

THE CONTEXTUAL ISSUES ASSOCIATED WITH SEXUAL HARASSMENT EXPERIENCES REPORTED BY REGISTERED NURSES

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ABSTRACT

Objective:

The study aimed to explore contextual conditions in Australian health care workplaces that make sex-based and sexual harassment (SB&SH) a relatively common experience for registered nurses (RNs).

Design:

Unstructured, in-depth interviews with a convenience sample of Australian RNs.

Participants:

The informants were 16 RNs (15 female and one male), working in health care, who were students enrolled in advanced tertiary preparation in nursing, counselling, and health care management at an Australian university.

Main outcome measure(s):

Experiences described by the interview informants identified four conditions present in their workplace when they experienced SB&SH.

Results:

Informants noted: 1) the silence that surrounds harassment; 2) that they could not expect support from their peers and professional colleagues; 3) that education did not exist in their workplaces regarding (SB&SH); and, 4) that traditional stereotypes associated with RNs were closely linked to the experience of harassment in the workplace.

Conclusions:

Inadequate coverage of workplace issues related to (SB&SH) in undergraduate or postgraduate educational programs were identified.

INTRODUCTION

Research into the experiences of RNs indicate that uninvited, unwelcome behaviour of a sexual nature in the health care workplace is not uncommon (Cox 1987; Cholewinski and Burge 1990; Donald and Merker 1993; Libbus and Bowman 1994; Kinard et al 1995; Finnis and Robbins 1994; Dan et al 1995; Madison and Minichiello 2001). Two widely quoted studies which have examined the problem across a wide range of occupations are the United States (US) 1981 and 1987 Merit Systems Protection Board (MSPB 1981; MSPB 1988) studies of 20,000 federal employees. These found sexual harassment was widespread with 42% of all female and 15% of all male employees reporting SB&SH. The targets were likely to be young, not married, educated, and/or members of a minority group (racial or ethnic). They were likely to hold trainee positions or hold non-traditional positions for their gender (eg. female law enforcement officer), and have an immediate work group composed predominantly of the opposite sex.

The MSPB studies showed that when women were working in 'traditional roles', four out of 10 women reported being harassed. However, a computerised search of Australian health care literature failed to find articles with RNs in Australia and sexual harassment in the title. In contrast to British or North American nursing, health care literature in Australia is unexpectedly silent on the topic of harassment of RNs. Using a quantitative approach Madison (1996; 1997; 2000) is one of the few Australian researchers to examine the topic.

Studies into SB&SH often focus on personal or professional characteristics or roles rather than interactional dynamics. There is a need for greater understanding of the experience of the harassed worker related to contextual conditions present in the workplace.

METHOD

In-depth interviews of approximately one hour were conducted with a convenience sample of 16 volunteers. Interviews were based on the premise that SB&SH is a socially constructed symbolic phenomenon which can occur in interactions with others. The purpose of the interviews was to investigate how informants recognise and label their harassment experiences. University ethics committee approvals were obtained for the study. The informants are referred to using pseudonyms.

The informants were RNs practising in a variety of settings across Australia and enrolled in advanced tertiary preparation in nursing, counseling, and health care management at an Australian university. They had previously completed a survey on sexual harassment. The informants were between the ages of 29 and 46 and all but one was female. The informants had been employed as RNs from five to 29 years. Fifteen worked full time and the other part time. Ten informants identified their workplace as urban based and six as rural.

The interview data were reviewed and categories developed based on recurring themes or concepts.

FINDINGS

The categories that became clear were: silence; lack of support; lack of education; and, perpetuating myths.

Silence

The silence which shrouds harassment and the effect on RNs was notable. Mary's comment is typical:

I feel very strongly about the issue of education and did my initial nursing education in a hospital based environment and we had absolutely nothing about issues like this. (Metropolitan, community-based, RN for 13 years)

Another informant supported this view and explains her own silence:

If you don't say you don't like what they say, I think they take your silence as permission to continue, so unless you say something, they don't stop. So maybe you should say, 'I'm sorry, I'm not finding that funny. Do you mind going elsewhere'. But I don't think, even as a unit manager, I don't know that I would have felt comfortable saying that to one of the obstetricians because it really was a small unit and you have to deal with them every day, so that you have to find some way of, you know, having some sort of working relationship. It wasn't like you could say, 'Oh, I'm not going to talk to him anymore because I think he's a rude person'. (Metropolitan, hospital-based, RN for 15 years)

Another informant agreed that there is little discussion about 'incidents':

... maybe that if like me nurses are probably reluctant to talk about the incidents. That they're covered over and

maybe they do happen and we don't hear about them or maybe they don't happen but I...judging... if you can take my experiences as an indication, then they do happen and nurses are reluctant to pursue further options about them. (Regional/rural, community-based, RN for seven years)

Michelle described another reason why nurses are inclined to remain silent:

I didn't tell anyone about it for a long time. I felt they might think that I'd invited it in some way, and I didn't think I had, but I wouldn't have liked people to think that I had. (Metropolitan, community-based, RN for 13 years)

Certainly the fear of possible consequences of breaking the silence works to continue the silence. (Madison 1997; MSPB 1981; 1988). This is described by Helen:

...you really felt disempowered as to, well, 'How hard am I going to make it on myself if I take it any further?' (Regional/rural, nursing home, manager, RN for ten years)

Absence of supportive behaviours

At the time of the harassing incident counselling was not offered or did not seem to be available or was not seen as necessary. The informants described the absence of supportive behaviours from colleagues in the work setting and revealed ways in which RNs are made to feel unsupported by other nurses and the nursing hierarchy:

... probably fear of being ridiculed or not taken seriously, maybe again regarding, 'Oh, the patient didn't really mean to do that', you know, 'That's not an action that they'd do if they were in their right mind', and maybe, 'Oh, you're really stupid - you put yourself in that position in the first place, so how can you complain about it?' (Regional/rural, community-based, RN for seven years)

Lucy perceived that her colleagues at work would 'ridicule' or see her as 'stupid', and somehow responsible for the harassment. The implications of this are serious. With this mindset, Lucy was unlikely to divulge or share her situation with professional colleagues and so discussions at a professional level were greatly reduced. Also individual as well as collective awareness strategies and action would therefore be limited.

One respondent describes how she was so sure that support would not be forthcoming from her organisation that she took the matter into her own hands and asked fellow workers of the harasser to 'take care of it':

I did go and try and look for the sexual harassment policy, or procedure, and I created so much trouble just by mentioning the word in the hospital, because (laughs) they were all, 'What's going on? What's wrong with Jocalyn?' ... they all wanted to know why, why, why, why, and I just wanted to know: 'is there a policy, does it exist, how do you go about it, what are the procedures involved if you are sexually harassed' ... but to actually get the

information, I was very much... interrogated, I guess... I think they were more curious than anything as to what was going on... and I wasn't prepared to give that information to them because I didn't think that they'd be able to handle it in the way that I wanted it to be handled. (Regional/rural, hospital-based, RN for 16 years)

Informants described unsupportive supervisors, efforts to limit or eliminate complaints or concerns, and being encouraged to smile and play a compliant role:

Pretty much 'You must have done something to deserve it - you sort it out.' I just gave up after that because I'd spoken to my charge sister, I'd spoken to my peers, and they all thought I was making a bit of a fuss about it. (Metropolitan, hospital-based, RN for 15 years)

I still think that there are a lot of ramifications - you need to be prepared if you're going to confront something like that within a hospital you need to be ready, you need to be strong, because you're still going to handle a lot of problems to confront it and to deal with it. You may not be supported by your organisation. You could receive flak from other members of staff as well, so you need to be ready to deal with it. (Metropolitan, community-based, RN for 13 years)

One person was not sure that 'management' really had, or accepted, ultimate responsibility. She suggested that the real responsibility lies with the harassed:

... but I really feel for that behaviour to stop that it needs to really come from the people that the behaviour's directed to. (Metropolitan/community-based, manager RN for eight years)

Another reflected a mixed responsibility and identified the importance of employers supporting employees with complaints, but also equivocated about the role of the complainant:

... the people who need to be on top of it are the branch managers and I know that there are staff who have felt that when they have been harassed that they haven't been adequately supported by their managers. (Metropolitan, community-based RN for 13 years)

It seems that neither a religious environment nor sexual preference can assure nurses of a supportive environment. One informant recalled a fellow student who left a Catholic nursing program because she was not believed following a rape. This experience happened many years before the interview yet her recall was vivid:

And then, one girl was actually raped by the maintenance person... that was in a Catholic nurses' home the nuns didn't believe they could do such a thing, that she encouraged it, and she left, actually, and none of us ever heard from her again... he said she asked him to sleep with her, but she maintained she didn't. She was very shattered by the experience, so... it was really horrible. (Metropolitan/community-based, RN for 24 years)

Another spoke of encountering harassment both as a heterosexual woman and a lesbian and commented on the generally unsupportive atmosphere in the workplace:

... it's very strange... that women are so damaging to other women and I think nowhere more so is this demonstrated than in nursing, that we don't care and nurture each other at all, because I don't think we're terribly good at nurturing ourselves... to be selfish, to take time for themselves. (Metropolitan, nursing home, manager, RN for 29 years)

Another informant described the homophobic harassment she endured in two different work place environments:

... it's amazing how powerless you feel... like, I'm a pretty strong person and I've survived all sorts of things, and that just floored me... it's almost like they took advantage of me... feeling powerless because you're a woman and so therefore they pick on you, and being somewhat different... But, where I am now is certainly more accepting of my sexuality, so that isn't an issue for them. I was really surprised that women do it too, women harass, differently. (Metropolitan, hospital-based, RN for eight years)

Not all informants described behaviours that were unsupportive. One of the informants had agreed to the interview only to describe harassment experienced by a younger RN colleague. She apparently had no experiences of her own to offer. She described, in an almost self-deprecating way, how she supported her colleague in a particular episode of harassment. A formal complaint was followed by a high-level formal hearing that required 'testimony' and substantiating 'evidence'. Paula willingly provided the necessary 'testimony' despite potential personal and professional repercussions. She continued by describing a personal ethos or professional commitment to an appropriate workplace, free of threatening or harassing behaviours:

And if something continues, I'm not averse to taking someone aside and saying 'I don't like your behaviour and I don't want to hear that sort of thing again as far as the girls - young, old or me!' I guess a lot of people aren't able to do or say that so you've got to look after them, but you encourage them. I see that as part of my role - you have to be a patient advocate and you have to be a staff advocate. (Metropolitan, hospital-based, RN for 14 years)

Unfortunately, this informant does not seem typical. The perception conveyed in the interviews indicated that when assertive confrontive strategies are employed, the trend is for the harasser to remain in their current position with the harassed person being removed. In an unsupportive workplace, when assertive or formal complaints are received, it seems that resignation, shift change or job transfer for the harassed person are the norm.

I believe somebody did put in a written... a formal complaint, but he's still there. I think that particular person [the harassed] was moved to another area of the campus. (Regional/rural, nursing home, manager, RN for ten years)

Lack of education

No informants described an organised educational approach about harassment in the workplace. For these informants the topic is not covered in undergraduate education or in hospital orientation, other than occasionally under a general topic of professional relationships and behaviour or general equal opportunity discussions. Madison (1997) revealed that 45% of survey respondents either did not know if their Australian health care workplace had an organisational policy to deal with sexual harassment or thought that it did not have such a policy. This should not be construed as indicating that a policy did not exist. Rather almost half of the survey informants worked in an organisation in which they did not know or believe a sexual harassment policy existed.

In this study the male interviewee indicated he was unaware of any policy or educational programs on sexual harassment at his hospital, commenting:

This hospital's notorious for having all these policies that sort of sit on the shelf and never get looked at until the situation arises, [laughs] and then there's a mad rush to find it. (Regional/rural, hospital-based, manager, RN for 13 years)

Jenny talked about the failure of nurses to 'organise', which would suggest she believed sharing information about harassing incidents would educate nurses in developing strategies to help all nurses in dealing with harassment:

I think sometimes we're... overrun when we shouldn't be... or it'll only be talked about in terms of: this particular incident pissed me off and I'll talk about it in the tearoom and it's gone over... we're often not very cohesive. (Metropolitan, hospital-based, RN for five years)

She seemed to be saying that when nurses fail to confront, deal with and discuss harassment, it makes it easy for the harasser to continue with his behaviour:

'Oh well, it's your problem', he will say, leaving the nurse to believe she is the only person who has a problem [with him].

Education concerning harassment would reduce the sense of isolation and silence for the harassed.

Similarly, when a patient pulled Bess down onto his bed, prompting her to scream, Bess was not offered any counselling or education. She was reassigned so she would not work with that patient again. She describes the response from her employment setting as 'We'll think no more about it, and neither will you, you'll get on with your work'.

One respondent suggested that by educating RNs about the issues, addressing responsibility and empowerment, nursing in general may benefit:

We're letting ourselves down because empowerment comes from within and somehow we're letting our nurses down by not addressing that issue of empowerment, we're not accepting personal responsibility or confronting issues and helping them deal with the issues. (Metropolitan, community-based, RN for 13 years)

Jane described some education about SB&SH that was discussed at her place of employment under 'other EEO stuff'. When a complex topic is discussed under an already complicated umbrella (EEO), one wonders how it is unwrapped and presented to employees. However, one informant, an enlightened, contemporary manager, admitted that she had not assumed responsibility for a specific educational forum on sexual harassment. She was fairly certain that inappropriate behaviours on the part of patients would not be considered sexual harassment, suggesting that inappropriate patient behaviours should be considered simply as part of the 'patient role'.

Perpetuating myths

According to Muff (1982), stereotypes and myths provide an easy solution to the complexities of human relationships. They obviate the need for men to understand individual women and are thus, according to Muff, tools of oppression.

These myths are entrenched in Western cultures and provide a way to think about nurses who often must transgress normal appropriate social distances and have to perform intimate procedures for patients. These myths serve to keep nurses 'in their place' and often impact on their professionalism. RNs in Australia were and sometimes still are referred to as 'sister', an acknowledgment of the religious roots of nursing and of a comfortable, sibling role for nurses. In this study, the myths associated with nurses as sexy, nurturing, differential, female, intimate carer, bath lady or battleaxe were described. The caring, 'mother' myth was identified:

Woman, that's right. Mother, nurse, you know? Not professional, no. I mean, it'd be different if it was a doctor. (Regional/rural, hospital-based, RN for 16 years)

... my vision of a woman was the traditional one and they kept the house very nice and placid and soothing around the family and then all of a sudden I worked with these professional women and they were intense! (Regional/rural, hospital-based manager, RN for 13 years)

Another was the popular stereotype of a dependent practitioner, unable to function without direction and orders from the doctor:

I did not come out of my nursing education with a sense of nursing having any status as a profession and I did not feel that we were treated as professionals... my

perception was that we were still very much the doctor's handmaiden. I think these students coming through are going to find it very difficult because they're being taught that nursing is a profession, nursing has value, that we have ethics that we need to follow, that we are here, we are thinking, we are reasoning and we have standards we need to meet. And they are still walking out there into a nursing setting where they are part of the time still expected to be handmaidens and to swallow what's being given to them by the predominant medical situation. (Metropolitan, community-based, RN for 13 years)

The stereotypical nurse in a tight, short uniform looking adoringly at the handsome young doctor is not an uncommon depiction of nursing and belies the work responsibilities of contemporary nurses. Several informants described the myth of the 'easy' nurse, 'available' and sexy:

... the perception by the outside community that as a nurse you were 'easy' for an affair, was very annoying... I was the youngest of the occupational health nurses and there was a general perception that you were, fair game, you were available, you were ready, you were willing. (Metropolitan, community-based, RN for 24 years)

I wonder though whether that professional respect is existent in hospitals or whether it is like it was when I did my training and nurses were - particularly with the consultants - the nurses were just there to do the consultant's bidding and - I can remember the old ward rounds when the sister, the charge nurse, used to run after the consultants and pick up after them or that sort of stuff. (Metropolitan, community-based, manager, RN for eight years)

DISCUSSION

The in-depth interviews constituted an effort to recognise and understand the context in which the complex social interactions of harassment occurs in order to build awareness and a richer understanding of the issues (Taft 1987).

There seems to be little consensus about an identifiable SB&SH phenomenon. Stockdale and Hope describe it as a 'messy' concept (1997, p.355). Harassment challenges the way in which individuals think about themselves and others. Analysing SB&SH from a symbolic meaning perspective enables an understanding of the importance of interventions to reduce and eliminate harassment being based on knowledge of interactional and contextual issues. Contextual issues affect the way harassment is constructed as a personal and social issue with consequences that are not static, but continue to evolve.

The incidents of harassment, as well as the context in which they occur, vary with the harasser as well as the harassed. Informants were able to describe some common conditions that surround their experiences of harassment. The silence that surrounds SB&SH, the lack of

professional support and education, as well as the perpetuation of stereotypes and myths have been highlighted as particularly problematic.

Despite extensive research, national and international media attention, and onerous legal sanctions, RNs describe a silent, unsupportive workplace replete with negative stereotypical expectations. Nurses have been unable to translate the plethora of available information to the Australian health care workplace. Organisational policies and procedures do not seem appropriate or 'user friendly' to the RNs in this study. Few use them.

Consequences of assertive and direct action when confronted with sexual harassment are nebulous at best under the circumstances described. Despite their own discomfort and angst, informants felt abandoned, fearful and alone. This is not a good frame of reference for assertive action.

There is confusion among meanings that society has attached to SB&SH. On the one hand, the media sensationalise the issue causing people to link SB&SH with the courts, litigation and a few high visibility financial settlements. Not only are the issues often sensationalised, but they are dealt with superficially and generally. On the other hand, RNs in this study failed to see the efforts of most large organisations to promulgate policies and procedures regarding harassment and seemed able to disassociate themselves from the media hype.

For these informants there existed an articulate and almost passionate revulsion to the experience of harassment. Yet harassment evoked a passive inaction and what seems to be an almost disinterested response from others. RNs do not see the issue taken up by their professional journals, present in their educational curriculum, or on the agenda of workplace meetings.

Furthermore, construction of the event takes place in organisations that seem uninterested in reducing or eliminating harassment and within a hierarchy which is viewed as unlikely to support the harassed.

Informants described the many roles and stereotypes used to explain the harassing behaviour. Few of these roles and stereotypes are linked to contemporary nursing or society. Nurses may have moved beyond the myth of handmaiden, sex goddess and mother, but seem to remain in the process of reinventing or reconstructing themselves.

Not only are nurses talking about a high impact experience, but they are also struggling with words, descriptions, embarrassment and fear. To construct a meaning for their harassing interaction, much of their efforts needed to be directed toward minimising or explaining it away as not harassment. Given that their literature, professional organisations and employers did not speak to them about harassment and were seen as unsupportive, why would the RN 'confront' the issues, much less the harasser? When they did recognise 'something was amiss', they were usually overloaded

with emotional and physical responses. In the midst of personal physical and emotional anguish they were quick to develop rationalisations to explain their own behaviour as well as the behaviour of the harasser. Powerful entrenched socially constructed stereotypes provided a necessary framework to support the RNs' explanations. Possible strategies and appropriate tools to use when confronted with harassment were not part of the nurses' armamentarium.

Implications for policy and change

Few would argue with the idea that structural forces are in place that impact on SB&SH. For the informants, the experience of SB&SH in the workplace was closely linked to male:female. Although the employer/employee relationship, the doctor/nurse relationship and other roles were a part of the harassing interaction, the meanings that these informants attached to their roles as women was the most imperative. During the interview process informants would be describing their behaviour as a nurse, employee or work mate, but would return or revert to their most familiar and comfortable base, 'female' and 'male', 'women' and 'men'. Men are in decision-making roles in most organisations, the legal system is predominantly male oriented, and our university hierarchies are male dominated. Health care organisations are led largely by male executives and medical practitioners. The scarcity of females in these roles contributes to a lack of understanding of the scope and impact of sexual harassment in the health care workplace. These structures must change to achieve a reduction or elimination of harassment in the workplace.

The current desire, not merely to tolerate diversity in the workplace, but to welcome it should help attenuate some of the entrenched patriarchal value system. Cultural and social diversity can work slowly to open up patterns of employment and work practices to new and more open ways of thinking. Legislation to this end should be supported and any effort to reduce or restrict diversity in the workplace should be exposed.

Many of the implications associated with this research project are not new. What may be new is the imperative to act. It is evident that much work remains to be done to rid the Australian health care workplace of sex-based and sexual harassment. This study has confirmed the

seriousness of the problem and identified the unmet need for extensive, high visibility education.

Education must begin in health programs that spawn our health professionals and continue in individual workplaces throughout Australia. Open discussion among and between professional groups is essential as an initial step in the educational process.

The starting point for education must be at the most basic level of information about harassment and proceed to the more complex social, cultural and interactional issues identified here. Research and publication on the topic must be encouraged and financially supported.

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