

Australian registered nurses and sex-based harassment in the health care industry

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The beginning of wisdom, as the Chinese say, is calling things by their right names.
EO Wilson

Abstract

This paper discusses sex-based harassment in the nursing profession in Australia. The paper generates industry-specific hypotheses which may provide insights into sex-based harassment in the Australian context. A good understanding of sex-based harassment in health care is essential for reducing and eliminating the problem and its toxic sequelae.

Introduction

While there has been considerable comment on sex-based harassment (SBH) in the nursing and health care literature (for example, Bullough 1990; Chapman 1993; Goodner & Kolenich 1993; Horsley 1990), there is little empirical research in Australia. Certainly there are claims in the nursing literature which suggest that it is a major problem for the profession but, except for the work of Madison (1995a; 1995b), little empirical evidence exists to support these claims. The current paper has been written to heighten awareness of some potential issues associated with SBH and registered nurses in the Australian health care industry which we believe add to this important discussion. This paper discusses the existing literature on the general topic of SBH and identifies problems that exist in nursing and the health profession which may be unique to that

profession. In addition, it discusses features of Australian culture which may influence SBH in health care. Whether these profession and culture-specific features make any difference to the nature and incidence of SBH in nursing is not clear. This is a question which can be answered with further appropriate empirical study which builds on the work already done by Madison (1995a; 1995b).

This paper aims to not only review the literature on SBH, but also to open up the complex social, organisational and biological issues associated with SBH so that factors which may be critical to prevention can be identified. This paper talks about factors which are politically sensitive and which sometimes tend to be excluded from discussion. We believe it is important to raise these issues in spite of their contentious nature as, without full discussion, potential solutions to the problem may be inadequate. We should make it clear from the outset that this paper does not provide a preventive strategy but rather examines a wide range of factors which may contribute to SBH in nursing.

Sex-based harassment in industry

According to Neuhs (1994), Marles (1990) and Goodner and Kolenich (1993) to name a few, preventing an harassing or hostile work environment through appropriate education is the best approach to reducing or eliminating SBH in the workplace. Health care professionals have attempted to make a shift in recent years from the curative, after-the-fact, medical treatment model to a preventive focus on health promotion and education. In other words, prevention is far more effective than a cure. It is important to make this shift in thinking when considering issues associated with SBH in the Australian health care workplace.

According to the Australian Institute of Health and Welfare's Biennial Report to the Minister of Health, *Australia's Health 1994* (1994), 272 370 Australians were employed in health occupations. The data collected from the 1991 census noted that the largest group was registered nurses (139 380), 92 per cent of whom were female. Although it is recognised that today's registered nurses work in a wide variety of work settings, most of them work in institutional settings (for example, hospitals). Sixty-nine per cent of persons employed in the health industry were employed in hospitals, nursing homes or community health centres. This discussion focuses on registered nurses working in institutions, although much of the discussion is pertinent to many other health-related work environments.

To obtain some notion of where the health care professions are placed with regard to SBH, it is useful to look at studies which have examined the problem across

a wide range of occupations. Two widely quoted studies of SBH are the 1981 US Merit Systems Protection Board (MSPB) study of 20 000 federal employees, and a second follow-up survey in 1986. These studies found that sexual harassment was widespread, with 42 per cent of all female employees and 15 per cent of all male employees reporting SBH. The findings supported the view that women were more often the target of harassment than men, and that the harasser was more often a man. The targets were likely to be young, unmarried, educated, and/or members of a minority group (racial or ethnic). In addition, they were likely to hold trainee positions or non-traditional positions for their sex (for example, female law enforcement officer) and have an immediate work group composed predominantly of the opposite sex. Over half of the women in the MSPB study employed in non-traditional work roles reported being targets of SBH. Other findings indicated that the targets of SBH were generally unaware of any formal procedures for dealing with it in their organisation.

Sex-based harassment and traditional and non-traditional occupations

There are conflicting views about the frequency of SBH in predominantly female occupations. Some literature suggests that occupations which have a high female workforce are more subject to complaints of harassment than those occupations which have a more balanced gender mix. For example, Ryan and Kenig (1991) found an increased incidence of reports of harassment in traditional female occupations. They noted that women in non-traditional fields might possess personal strategies for dealing with harassment effectively. Rather than accepting harassment as part of the territory as women in the traditional workforce appear to do, these women seem to have developed effective strategies to deal with the problem.

On the other hand, Gutek and Morasch (1982) described female-dominated occupations as experiencing few complaints of SBH. While it is still common, these women make few complaints because they may expect harassment as a matter of course. It is 'part of the job,' so to speak. This finding is consistent with the view that harassing behaviour has become, effectively, institutionalised. Lawler (1991) has identified this as a major problem in the health care industry. Nurses may have come to expect SBH as part of the 'occupational territory'.

Sex-based harassment and registered nurses

We have been able to find only one study which deals with sexual harassment in the nursing profession in Australia. Madison (1995a; 1995b) surveyed 317 registered nurses from across Australia and obtained a 62 per cent response rate. She found that two out of three registered nurses in her sample experienced SBH. Even if all 38 per cent of non-respondents from her study did not experience SBH, this would still mean that 41 per cent would have experienced it. The nurses in Madison's study complained of uninvited sexual teasing, jokes, remarks or questions, and unwanted deliberate touching, leaning over, cornering or pinching. The most frequent perpetrators were identified as medical officers, co-workers and supervisors.

International research shows that sexual harassment of nursing staff is a major problem. Donald and Merker (1993) studied 461 registered nurses (licensed by the Kentucky Board of Nursing) and found that approximately one in three respondents had been the target of sex-based harassment. The perpetrator was often a medical doctor who was not the target's supervisor.

A study of 164 registered nurses and student nurses in Britain (Finnis & Robbins 1994), with a 56 per cent response, found that over half of the respondents had experienced sexual harassment. The perpetrators were, most frequently, doctors or patients. Frequency of harassment was similar to other industries. The respondents experienced predominantly 'innuendo' and 'unnecessary touching of the body'.

Overall, approximately a third to a half of those in the nursing profession experience SBH. The experience of SBH varies along a continuum from unwanted or uninvited remarks through to forced sexual encounter. While some might argue that the 'uninvited remarks' end of the continuum may not constitute sexual harassment, others would (Madison 1995b; Sommers 1994). We think it is critical to point out here that what is important is the recipient's perception.

Interdisciplinary dimensions of sex-based harassment

The issue of SBH is made more complex where there are teacher–student relationships, as in teaching hospitals. The potential for harassment clearly exists in these relationships because of the power differential between teachers and pupils (Little 1992; Bacchi 1992; Ryan & Kenig 1991). This special form of supervisory relationship may add to the complex dynamics of harassment. A student nurse might be subjected to harassment not only by the supervisor,

but also by the teacher, the doctor and the patient. In addition, other students may also harass.

Another factor which may contribute to the complexity of the problem is the steep hierarchical nature of health care organisations in which doctors have a great deal of discretionary and perceived power (Palmer & Short 1989; Bates & Linder-Pelz 1990; Lloyd 1994). There are no obvious supervisors watching over the behaviour and actions of doctors. If there are supervisors for doctors, they are usually other doctors, who may only be present in name. It should be recognised that there are now newer management relationships involving multidisciplinary teams. These arrangements may have some influence on hierarchical power structures and the incidence of SBH, but male-dominated, steep hierarchical structures still predominate.

It is well known that the medical profession tends to 'close ranks' under difficult circumstances, particularly when there is a threat to its professional standing and image (Palmer & Short 1989; Bates & Linder-Pelz 1990). Hospital administrations and medical staff also may have tense relationships. Hospitals are loathe, and sometimes unable, to maintain 'control' over visiting medical officers who are not regular employees of the organisation. Rather, the doctors are 'visitors' with 'privileges' (Dowell 1992). This issue of control, or lack of perceived control, over doctors may be a critical factor in the containment of SBH.

Health care organisations and sex-based harassment

Hospital and health care organisations send tacit but powerful messages to employees, including doctors, when these organisations fail to establish or police clearly proclaimed standards or codes of conduct. If staff have no clear guidelines to tell them how to behave, they fall back on their own standards (or lack of standards) in dealing with others. If there is no clearly stated policy about harassment being unacceptable, the lack of a formal policy may be seen as tacit permission for unacceptable behaviour to continue. Madison (1995a; 1995b) noted that 45 per cent of survey respondents identified their workplaces as not having a formal policy for dealing with SBH. The policy may well have been in place, but the respondents did not know about it. Finnis and Robbins (1994) call for a formal organisational response to the issue of harassment. They state that policies, management education and publicity are essential to reducing and eliminating SBH.

The problems of SBH may be worse in health care organisations because of the nature of the work itself. The emotional demands of intimate life matters are a

common feature of the health professions. 'Off-the-wall' humour and 'stepping over the line' are standard ways of coping with an emotionally-charged, stressful occupation. In the case of health care professionals, these intimate, experiential circumstances may predispose individuals to transgress boundaries which may otherwise be kept intact in less demanding psychological circumstances.

Sex role differences

Empirical evidence suggests that male and female sexualities differ and, following on from that, that men and women perceive sexual harassment behaviour in different ways (US MSPB 1981; Gutek 1985; Padgitt & Padgitt 1986; Symons 1987). What may be seen as 'normal' for a man in terms of what is acceptable behaviour in interactions with women may not be perceived as such by women. Furthermore, even men may not agree with other men about what is normal just as women may disagree with other women (Sommers 1994). We believe that this is fertile ground for future research.

The differences between women and men described in the previous paragraph may be reflected in the way males deal with SBH. For example, males may tend to rationalise certain activities, often of a sexual nature, and see them as part of normal interaction. When confronted by a non-compliant recipient, males may shift responsibility by claiming the target of harassment 'can't take a joke' or that the person 'asked for it' (Gutek 1985). Recent events in public life in Australia, in both the courts and public service, provide examples of males tending to rationalise sexual harassment (Niland 1994). Both Australia and overseas countries have prominent political figures who often remain in influential and highly paid positions despite dozens of complaints of sex-based harassment. 'I will not resign,' they exclaim. 'We all know that most women sleep their way to the top'. And so on.

Stereotypical views of health professionals

The public's stereotypical views of nurses as the 'doctor's handmaiden' and 'easily available for sex' may serve to perpetuate the problem. Lawler (1991) is one of the few Australian nurse scholars who explores the myths and stereotypes associated with sexual harassment and the nursing profession. Her emphasis is on harassment from patients and she identifies and discusses the 'sexualised' nature of nursing. She describes the difficulty nurses encounter when moving from harassing patient care situations to the harassing co-worker, supervisor or medical staff member.

Health professionals are inculcated with the notion that any behaviour of a patient is acceptable because people who are ill are more inclined to behave in unusual ways. As a result of these experiences, nurses develop elaborate tactics to deal with unwelcome sexual advances from patients. Lawler (1991) notes the low level of empirical research that exists in this area. She raises a rhetorical question about the reasons why nurses haven't investigated this issue more carefully. This would be important because SBH is known to have a significant impact on work performance and professional and personal image (Bullough 1990; Chapman 1993; Goodner & Kolenich 1993; Horsley 1990; McMillan 1993).

Influence of Australian culture

Another factor which might be at work in perpetuating SBH in the health care industry in Australia is the 'she'll be right mate' syndrome. Mackay (1993) discusses the fatalistic Australian idea that everything will eventually turn out alright or that solutions will magically appear. Another characteristic of the she'll be right syndrome is that individuals, at a personal/professional level, often do not assume responsibility for confronting unacceptable and unwanted harassment. The she'll be right thinking works against enlightened discussion and consequent action and reduction in the incidence of SBH. Failing to assume personal responsibility facilitates the continuation of harassing behaviour. Personal and professional strategies of response are not easy to acquire and there may be a mind set that it is really the responsibility of government, the law or some nebulous 'other' to solve the problem. Whether this feature of Australian culture has an impact on the incidence and severity of SBH needs to be subjected to empirical study.

While there is legislation against harassment, the legislation is complaint-based in nature and the target has to take personal steps to make sure that a complaint is brought against a harasser. Unfortunately, there is no 'unseen hand' dealing with the problem on behalf of the complainant. There is no-one there other than the target to see that justice is done, even though employers are formally required to have a policy dealing with SBH. In addition, there is no assurance that organisations will have such policies in place or, if they are in place, that they are effective. There appears to be very little evidence that people have used existing legislation in the health care industry. One has to look to overseas studies for information. In the United States, 77 per cent of registered nurses studied in Kentucky who had experienced sex-based harassment did not report their complaints (Donald & Merker 1993). It is a serious concern that the same

percentage indicated that employers did not have formal policies in place. What the situation is in Australia, and particularly in the health care industry, is unclear.

The Australian ethos, 'never dob in a mate', could be another factor constraining the reporting of SBH. In addition, a number of Australian court judgments have acted to impede people from taking legal action against perpetrators of SBH. Fear of victimisation, even when the court acts in the harassed person's favour, has negative consequences for those contemplating the use of statutory mechanisms. People who do take action are perceived as troublemakers and may reasonably expect a great deal of difficulty finding a job or difficulty in remaining in an existing position (Niland 1994; Gutek 1985; US MSPB 1981). The social pressures are enormous and the 'informal' health care network is powerful. Part of the reason for its power is the relatively small population of health care professionals in Australia. Informal communication crosses State and regional boundaries easily. It operates to prevent people with a 'whistle blower' reputation from going to other jobs (Debelle 1993).

Biological factors

The biological basis of sexual harassment has received scant attention in the research literature. While much information exists about the sociological, organisational and cultural characteristics associated with SBH, the biological side of the issue has been neglected. There may be a variety of reasons why this has been overlooked, but it seems that the politically sensitive nature of the topic may have led to this outcome. After all, the notion that biology may be involved smacks of determinism. If the problem has a biological component, then it is unlikely that the problem can be easily rectified using conventional social and cultural strategies. But much can be learned by understanding the biology of potentially vulnerable targets and alleged perpetrators of harassing behaviour. Certain things such as changes in brain function with age, attractiveness, propinquity and marital status have roots in evolutionary biology and increase the probability of certain people being targeted for SBH (Symons 1987). In addition, understanding some of the biological features of SBH in perpetrators may help to deal with the problem more effectively. It is clear that not all males are perpetrators and there may be markers which distinguish who does and who doesn't harass (Watson 1995). Just because the problem contains a biological element does not mean that the actions of the perpetrators are beyond remediation and control.

It is clear that women and men have a biological imperative to propagate the species which is stronger and often more irresistible than any message from past

socialisation. This imperative to maximise 'reproductive success' is very strong, but there is evidence that suggests that the way in which this imperative is expressed is different for women and men. Women and men appear to have evolved different mating strategies (Symons 1987; Diamond 1992). Women appear to seek out a strong and powerful protector for the long gestation, lactation and childhood of their offspring. To make such an investment in children, without male protection, would be an unwise evolutionary strategy as children would be unlikely to survive to an age where they are capable of reproduction. On the other hand, males, with little investment to make in terms of raising children to maturity, optimise reproductive success by mating with as many females as possible, thus maximising the number of offspring and enhancing chances of their gene pool surviving to the next generation. The more children the male has, the better the chance of this occurring. This sexual dimorphism or divergence in the behaviour of women and men may well influence SBH, with females being very selective with whom they allow intimacy, while males are less choosy and prepared to pursue those who appear to be in a state of reproductive readiness. Of course, not all males act on these drives and there must be biological and psychological characteristics which set aside those who harass from those who do not.

One critical issue for the sexual dimorphism described above is the notion that the behaviour is determined by conscious, rational mechanisms. Recent evidence suggests that behaviour, which has a strong biological-emotional basis, is not driven by such mechanisms, but rather has a strong, often pre-conscious or unconscious, 'automatic' component (Epstein 1994). In other words, the heart governs the mind. This does not mean, however, that individuals are Skinnerian automatons unable to regulate their behaviour. While they may not be able to change their fundamental nature, in most cases they can change actions and behaviour (Goldsmith 1991). Although criticism exists regarding the use of this evolutionary biology approach (and is beyond the scope of this paper), adding this component to the discussion provides a more comprehensive picture of SBH.

Paternalistic hierarchies and power

It would seem reasonable that the male-dominated power hierarchies of the health care industry might create additional vulnerability to SBH for nurses. To what extent this hierarchical organisational structure reflects some of the mechanisms described in the previous paragraph is unclear, but it is possible that the mechanisms of formalised organisational power, combined with biological

imperative and related issues specific to health care, may be difficult to deal with effectively. As this complicated and highly politicised area of study expands, new ideas or ways of thinking could help us understand more about SBH. Current research linking these biological mechanisms with the Australian work situation of the 1990s is essentially silent.

In addition to the problems of the power hierarchy outlined in the previous paragraph, younger, less experienced nurses often bestow much power and authority on supervisors, including medical officers, and this is reinforced by the prevailing ethos. No institutionalised structures or processes are present to dispel or counteract this prevailing attitude. Nurses may attribute 'line' or management power and authority where it does not exist. While medical officers can make life difficult for those with less power, only occasionally are they directly responsible for the hiring or firing of registered nurses. In addition, inexperienced staff may not have the necessary understanding and skills to deal with these problems. Such matters are not dealt with in most nursing curricula, a not uncommon problem for professional education.

A contributing factor to change in this area would be the improved education and qualification of hospital and health care managers. The establishment of multidisciplinary approaches to work is an important change occurring in the health care industry. Health care organisations are working towards participative and more interdisciplinary decision-making, such as in the areas of total quality improvement and the development of critical pathways (Wakefield & Wakefield 1993; Gale 1994; Falconer et al. 1993). Change in this area is occurring also as the gender mix at all levels of the health hierarchy becomes more equitable.

Conclusion

This discussion has examined SBH in the Australian health care arena, with particular emphasis on registered nurses. We have tried to touch on some of the major influences at work with this professional and organisational problem. SBH is costly in human terms and in the impact on an organisation's effectiveness. The complexities of SBH in the Australian health care system are of concern for health care organisations not only in Australia, but overseas. The fact that the area is not well understood and is poorly researched does not help to resolve the problem. While equal employment opportunity legislation may have helped to raise consciousness concerning SBH, legislation is only part of what is needed to solve the problem.

The intimate circumstances in which many doctors and nurses have to work, the hierarchical power structures of the organisations in which they work, the gender

issues associated with nursing and nursing practice; and some peculiarities of the Australian mind set may combine to increase sexual harassment workplace problems. The concatenation of these events may produce more than a simple summative effect. The whole of the problem may be more than just the sum of its parts.

The aim of this preliminary paper is to generate debate and reaction to the views expressed here. Health care administrators and practitioners alike must educate themselves and their organisations regarding the issues surrounding SBH. Moreover, this education must be based on sound and broadly based research which canvasses the diverse issues involved from a multidisciplinary perspective. We can no longer rely on uninformed opinion to drive SBH policy and practice in the health care work setting. Nurses are well placed to be in the forefront of both research and management of the problem because of their education in both the biological and social sciences. This multidisciplinary background is essential for a good understanding of the issues involved in SBH. We believe that high-quality research, education and informed discussion are essential to the understanding and prevention of SBH.

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