in the workplace. I am collecting information for both test subjects and comparative control groups.

My first aim is to determine the level of stress or trauma symptoms in nurses when they begin counselling, when they complete counselling, and six months after completion of counselling. This is done using an established questionnaire, the PENN Inventory. I am also asking permission to use the data from the CORE System audit tool which we use in the counselling service with all clients.

At some stage I may also be asking you to complete a personality profile test.

All these are tests I would regularly use with clients as part of the therapy and I will be happy to share and explain the results with you. What I am asking for is your permission to use this data for my personal research.

I will also need to collect some coded demographic data such as, age band, grade, how long sick, medication, type of symptoms, duration of symptoms etc, You will only be known as a code number and your information will be statistically encoded and not held as narrative or notes. Any information you supply will be treated with the same terms and conditions of confidentiality as contracted for the counselling and within the guidelines of the Data Protection Act 1998.

Participation in this project is entirely voluntary and will not affect the counselling and you can withdraw anytime you like right up to the six month follow up.

To explore the causal relationship between incidents and experiences in the workplace and the resulting symptoms I will need to retrospectively collect some data from the records I keep both for the counselling agency and for my own professional accreditation and supervision. I will need your permission for this. Remember these records are open to you and you can ask to see them at any time. This would not be personal material or material that would identify you. Examples would be whether you are on long term sick or have been through formal discipline, the nature of the experience that precipitated this, your grade, the grade of other people involved in this incident, background information concerning the changes and pressures in your workplace.

You will only be referred to by a code number, I will be the only person to extract information from the records and I will encode it as numbered categories to remove individual or personal details.

If you do not want to take part in the study or are uncertain you need do nothing. If you do want to take part then returning the pre and post counselling questionnaires will be taken as consent to use the data in the Inventory and to retrospectively extract background information under the terms and conditions outlined above.

Yours faithfully

Karen Doherty